Expanding the Use of HIV Prevention & Care Peer Support Models in Connecticut

A briefing paper prepared by the Connecticut HIV Planning Consortium

August 31, 2017

Summary. Peer support models inspire and motivate patients to improve their health outcomes and quality of life through by engaging individuals in the service delivery system who can apply their first-hand knowledge, perspective, and experiences (e.g., social, emotional) of a disease with the patient population. Peer support models produce several benefits for healthcare delivery systems that improve patient experience, patient outcomes, and more effectively address health inequities and racial disparities often seen in diseases such as HIV. The Connecticut HIV Planning Consortium (CHPC) acknowledges that HIV peer support models hold a valuable place within the HIV prevention and care delivery system as well as within other population-based health efforts (e.g., mental health, diabetes, infant mortality). Connecticut, like many other states, offers training to become a peer support staff person, chief among which includes a recent effort to increase the number of Community Health Workers. Training represents one component of effective peer support models. This paper offers resources and recommendations for how the HIV prevention and care service delivery system can accelerate and scale the use of peer support models.

Context and Purpose

The Connecticut HIV Planning Consortium (CHPC) exists to reduce the rate of HIV infections in Connecticut and to increase access to appropriate services for Persons Living with HIV (PLWH) and individuals affected by HIV.

The CHPC convenes diverse stakeholders, including persons living with HIV (PLWH), for the specific purpose of creating a coordinated statewide prevention and care system. The CHPC takes a leadership role in developing Connecticut's Integrated HIV Prevention and Care Plan (2017 – 2021).[1] The "Plan" complies with federal HIV prevention and care funding requirements, aligns with the National HIV/AIDS Strategy, and positions the state to achieve relevant objectives identified in Healthy People 2020.

The Plan identifies four primary goals: 1) Reduce new HIV infections; 2) Increase access to care and improve health outcomes for PLWH; 3) Reduce HIV-related disparities and health inequities; and 4) Achieve a more coordinated statewide response to the HIV epidemic.

The Plan specifically identifies the use of peer support models as an important method to improve health outcomes and reduce health disparities associated with HIV. This paper offers resources and recommendations for how the HIV prevention and care service delivery system can accelerate and scale the use of peer support models.

Definition of Peer Support

Peer support refers to people helping each other by sharing knowledge and experience as well as providing emotional, social or practical support.

A peer supporter makes a personal commitment to his or her own personal health and receives training and guidance to help others. Peer support models can improve patient outreach and engagement, and improve the level of trust and confidence by patients in the healthcare delivery system.

[11] To access a copy of the plan, visit: https://websites.godaddy.com/blob/6f36156c-17cd-4a7b-b98b-6cbc58d07b94/downloads/1bhv7cmsh_640488.pdf?00657a61

Individuals suffering from traumatic conditions, including PLWH, can benefit from appropriate and high quality peer support. Peer supporters inspire and motivate others to take action on improving their health outcomes and quality of life.

The most effective way to reduce stigma is through direct, personal contact with the stigmatized group.[2]

Peer supporters can help PLWH come to terms with their HIV status through one-on-one, private conversations as well as in group support processes. A powerful incentive for a peer supporter to stay well relates to his/her position as a role model for others. Research shows that "peer support workers feel empowered in their own recovery journey (Salzer & Shear, 2002) have more confidence and self-esteem (Ratzlaff *et al.*, 2006) and a more positive sense of identity, feel less self-stigmatization, have more skills, more money and feel valued (Bracke *et al.*, 2008)."[3]

A Bridge to Strengthen Peer Education

Peer support models contain a natural overlap with peer education strategies. Peer education strategies disseminate accurate and relevant information and encourage activities that promote health, especially in high risk populations and populations experiencing chronic diseases. Peer education models leverage the impact of peers within their own social networks to influence knowledge, attitudes and behavior.[4]

Peer educators receive expert training in specific subject matter(s), and share information among their peers to influence change among members of the same group.

Understanding the health impact of HIV as well as the impact of general health and risk behaviors plays a critical role in health outcomes, life expectancies, and quality of life for PLWH. For example, research shows that: 1) HIV co-infection with HCV increases the risk of death for patients with AIDS by 50%. Liver-related cause of deaths was five times higher than in people who are not co-infected with hepatitis C; and 2) one third of the HIV/HCV co-infected persons were unaware of their hepatitis C infection.[5]

A meta-analysis of studies has shown that HIV/HCV co-infection increases the risk of death by about 35%.[6] The negative impact of HCV on HIV survival rates emphasizes the need for screening, linkage to care, treatment and ongoing harm reduction related to HCV.

Impact of Peer Support Models

Numerous fields (e.g., mental health, substance use) use peer support models.[7] The Substance Abuse and Mental Health Services Administration defines a specialty model that includes peer support as a means to achieve "whole health" or to integrate primary care settings.[8]

Peer support models produce significant impact on a variety of outcome measures, chief among which include reaching vulnerable populations and improving health outcomes. For example:

- The Pierce County Washington Regional Support Network employs certified peer specialists. Since the program's implementation, hospitalizations over five years were reduced by 31.9%; 30-day admissions were reduced by 32.1%; and

[2] University of Colorado 2015, Dimensions: Peer Support Program Toolkit, University of Colorado Anschutz Medical Campus School of Medicine Behavioral Health & Wellness Program, Anschutz. https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf
3 Implementing Recovery through Organisational Change, J. Repper *et al.*, 2013. Visit: http://yavee1czwq2ianky1a2ws010-wpengine.netdna-ssl.com/wp-content/uploads/2013/06/5ImROC-Peer-Support-Workers-Theory-and-Practice.pdf
[4] UNAIDS 1999, Peer Education and HIV/AIDS: Concepts, uses and challenges, Report of a Consultation, UNAIDS, Geneva.
5 (Carter, M. Co-infection with hepatitis C increases mortality risk by 50% for patients with AIDS, Clinical Infectious Diseases: 06 May 2012; Branch AD et al. Mortality in HCV-infected patients with a diagnosis of AIDS in the era of combination anti-retroviral therapy. Clinical Infectious Diseases, online edition, 2012).
[6] www.aidsmap.com/outcomes and prognosis
[7] International Association of Peer Supporters. Visit: https://inaops.org/definition-peer-specialist/
[8] Visit: http://www.integration.samhsa.gov/workforce/team-members/peer-providers#General

the state average for inpatient days per thousand decreased by 22.5%.

- *Project Wall Talk*, implemented in 36 Texas State Prison Units, was a community-based and peer-led HIV prevention education program. Inmates participating in the programs reported decreases in high-risk sexual partnerships and injection drug use and needle sharing upon release; more use of community services in the first few months after release; positive changes in attitudes for condom use, and other positive outcomes.[9]

- A Whole-Health Peer Support pilot program aimed to promote engagement and foster recovery among elderly individuals with comorbid mental health conditions yielded significant health outcomes, including: 70% decrease in hospitalization, and 62% reduction in length of stay.[10]

- A research team from the University of Alabama at Birmingham examining peer support interventions among rural, low income African Americans in Alabama living with diabetes, as well as other peer projects, found that peer support interventions (as compared to usual care) had a 55% probability of being *cost-saving* and from a societal perspective, a 55%-93% probability of being *cost-effective*.[11]

- Peer support programs in New York and Wisconsin have been developed to assist individuals covered by Optum as they transition from the hospital to the community. The following outcomes were identified when comparing six months pre- and six months post-treatment data: significant decreases in the use of inpatient services; significant decreases in the number of inpatient days; and significant decreases in overall behavioral health costs per person.[12]

Peer Support Roles and Responsibilities

Job Titles

Peer supporters may be paid or volunteer their time. Diverse job titles exist for peer support providers. Some titles include the use of the word "peer" while others do not. Job titles that do not use the term "peer" must explain the peer support model clearly in the job description. Examples of job titles associated with peer support models include:

- Community Health Worker
- Health Navigator
- Peer Health Coach
- Peer Health Specialist
- Peer Wellness Coach
- Peer Wellness Specialist
- Peer Health Navigator
- Peer Support Specialist
- Peer Provider
- Peer Counselor
- Peer Educator
- Peer Mentor
- Consumer Case Manager
- Peer Advocate
- Peer Leader
- Lay Health Advisor
- Consumer provider

9 AIDS Education and Prevention, 18(6), 505, 2006, The Guilford Press. Visit: http://assets.donordrive.com/aidsfoundationhouston/files/cms/100/1632.pdf
[10] AIDS Education and Prevention, 18(6), 505, 2006, The Guilford Press. Visit: http://assets.donordrive.com/aidsfoundationhouston/files/cms/100/1632.pdf
[11] Peers for Progress, Economic Analysis in Peer Support. Visit: http://peersforprogress.org/wp-content/uploads/2015/04/150417-economic-analysis-in-peer-support.pdf
[12] Optum, Peer Support Services Improve Clinical Outcomes by Fostering Recovery and Promoting Empowerment, 2016. Visit: https://www.optum.com/content/dam/optum3/optum/en/resources/white-papers/PeersImproveOutcomes.pdf

The Connecticut HIV Planning Consortium prefers peer support provider job titles that focus primarily on peers who use their personal experience with HIV in the service of improving the HIV care and treatment of people living with HIV/AIDS (PLWHA)[13], in alignment with the following resource identified on page three (3): Building Blocks to Peer Program Success: A toolkit for developing HIV peer programs.

Primary Responsibilities

The primary job responsibilities of peer support providers vary according to priority populations. For peer supporters who serve PLWH, responsibilities may include but are not limited to:

- *HIV Testing,* including rapid testing and client follow-up
- *Engagement, Linkage and Retention to Care*, including conducting community outreach and engaging clients
- *Patient Navigation,* including sharing materials, conducting facility tours, and informing new clients of services
- *Client Self-Management*, including working with a team to help clients meet self-management goals
- *Harm Reduction, Syringe Access, and Health Promotion,* including referring to clients to educational resources and researching relevant community information
- *Support Groups*, including marketing a support group, recruiting clients to join, and serving as a facilitator
- *Supportive Services,* including working with a team to identify supportive services, assisting clients with scheduling appointments, and accompanying clients to supportive service appointments.
- *Case Conferencing,* such as providing a brief summary of their work with a client, including reporting on psycho-social issues, barriers, or facilitators to care
- *Facilitating Client Involvement in Continuous Quality Improvement Efforts,* including participating in quality improvement (QI) activities and actively participating in efforts to improve an organization
- *Health Coverage,* including identifying local resources that can assist clients with health coverage
- *Documentation & Record-Keeping,* including following agency policies for handling client records[14]

The CHPC recommends that peer support providers hold competencies in at least the following areas:[15]1) Roles and responsibilities of a peer supporter and what constitutes a "peer"; 2) Confidentiality and privacy; 3) Culture competence and cultural sensitivity; 4) Fundamental knowledge of HIV; 5) knowledge of available HIV services and resources; and 6) Documentation relevant to record tasks.

Knowledge, Skills and Abilities

Individuals interested in becoming part of a peer support model will show a clear connection to the community and a motivation to help their community. The community may be geographic, cultural, and/or relevant to a population-based health issue. Effective peer supporters communicate well and show compassion, authenticity, and empathy.

[13] https://careacttarget.org/sites/default/files/file-upload/resources/BuildingBlocksPeerProgramSuccess2009.pdf
[14] *Bulleted items:* New York State Department of Health AIDS Institute, 2015: Core Competencies for HIV Peer Workers. Visit: https://www.hivtrainingny.org/FAQDocs/corecompetencies-hivfinal-october2015.pdf
[15] Peer support providers may also need competencies specific to the job title.

Peer supporters must be civil, respectful, and non-judgmental, and honor relevant confidentiality and privacy policies associated with their sponsor organization.

Peer supporters must show the capability to work on teams and to work in an individual, self-directed manner. Dependability, reliability, and passion create a strong foundation for success.

Peer Support Training

Organizations that use peer support models tend to require peer support providers to complete training that is specific to the expected responsibilities of the job. The process to become a peer support provider differs by state and by industry sector. Some states use a formal process to certify peer support providers (i.e., competency-based testing) before allowing a peer support provider to perform specific job responsibilities.

> *Structured peer support models train individuals to identify, engage, listen, educate, teach, coach and/or counsel on a variety of issues such as health topic specific, navigating the healthcare system and communicating with healthcare providers, among others.*

The Community Health Worker (CHW) certification training represents the initial commitment to train[16] peer providers in a more meaningful way to improve the quality of care, improve health outcomes and reduce health disparities. The American Public Health Association defines community health workers (CHWs) as:

> *Frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison … between health / social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.*[17]

Financial support from a Statewide Innovation Model grant supported the development of curriculum. The Area Health Education Centers (AHEC) lead this effort and offer training through the AHEC network statewide an in collaboration with community colleges in Bridgeport, Hartford, and New Haven.

Numerous individuals have completed the CHW training and received a certification. However, the CHW training does not (yet) include any HIV specific prevention or care training.

- The Connecticut Department of Public Health (DPH) now offers curriculum modules on core competencies for workers in the HIV field. This content holds relevance to building a peer support provider training model.
- The Department of Mental Health and Addiction Services (DMHAS) continues to encourage individuals working in the prevention workforce to secure their certification as a Prevention Specialist.

Common ground exists across these efforts to create a robust pipeline and career pathway options for peer support providers across the health care industry.

Toolkits and Resources

Research and efforts to improve the efficacy of peer support models has resulted in a growing base of tool

[16] Other well-intentioned efforts exist to hire "peers" in outreach-related positions. Employers cannot ask questions about medical status, among others. Holding a hiring preference differs significantly from developing a pipeline of trained peer support providers who can use the jobs as a stepping stone along their career pathways – simultaneously helping themselves and others.
[17] https://www.apha.org/apha-communities/member-sections/community-health-workers

kits and best practices to create an environment in which peer support providers flourish. For example:

- Building Blocks to Peer Program Success: A toolkit for developing HIV peer programs. Visit: https://careacttarget.org/sites/default/files/file-upload/resources/BuildingBlocksPeerProgramSuccess2009.pdf
- DIMENSIONS: Peer Support Program Toolkit. Visit: https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf
- Peer Education and HIV/AIDS: Concepts, uses, challenges. Visit: http://www.unaids.org/sites/default/files/media_asset/jc291-peereduc_en_0.pdf
- Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. Visit: https://www.mentalhealthamerica.net/sites/default/files/Peer_Services_Toolkit%204-2015.pdf.

Financing and Reimbursement

Leaders in the healthcare industry continue to advocate for mechanisms to finance peer support models. For example, a mechanism exists to receive Medicaid billing for the delivery of peer support services.

The timeline shows milestones associated with Medicaid billing for the delivery of peer services.

1999 Georgia became the first state to use Medicaid billing for peer support services.

2007 The Center for Medicare and Medicaid Services (CMS) sent guidelines to states on how to receive reimbursement for services delivered by peer providers.

2012 Georgia received approval to bill for a peer "whole health and wellness service"[18]

2013 CMS issued Clarifying Guidance on Peer Services Policy to states that any peer provider must complete training and certification by the state before providing billable services.

2014 CMS expanded the practitioners who can provide Medicaid prevention services beyond physicians and other licenses practitioners, at a state's discretion, to include peer providers.

Peer providers must complete training and certification (approved) by the state. A formal process has begun to emerge in Connecticut (described above in certification and training).

A Call to Action

In conducting thorough research on these models, the CHPC acknowledges a sense of responsibility in promoting peer support models across the state and in response to population-based health issues. We urge you to do the same.

Only through educating others on the validity of peer models and the success of such models in healthcare settings will our state's landscape truly adjust to accommodate, promote, and fund them.

Peer support models represent a promising and underutilized solution toward ending the HIV epidemic and in addressing many other health disparities. The CHPC commits to further promotion, exploration, expansion, funding and implementation of peer-driven models in its 2018 Update to Connecticut's 2017 HIV Prevention and Care Plan.

[18] Peer support providers completed training by Whole Health Action Management (WHAM). WHAM uses an in-person, 2-day group training that equips peer providers to help the people they serve set and achieve whole health goals to improve chronic health and behavioral health conditions. The WHAM training is available in Spanish.

The CHPC recommends specific actions within the HIV funding community to expand peer support models. These recommendations as well as the resources in this paper represent a "starting point" for those interested in adapting peer models, a significant step toward reducing health disparities and promoting and improving overall health.

Recommendations

The CHPC recommends expanding peer support models in HIV prevention and care. The recommendations focus on PLWH, persons at risk of HIV transmission, and/or persons affected by HIV.

The recommendations are designed with flexibility to apply to the prevention population (individuals at high risk); individuals living with HIV and Hepatitis C Virus (HCV) co-infection; and others, including discrete healthcare populations such as mental health and diabetes patients.

Organizations implementing peer support models should tailor the specific parameters of the model to fit the needs of an organization, align with available community resources, and address the priority population(s) within the community.

1. Identify funds to field test peer support models in three areas of the state (selected to align with the Plan): a) Ryan White Part A - New Haven and Fairfield Counties; b) Ryan White Part A Transitional Grant Area – Hartford, Tolland, and Middlesex Counties; and c) Balance of the state (BOS).

2. Align performance measures of peer support models to specific HIV indicators and outcomes identified in the Plan. Attachment A shows more information on all CHPC Indicators. Priority areas may include: a) CHPC Indicator #3 - Viral Load Suppression among Persons in HIV Medical Care; b) CHPC Indicator #5 - Retention in HIV Medical Care; and/or c) CHPC Indicator #11 - Disparities in New HIV Diagnoses.

3. Require organizations that propose the operation of peer support models to demonstrate readiness and commitment to the peer support model by considering a thorough range of questions across significant themes. Attachment B outlines these themes such as: a) buy-in; b) organizational values; c) roles and responsibilities; d) program and policy development; and e) community engagement.

4. Identify key steps and categories for orienting and training staff, both peer and non-peer. Attachment C for a comprehensive list of 11 recommended competencies, including priority competencies such as confidentiality and privacy, and cultural competence and cultural sensitivity.

5. Provide capacity building and technical assistance support to organizations implementing peer support models. This includes: a) Creating and maintaining a learning community to share best practices; b) Continuous quality improvement process (not just monitoring) and support tools; and c) Access to national and/or in-state experts (including funding for training peers)

6. Engage in field building efforts to support adoption and sustainability of peer models beyond prevention and care by: a) Developing standard curriculum, training modules and a delivery system; b) creating an environment to support Medicaid billing for peer support providers and to increase the financial viability of HIV service organizations – positioning them to support other (non-HIV) chronic disease prevention and management initiatives; and c) Integrating peer support work into other relevant workforce development efforts (e.g., substance abuse prevention, CHW, peer education / chronic disease management)

Contact for More Information

For additional information, contact Gina D'Angelo at the Connecticut Department of Public Health: Tel: 860-509-8130 (telephone) or gina.dangelo@ct.gov (e-mail).

CHPC Indicator	2015 goal	Met	2021 goal
1. HIV Positivity Rate (Biological): Number of newly diagnosed (dx) in the 12-month calendar year per 100,000 people.	315 newly diagnosed	√	218 newly diagnosed
2. Seropositivity Rate (Service / Access): Number of OTL and ETI HIV positive tests in the 12-month calendar year.	0.2% ETI; 0.3% OTL	√	0.2% ETI; 0.3% OTL
3. * Viral Load Suppression Among Persons in HIV Medical Care: Number of persons with an HIV diagnosis with a viral load <200 copies/ml at last test in the 12-month calendar year.	85%	√	90%
4. Linkage to HIV Care (Biological): Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis.	90%	√	95%
5. * Retention in HIV Medical Care (Service / Access): Number of patients who had at least one HIV medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period.	65%	√	70%
6. Late HIV Diagnoses (Late Testers) (Biological): Number of people who had their first HIV positive test less than 3 months before receiving AIDS diagnosis.	35%	√	25%
7. Antiretroviral Therapy Among Persons in HIV Medical Care (Service / Access): Number of persons with HIV diagnosis who are prescribed ART in the 12-month calendar year.	95%	√	97%
8. Partner Services (Service / Access): Number of newly diagnosed interviewed (i.e., linked) by Partner Services.	95%	√	95%
9. Housing Status (Service / Access): Number of persons with an HIV diagnosis who were stably housed in the 12-month calendar year.	80%	√	85%
10. Syringe Services Program (SSP) (Service / Access) 10a: Number of SSP clients served: (Baseline: 3,642 [YR 2015]) 10b: Number of syringes collected: (Baseline: 356,112 [YR 2015]) 10c: Number of syringes distributed: (Baseline: 369,665 [YR 2015])	**N/A**	**N/A**	10a: **4,000** 10b: **450,000** 10c: **500,000**
11. * Disparities in New HIV Diagnoses: Number of newly diagnosed (dx) in the 12-month calendar year for each of the following: Men who have sex with men (MSM), Black/African American/Latino men and women.	**N/A**	**N/A**	Reduce new HIV dx by 15% for each priority population.

Questions to Consider re: Organizational Readiness

Staff, Peer and Stakeholder Buy-in

Current staff:

□ How will peers enhance or challenge the jobs of current staff?

Peers:

□ How will their relationships with staff and clients be impacted when they become paid professionals rather than volunteer peers or clients?

Key providers in the community:

□ How will providers work with peers?

□ What are providers' concerns or challenges about working with peers? (Develop strategies to address them)

□ How will current clients be informed about the program? How might current clients feel about the program?

Key stakeholders and non-formal community groups (i.e. providers, donors, board members):

□ How will stakeholders work with peers?

□ What are stakeholders' concerns or challenges about working with peers and/or strategies to address them?

□ Can leadership demonstrate how they will promote and/or fundraise for peer programs?

□ Can leadership demonstrate how they will continue to support and sustain programming?

□ Will stakeholders work to promote and market the peer program?

Organizational Values

Organizational Foundation:

□ Does the organization's Mission Statement reflect its mentality and capacity regarding peer model implementation (e.g., align with recommended indicators, place emphasis on outreach)?

□ Does the Mission Statement distinguish it from other organizations?

□ Is the organization's work consistent with and driven by its Mission Statement?

Value of Peers:

□ Are peers valued equally with other staff at the organization?

□ How is a peer's life experience valued?

Challenges and benefits of incorporating peers:

□ What do you predict as the challenges of incorporating peers?

□ What do you predict as the benefits of incorporating peers?

□ Can the benefits outweigh the challenges?

□ Identifying Funding Sources and Other Financial Issues

Salaries for peers:

□ Will your organization provide fair and equitable living wage with benefits for peer staff?

Roles and Responsibilities

- □ Is your organization prepared to develop and implement / conduct the following: 1. Job descriptions; 2. Criteria-based evaluation; 3. Training for the position; 4. Provide adequate supervision; 5. Monitor and teach necessary competencies.
- □ Is your organization prepared to recruit, hire, integrate and implement the peer role into the existing operations of the organization?
- □ Can your peers protect their needs as consumers while advocating in organizations where they also receive services? ("If I complain about treatment my client got, will my own doctor / case manager be mad?")

Developing Programs and Policies

- □ Is the leadership of the organization ready to accept a peer program?
- □ Will the peers have a role in decision making? What will their role be?
- □ How can peers communication between the client and the organization / administration (e.g., participate on quality management team, participate on care team, provide input to care team)?
- □ Are devices in place for clients to express concerns to peer workers, and for peer workers to advocate for their clients in a professional manner?
- □ Is the organization prepared to spend extra time on professional development for peers?
- □ Is staff familiar with ADA requirements?

Community Engagement

- □ Is community engagement part of the organizational culture?
- □ Is your organization visible in the community?

Recommended Peer Roles & Responsibilities

Adapted from Building Blocks to Peer Program Success

- □ Engaging and supporting HIV-positive persons in the management of the disease
- □ Providing psychosocial support to clients
- □ Supporting clients to practice health behaviors and promoting health behaviors
- □ Identifying HIV-positive persons in the community and linking them to care
- □ Helping PLWHA navigate the service system and access care and treatment services
- □ Providing community awareness, advocacy and prevention education
- □ Advising programs on all aspects of service delivery

Recommended Core Competencies - Adapted from Building Blocks to Peer Program Success

* denotes high-priority competency; these have been "ranked" by the CHPC Needs Assessment Projects Team

- "What is a peer?"*
- Culture & cultural competence*
- Confidentiality*
- Asking tough questions
- Basics of counseling & motivational interviewing
- Meeting all barriers to learning
- Creating & setting appropriate boundaries
- Communication skills: verbal & non-verbal
- Responding to conflict
- Workplace relationships & etiquette
- Self-care