Qualitative Analysis of Peer Coaches' Experiences with Counseling African Americans About Reducing Heart Disease Risk

Frances K. Barg, PhD MEd[1,3,5], Mark G. Weiner, MD[2], Shelly Joseph, BA[6], Kavita Pandit, BA[7], and Barbara J. Turner, MD, MSEd[4]

[1]Department of Family Medicine and Community Health, University of Pennsylvania School of Medicine, Philadelphia, PA, USA; [2]Division of General Internal Medicine, University of Pennsylvania School of Medicine, Philadelphia, PA, USA; [3]School of Arts and Sciences, University of Pennsylvania, Philadelphia, PA, USA; [4]University of Texas Health Science Center and University Health System, San Antonio, TX, USA; [5]University of Pennsylvania, Philadelphia, PA, USA; [6]College of Medicine, SUNY Downstate, Brooklyn, NY, USA; [7]School of Medicine, University of Pennsylvania, Philadelphia, PA, USA.

BACKGROUND: Despite mounting evidence that peer coaches can make significant contributions to patient health, little is known about factors that must be addressed to engage and retain them in their role.

OBJECTIVE: To identify motivators and barriers to serving as a peer coach.

DESIGN: Open ended semi-structured interviews.

PARTICIPANTS AND SETTING: In a randomized trial of peer support, patients with well controlled hypertension and good interpersonal skills were recruited and trained to serve as peer coaches for African-American patients from the same practices who had poorly controlled hypertension. Peer coaches spoke by telephone at least three times with their same sex patient–clients on alternate months during the 6-month intervention and counseled about medication adherence as well as other healthy lifestyles.

KEY RESULTS: Of 15 trained peer coaches, ten were contacted and agreed to participate in the qualitative interview. Peer coaches had a mean age of 66 years, 50% were women, and 80% were African-American. Themes regarding favorable aspects of the peer coach experience included: meaning and satisfaction derived from contributing to community health and the personal emotional and physical benefits derived from serving as a peer coach. Negative aspects centered on: challenges in establishing the initial telephone contact and wanting more information about their patient–clients' personal health conditions and status. Peer coaches endorsed gender matching but were less clear about race-matching.

CONCLUSIONS: Programs that utilize peer support to enhance positive health behaviors should recognize that a spirit of volunteerism motivates many successful peer coaches. Program planners should acknowledge the special characteristics required of successful peer coaches when selecting, motivating and training individuals for this role.

Electronic supplementary material *The online version of this article (doi:10.1007/s11606-011-1883-6) contains supplementary material, which is available to authorized users.*

Received January 26, 2011
Revised July 21, 2011
Accepted August 25, 2011
Published online September 28, 2011

KEY WORDS: peer coach; peer counseling; navigator; risk counseling.
J Gen Intern Med 27(2):167–72
DOI: 10.1007/s11606-011-1883-6

INTRODUCTION

When individuals confront a distressing physical problem, they typically turn first to a lay family member or community-based friend instead of a health care professional.[1] This "therapy management group" of friends, family and neighbors offers health advice and referral information that is grounded in many unspoken, shared understandings about lifestyle, health values and health care preferences.[1] Over the last decade, health care programs have increasingly incorporated peer coaches, also known as community health workers, navigators, or *promotoras*, to counsel and support peers in achieving desirable health behaviors. Numerous studies have documented peer coaches' beneficial role in assisting patients with cancer screening and treatment,[2–7] diabetes control,[8] and blood pressure control.[9,10] Lay persons who have been trained as peer coaches can be especially effective as counselors for persons from minority or lower socioeconomic groups.[3–8] Peer coaches can provide a valuable practical support in health care settings that serve as safety nets for vulnerable populations.[11,12] Peer coaches who share a similar community background and sources of health care as their patient–clients may have greater credibility because they have achieved treatment goals despite needing to overcome similar circumstances and barriers.[13]

Despite mounting evidence of the beneficial role for peer coaches in improving patient care, surprisingly little is known about the personal experience of serving as a peer coach. We conducted a qualitative study of the challenges and personal benefits experienced by individuals who worked as peer coaches in the Heart Health Trial, a randomized controlled trial of peer coach telephone counseling combined with office-based, staff counseling for African-American primary care patients with poorly controlled hypertension. This qualitative examination of the experiences of a group of peer coaches offers insights into the motivations, benefits and barriers to serving in this capacity and may help inform the structure

and content of programs that use peer coaches in this important adjunctive role.

METHODS

Trial Overview

The Heart Health Trial is a randomized controlled trial designed to improve hypertension control and reduce cardiovascular risk in a sample of African-American patients with uncontrolled hypertension in two urban primary care practices neighboring a largely African-American, low income community. The practice-based intervention implemented aspects of the chronic care model including an electronic medical record-based patient registry, team-based management, and community engagement. In this trial, African-American patients with sustained uncontrolled hypertension over a two year timeframe were identified from a registry of patients with hypertension. Eligible consenting patients were randomly assigned to a six-month intervention of bimonthly telephone calls from trained peer coaches from the same practice or community alternating with bimonthly office-based visits with trained professional staff to address barriers to cardiovascular risk reduction. The peer coaches called their assigned patient–clients at least once on alternate months.

Recruitment of Peer Coaches

We asked physicians from study practices to select potential peer coaches who had the following characteristics: African-Americans aged 50 – 75, with well controlled hypertension, good communicators, adherent to medical care, and likely to serve in a motivational role. Of 20 nominated patients, 12 agreed and 11 completed the training program that was developed in consultation with an advisory board of six local African-American community members. Two peer coaches coached one or two patients and withdrew, finding counseling uncomfortable. Subsequently, another four peer coaches withdrew; two due to personal time commitments and two later withdrawals due to health problems. Four replacements were recruited from study practices (one of whom was not African American) or from volunteers in our local American Heart Association (AHA) chapter. Of these four replacements, one decided not to participate after completing training, but before being assigned a patient-client. A flowchart describing the recruitment, retention and withdrawal of peer coaches is included as Figure 1.

Peer Coach Training Program

Peer coaches attended two half-day training sessions where they viewed 12 illustrated slide shows created by the study team about CHD in the community and risks (e.g. unhealthy food, lack of exercise, non-adherence to medications, tobacco use) as well as practical ways to reduce risks and improve blood pressure control. An outline of the training program, and sample slides are included in the online appendix (Appendix 1 and 2.)

The content of the program was structured by the Theory of Planned Behavior (TPB) and focused on changing patient attitudes through evidence-based advice, influencing social norms by role modeling successful behaviors, and increasing perceived behavioral control with practical tips and links to community resources. An experienced lead peer coach demonstrated telephone etiquette and support techniques. Peer coaches reviewed a suggested conversation guide but adapted it to their own conversational style after practicing in two simulated phone calls with study physicians or the lead peer coach. This conversation guide is included in the online Appendix as Appendix 3. Peer coach telephone calls to patient–clients lasted 15 to 30 minutes. Progress toward agreed-upon goals was addressed by the project team and/or lead peer coach during subsequent phone calls at bimonthly intervals. Peer coaches discussed challenges and successes during conference call or face-to-face meetings at six month intervals during the two year study. A lead peer coach with previous experience also contacted all peer coaches at least once a month to review progress, trouble shoot problems, offer support, and identify areas to refine the study procedures. The peer coaches were reimbursed at $20 per completed call or a total of $60 for all calls to each patient-client.

For this paper, towards the end of the study, qualitative, semi-structured telephone interviews were conducted with 10 peer coaches who had participated in the Heart Health Trial. Eight of these remained active through the end of the trial and two had stopped taking patient–clients because of health problems. To reduce social desirability bias, the interviewer (FKB) was not involved in the trial and the peer coaches were assured that their responses would be de-identified and reported only in the aggregate. The interview consisted of a series of open-ended, semi-structured questions designed to elicit information about: facilitators and barriers to the peer coach role; qualities necessary for effective coaching; need for support in serving as a peer coach; and recommendations for the peer coach role in future projects. Interviews with peer coaches were audio taped, transcribed, and entered into NVivo 8.0 software for analysis.

We used a modified Grounded Theory approach for our analysis. In addition to standard Grounded Theory practice in which we coded transcripts based upon key ideas that emerged during a close reading of the text, we also applied an a priori set of codes based upon our study question.[14] We achieved saturation of central themes after eight interviews. This project was approved by the University of Pennsylvania Institutional Review Board.

RESULTS

Of the 15 trained peer coaches, ten agreed to participate in the qualitative interview. Of these, eight peer coaches were actively participating in the study at the time of the interview. The interviewed peer coaches had a mean age of 65 years, were evenly represented by gender and the majority were African-American. Equal numbers were employed versus retired. The peer coaches had served an average of one year in this role and coached an average of 11 patient–clients each. One outlier was the lead peer coach who had counseled 38 patient–clients. Excluding the lead peer coach, peer coaches counseled an average of eight patients each over the course of their

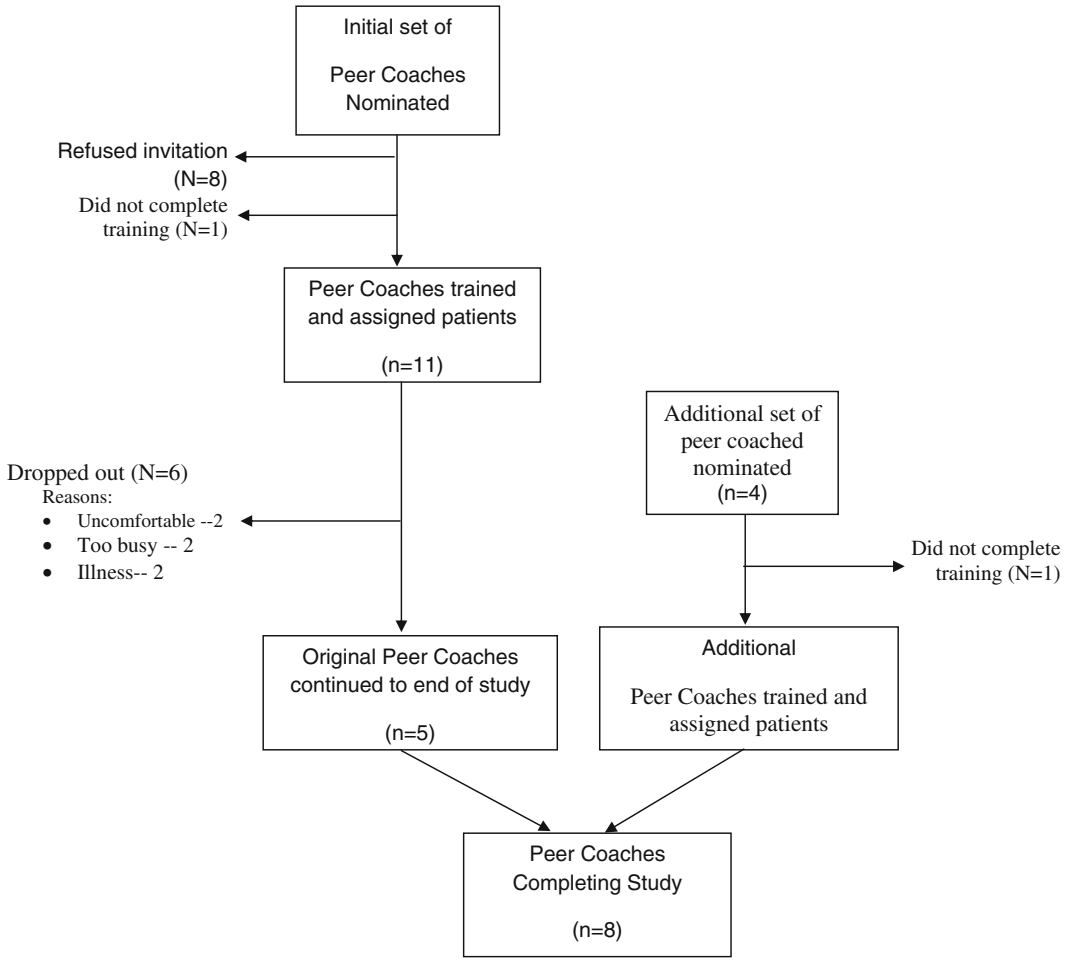

Figure 1. Recruitment and retention of peer coaches.

participation. Two main themes emerged in regard to the benefits of serving as a peer coach: contributing to community health and improving personal health. A third theme related to the challenges of serving in this role. Quotes that illustrate these themes can be found in the on-line appendix.

Contributing to Community Health

Our qualitative analysis of interviews revealed several strong personal benefits that the peer coaches attributed to serving in this role. Most peer coaches reported that serving as a peer coach offered an opportunity to fill an important complementary role to that of the primary care physician. Peer coaches felt that their role was motivational and educational in nature. By describing their own approaches to self-management and healthy living, supplemented by information learned in their training sessions, the peer coaches believed that they were able to help patient–clients to identify specific strategies to improve adherence to medications and adopt healthier habits. However, the peer coaches also readily differentiated their own role from that of the primary care physician and thought that their advice was far more practical than that of the physician. They emphasized that the physician was simply too busy to address many specific challenges to patients in adopting healthier lifestyles. Therefore, the physician could in essence, offer more support to the patient through the coach. They felt that they were able to empathize better with the patient–clients' situation and were proud that their own struggles with hypertension control and other healthy behaviors could benefit others.

Many peer coaches were willing to make additional calls to their patient–clients to foster stronger relationships and support. Several peer coaches even reported making additional calls to patient–clients during holidays or around the time of a medical appointment or procedure. Peer coaches felt that they had a real connection with their patient clients.

Although the peer coaches received $20 for each call, they affirmed that their participation was primarily driven by a nonfinancial motivation. Participation afforded an opportunity to "give back" to their own community by educating others about ways to improve their own health. Two peer coaches stated that, as African-Americans, it was important to them to be able to offer support to other African-Americans. Additionally, a majority of the peer coaches thought that this position helped them to repay their personal "debt" of gratitude to their own physician in the practice.

Improving Personal Health

The peer coaches also believed that this role had greater impact on their lives than they would have experienced by

participating in other volunteer jobs. They believed that their personal understanding of how to manage hypertension and reduce their cardiovascular risk through a healthier lifestyle had greatly increased after their training program and the experience they gained by counseling others. In addition to the satisfaction derived from promoting behavioral change, peer coaches commented about the personal emotional and health benefits of becoming part of a community of lay health advisors who shared the same challenges as members of their own community. They derived tremendous satisfaction from being part of this group through conference calls and real-time feedback from the clinical project team.

Challenges of Serving as a Peer Coach

The positive aspects of serving as a peer coach were counterbalanced by difficulties in engaging patient–clients. The peer coaches expressed unanimous frustration with the need to make multiple attempts to establish an initial contact with assigned patient–clients even after a research assistant had recruited and informed them about the upcoming call. That initial contact often required leaving multiple messages to find a good time to reach the patient-client. However, the peer coaches discovered that, once contact had been established and a relationship started, subsequent communication came with greater ease. This frustration was ameliorated to some extent when peer coaches learned at support sessions that others shared the same difficulty.

Peer coaches also expressed dissatisfaction about being poorly informed about their patient–clients' age and risk factors such as tobacco use. Peer coach believed they should have received more information regarding specific clinical conditions such as elevated cholesterol, severity of hypertension, and types of medications. They felt that such information would have made their phone calls more efficient and relevant to their patient–clients' conditions and concerns.

At times, patient–clients became emotional during counseling sessions. Peer coaches felt that they were equipped to handle patient–clients' concerns, but these contacts frequently required an extensive time commitment. Peer coaches benefitted from a list of resources and real-time feedback from project staff when they encountered issues outside their expertise.

All the peer coaches greatly appreciated the guidance provided by the lead coach. She regularly contacted all the peer coaches to inquire about their progress and to make specific recommendations to handle challenges based on her experience. Several peer coaches praised the benefits of having a strong relationship with this leader, including learning from and being comforted by her advice and collegiality. The peer coaches found that troubleshooting specific challenges with her, such as establishing the initial contact with patient–clients or a particularly difficult interaction, was especially beneficial and helped to normalize their experiences.

DISCUSSION

Our qualitative study offers insights into factors that engage and retain potential peer coach candidates. It adds to the existing literature on peer support in several ways. First, it adds a new dimension to our understanding of the experience of peer coaches who are trying to change lifestyles. The most successful role to date for peer coaches has been in increasing receipt of appropriate breast, prostate [15] or colorectal cancer screening [16]. Navigators have also played a prominent role in helping patients follow up abnormal cancer screening tests. However, motivating peers to get a screening test is a very discrete goal whereas it is much more challenging to help peers to change daily life patterns. Second, our study highlights the importance of altruism and the opportunity that peer coaching provides that allows the coach to give back to the community and their care provider. Our results also add a discussion about the challenges peer coaches face regarding confidentiality issues and the importance of gender and race concordance.

The participation of peer coaches in this peer support program to reduce cardiovascular risk and improve blood pressure control in a minority patient population reflects a spirit of volunteerism. Volunteers subjugate their own personal interests for the cause at hand but also gain personally from the process of giving to others. According to the enlightened self-interest construct described by Frimer and colleagues[17], volunteers are motivated by benevolent impulses that inspire one to reach out and care for others while still achieving self-gain needs such as learning about one's own condition. Thus, according to this construct, peer coaches can be seen as individuals who wish to improve the health of individuals in the community who are not succeeding in meeting treatment goals but who also have their own personal needs that they would like to meet. Indeed our qualitative interviews found that the benefits of serving this role fell into two categories improving the health of the community and improving one's personal health.

It clearly takes a special personality type to be willing to reach out to strangers. However one peer coach admitted that, even though he was not an outgoing person, he felt that this position offered a special opportunity to connect with strangers. We found that of 20 individuals who were suggested by their physicians as being potentially interested in this role only 12 initially accepted and 11 went through the training process. Then five did not continue throughout the study. We were not surprised to find that only about one out of two nominated individuals were willing to adopt this role and then half of these individuals were willing to persist. In finding replacements for individuals who dropped out we turned to contacts in the practice and our local American Heart Association volunteer network. It makes sense to find individuals who are willing to promote the health of the community in the context of organizations that already have that mission.

Our results reveal that, when recruiting peer coaches, personal benefits can be invoked. Enlightened self-interest means that by helping others one can also help oneself. Similar to other studies of neighborliness and volunteerism[18], peer coaches increased their connections to their community networks and their social capital. It also provided them with an opportunity to create meaning for themselves out of their own illness experience. By having struggled with medication adherence and other health problems, individuals can reinforce their own positive behaviors while educating others.

With the exception of the lead peer coach who was white and lived outside the immediate urban area of the practices, coaches were African-American, had hypertension, and lived

in the same community as their patient–clients. This congruence between the life experience, medical condition, and health care setting of the peer coaches and their patient–clients enabled the peer coaches to convey empathy while offering credible, practical advice about overcoming similar barriers to those experienced by the patient–clients. Being a patient in the same primary care practice also provided an impetus to take on this challenging responsibility. Peer coaches spoke passionately about their gratitude to their own primary care physicians for the gift of improved health that their physicians had given them. Serving as a peer coach offered a way to return this valued gift.

The research team was also able to highlight that serving as a peer coach should be regarded as an honor because they were selected for their success in hypertension control and their physicians thought they would be excellent communicators.

Surprisingly, the approach of recruiting peer coaches from the same practice settings has been adopted infrequently in peer coach interventions.[19] In our study, the peer coaches expressed a conviction that they had become bona fide members of the health care team, offering special and unique contributions. The peer coaches thought that their counseling and support services were complementary and additive to advice provided by the physicians, whom they all acknowledged, did not have the time to offer this information. Indeed, the recently enacted Patient Protection and Affordable Care Act endorsed peer or community health worker programs by naming this type of position as one of the components of the nation's health care workforce.[20] Peer coaches can promote culturally competent care for patients and may be uniquely motivational as role models. In particular, community outreach is a key aspect of the chronic care model, which underpins many aspects of the chronic disease management support that is provided by the peer coach role as we have defined it.

A significant challenge will be finding ways to incorporate peer coaches as practice extenders while still respecting the confidentiality of patients' personal health information. We found that the peer coaches in our study thought their effectiveness was hampered by having insufficient personal health information about their subjects. Patient confidentiality requirements, however, must be respected. Because the patient–clients and peer coaches came from the same practices, we thought it was important that contact should be only by telephone to avoid embarrassment by meeting in the office. However, at the end of our project, we held a dinner for peer coaches and their patient–clients (who elected to come) and these reunions were very well received. Future work needs to evaluate the extent of the in person contact between peer coach and patient-client.

The importance of training and support for peer coaches cannot be overemphasized. Knowing facts about heart disease prevention, being aware of resources in the community, learning "delivery tips" from peers and from the lead coach were necessary to give the peer coaches the confidence and tools that they needed to be effective in this role. As other studies have described, training programs often offer inadequate support in dealing with clients' interpersonal issues.[21,22] Our peer coaches stated that these skills were as important, if not more so, than the content-oriented skills they were taught. Training programs should also provide a realistic picture of the coaching role. The peer coaches who participated in training but dropped out of the program before completing their first contact were unprepared for the time commitment and demands of extending themselves to strangers who might not welcome their initial attempts to connect. While it is difficult to screen for the right personality type who will be appropriate for this role, the training program should provide ample opportunity for the coach to gain a realistic picture of the challenges ahead and for the program leaders to develop insight into the trainees' strengths and weaknesses.

While there is some evidence that gender and race concordance are important to successful provider-patient relationships[23–25], it is not known whether gender and race concordance is required for successful patient-coach interactions. Our Community Advisory Board insisted that we attempt to match on both race and gender. Two of our peer coaches said that they felt that being African American and working with African American clients helped them feel that they were giving back to their own community, but none stated that it was essential to understanding the challenges the patient–clients faced. In addition, our lead coach was white and lived in the suburbs. She was universally admired for her ability to support and understand the other peer coaches, all but one of whom were African American. She was also successful in working with African American client-patients. The importance of demographic concordance, and the exact characteristics on which to match, should be an area for future research. The character of the individual who serves is likely to be the dominant determinant of success in this role.

While other studies have described peer coaches being worried that clients might ask them to perform duties beyond their scope,[26] this was not a problem for the peer coaches in this study. Some peer coaches acknowledged that significant emotional and personal support was occasionally sought by the patient-client, requiring lengthy phone calls. Approaches to dealing with boundary issues need to be addressed by the training. Peer coaches described the need to know when to triage issues that are outside their purview. Close collaboration with the clinical practice is required to help peer coaches with these more clinical or other demanding issues.

There are several limitations to our study. We were unable to contact one current peer coach and five peer coaches who were no longer participating in the study. In particular, those who dropped out of the study likely had less positive experiences from serving in this role, and possibly greater personal discomfort in reaching out to strangers. Peer coaches with daytime jobs or other family commitments did not want to take on this position, especially when facing personal health issues themselves. However, additional qualitative studies need to be conducted with peer coaches who fail to continue in this role.

When recruiting individuals to serve in the peer coach role, program planners should emphasize both the altruistic value and the personal benefits of greater positive health maintenance behaviors to the participant. Peer coach retention may be enhanced by strong peer support, continuous training and feedback, and rapid response to clinical questions.

Funding Source: *Funded by the Robert Wood Johnson Foundation Informing Disparities Program*

Prior Presentations: *Material included in this paper was presented in a poster session at the SGIM meeting in Minneapolis, MN, April 2010.*
The authors wish to acknowledge the contribution of the Mixed Methods Research Lab (MMRL) at the University of Pennsylvania, Department of Family Medicine and Community Health, in the management and analysis of the data.

Conflict of Interest: *None disclosed.*

Corresponding Author: *Frances K. Barg, PhD MEd; University of Pennsylvania, 141-2 Anatomy and Chemistry Building, 3620 Hamilton Walk, Philadelphia, PA 19104, USA (e-mail: bargf@uphs.upenn.edu).*

REFERENCES

1. **Feierman S, Janzen JM, eds.** The social basis of health and healing in Africa. Berkeley: University of California Press; 1992.
2. **Donelan K, Mailhot JR, Dutwin D, et al.** Patient perspectives of clinical care and patient navigation in follow-up of abnormal mammography. J Gen Intern Med. 2011;26(2):116–22.
3. **Steinberg ML, Fremont A, Khan DC, et al.** Lay patient navigator program implementation for equal access to cancer care and clinical trials. Cancer. 2006;107(11):2669–77.
4. **Hiatt RA, Pasick RJ, Stewart S.** Community-based cancer screening for underserved women: design and baseline findings from the breast and cervical cancer intervention study. Prev Med. 2001;33 (3):190–203.
5. **Jandorf L, Gutierrez Y, Lopez J, Christie J, Itzkowitz SH.** Use of a patient navigator to increase colorectal cancer screening in an urban neighborhood health clinic. J Urban Health. 2005;82(2):216–24.
6. **Perac-Lima S, Grant RW, Green AR, et al.** A culturally tailored navigator program for colorectal cancer screening in a community health center: a randomized, controlled trial. J Gen Intern Med. 2009;24 (2):211–7.
7. **Ferrante JM, Chen P, Kim S.** The effect of patient navigation on time to diagnosis, anxiety, and satisfaction in urban minority women with abnormal mammograms: a randomized controlled trial. J Urban Health. 2008;85(1):114–24.
8. **Heisler M, Piette JD.** "I help you, and you help me": facilitated telephone peer support among patients with diabetes. Diabetes Educ. 2005;31:869–79.
9. **Vale M, Jelinek MV, Best JD.** Impact of coaching patients on coronary risk factors: lessons from the COACH program. Dis Manag Health Outcomes. 2005;13(4):225–44.
10. **Douglas JG, Bakris GL, Epstein M.** Management of high blood pressure in African Americans: consensus statement of the hypertension in African Americans working group of the international society on hypertension in blacks. Arch Intern Med. 2003;163:525–41.
11. **Freund KM.** Patient navigation: the promise to reduce health disparities. J Gen Intern Med. 2010;26(2):110–2.
12. **Phillips CE, Rothstein JD, Beaver K, et al.** Patient navigation to increase mammography screening among inner city women. J Gen Intern Med. 2010;26(2):123–9.
13. **Thoits PA.** Social support as coping assistance. J Consult Clin Psychol. 1986;54(4):416–23.
14. **Charmaz K.** Grounded theory: objectivist and constructivist methods. In: Denzin NK, Lincoln YS, eds. Handbook of qualitative research. Thousand Oaks: Sage; 2000.
15. **Wells KJ, et al.** Innovative approaches to reducing cancer health disparities: the moffitt cancer center patient navigator research program. J Cancer Educ. 2011; epub ahead of print.
16. **Turner BJ, et al.** Overcoming poor attendance to first scheduled colonoscopy: a randomized trial of peer coach or brochure support. J Gen Intern Med. 2008;23(1):58–63.
17. **Frimer JA, Walker LJ, Dunlop WL, et al.** The integration of agency and communion in moral personality: evidence of enlightened self-interest. J Personal Soc Psychol. 2011;101(1):149–63.
18. **Haski-Leventhal D, Ben-Arieh A, Melton GB.** Between neighborliness and volunteerism. Fam Community Health. 2008;31(2):150–61.
19. **Heisler M, Vijan S, Makki F, Piette JD.** Diabetes control with reciprocal peer support versus nurse care management: a randomized trial. Ann Intern Med. 2010;153(8):507–15.
20. Patient Protection and Affordable Care Act of 2010 Public Law 111–148, 24 Stat. 119 (March 23, 2010)
21. **Meir ER, Olson BH, Benton P, Eghtedary K, Song WO.** A qualitative evaluation of a breastfeeding peer counselor program. J Hum Lact. 2007;23(3):262–8.
22. **Nguyen TN, Jacqueline TH, Marjorie K, Mary AF.** A qualitative assessment of community-based breast health navigation services for Southeast Asian women in Southern California: recommendations for developing a navigator training curriculum. Am J Public Health. 2011;101(1):87–93.
23. **Blanchard J, Nayar S, Lurie N.** Patient-provider and patient-staff racial concordance and perceptions of mistreatment in the health care setting. J Gen Intern Med. 2007;22(8):1184–9.
24. **Kneipp SM, Lutz BJ.** Means. Reasons for enrollment, the informed consent process, and trust among low-income women participating in a community-based participatory research study. Public Health Nurs. 2009;26(4):362–9.
25. **Street RL, O'Malley KJ, Cooper LA, Haidet P.** Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. Ann Fam Med. 2008;6(3):198–205.
26. **Hilfinger Messias DK, Moneyham L, Vyavaharkar M, Murdaugh C, Phillips KD.** Embodied work: insider perspectives on the work of HIV/AIDS peer counselors. Health Care Women Int. 2009;30(7):572–94.