7. EVALUATING PEER PROGRAMS

A goal without a plan is just a wish.

Antoine de Saint-Exupery
(1900 – 1944)

Introduction

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

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

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

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

EVALUATING PEER PROGRAMS

TIP

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

This section will help to answer the following questions:

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

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

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

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

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

FOR MORE INFORMATION

Read More for Section 7

- Differences between program evaluation and quality assurance and improvement

Additional Evaluation Subsections

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

Resources for Section 7

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

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

7. EVALUATING PEER PROGRAMS

READ MORE: EVALUATION VS. QUALITY ASSURANCE

Differences Between Program Evaluation and Quality Assurance and Improvement

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

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

[1]Patton, Utilization Focused Evaluation, 1997

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

This "Read More" section accompanies Section 7, Evaluating a Peer Program, part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit

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

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

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

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

Identifying Outcomes

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

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

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

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

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

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

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

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

5 KEY EVALUATION QUESTIONS
(from HRSA/HIV/AIDS Bureau)

1. **Assessing Unmet Need**: "To what extent are Care Act programs identifying HIV-infected populations who are not in primary health care (not accessing available services)? To what extent are grantees identifying HIV-infected populations who are not remaining in primary health care and the reasons for this lack of continued service utilization?"

2. **Removing Barriers to Care:** "Are grantees determining the specific reasons why individuals are not in care and removing barriers to their care? What are the providers doing to enroll and retain identified underserved populations in primary care?"

3. **Optimizing Local Service Delivery Systems**: "Have CARE Act grantees identified the most effective combinations or models of integrated services that improve the use of primary health care, taking into account the characteristics of local health care delivery systems and affected populations?"

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

5. **Adapting to Change:** "To what extent are CARE Act grantees adapting their service priorities and allocations to a changing and sometimes chaotic health delivery system and reimbursement environment?"

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

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

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

Evaluation Questions

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

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

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

TIP

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

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

Evaluation Question #1: Assessing Unmet Need

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

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

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

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

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

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

Short-term outcomes may include:

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

An **intermediate outcome** may be:

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

L**ong-term outcomes** may include:

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

Evaluation Question #2: Removing Barriers to Care

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

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

Example: In a community-based organization (CBO), the outcomes and goals of a peer program may be slightly different. For example, case managers often have to struggle to meet all the needs of their clients. A peer program component may help to facilitate the work of case managers in delivering support services to clients. (See Read More: The Smith County Service Program for a sample evaluation plan.)

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

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

Intermediate outcomes may be:

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

Longer-term outcomes may be:

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

Evaluation Question #4: Providing Quality Care

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

EVALUATING PEER PROGRAMS: CHOOSING OUTCOMES FOR PEER PROGRAMS

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

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

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

Outcome indicators may be:

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

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

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

Next Steps

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

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

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

▶ FOR MORE INFORMATION

Read More for Subsection 7.1

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

Additional Evaluation Subsections

- 7 Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
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- 7.6 Protection of human subjects and evaluation

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- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachussetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

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

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: HRSA INDICATORS

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

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

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

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

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: IMPROVE RETENTION IN CARE

The ABC Clinic's Peer Program

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

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

Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.1 Link at least 60% of those newly diagnosed with HIV by the Counseling & Testing sites (C &T) to HIV primary care at the clinic within 90 days of receiving test results	• Outreach peers attend weekly Counseling & Testing sessions with C &T staff • Outreach peers make initial introduction and appt for case management services • Outreach peers inform C & T sites that referrals are completed	• Outreach peers • Counseling & testing sites	• Number/demographics and time to entry to care at the clinic • Number of HIV-positive referrals to outreach peers from rapid HIV testing • Number of HIV newly diagnosed with at least 2 case management appts in 6 months time	Process: • Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Referrals logs	Reduce unmet need for HIV care & services

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: IMPROVE RETENTION IN CARE

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

Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.2 Link at least 60% of out-of-care clients from community partner sites to clinic services	• Outreach peers respond to referrals from other partner sites • Outreach peers link out-of-care clients to case managers at clinic and CBO partners	• Outreach peers • Community partner sites	• Number /demographics and time to entry to care at the clinic • Number of HIV-positive referrals to outreach peers from community partner sites • Number of HIV-positive clients with 2 case management appts. in 6 months' time	Process: • Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Referrals logs	Reduce unmet need for HIV care & services
1.3 Provide HIV primary care and social support services to 30 newly diagnosed persons living with HIV, 100 out-of-care clients and 1000 currently enrolled HIV-positive clients	• Adherence peers w/case managers develop care & treatment plan for HIV-positive clients • Adherence peers make follow up phone calls for HIV medical visits, lab tests and case management appts • Adherence peers accompany HIV-positive clients to HIV social and medical visits as requested	• Adherence peers • Case managers at clinic and CBO partners • Clinic staff	• Number/demographics of HIV-positive clients with care & treatment plan • Number/demographics of HIV-positive clients who achieve care & treatment plan goals • Number/type of services referred and used by HIV-positive clients • Number/demographics of HIV-positive clients with at least 2 medical visits in measurement year (both on ART and those not on ART) • Number/demographics of HIV-positive clients (both on ART and those not on ART) with at least 2 CD4 and viral load lab tests in measurement year	• Chart audits • Client surveys- HIV Patient satisfaction survey • Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Case manager treatment plans completed	• Reduce barriers to care • Increase in number of clients with undetectable viral loads • Increase in number of clients with 2 or more medical visits

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: IMPROVE RETENTION IN CARE

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

Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.4 Provide adherence education to at least 600 HIV-positive clients in the clinic	• Adherence peers provide support to HIV-positive clients currently on ART • Adherence peers assess HIV-positive clients readiness for ART	• Adherence peers • Medical staff at clinic • Case managers	• Number of HIV-positive clients receiving ART education adherence sessions • Number of HIV-positive clients with ART assessments completed • Knowledge, positive behavior and attitude regarding ART for HIV-positive clients receiving counseling sessions	• Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Treatment adherence survey • Focus groups • Attendance lists	Increase in number of clients with undetectable viral loads

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

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: INCREASE ACCESS TO SERVICES

The Smith County Service Program (SCSP)

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

Goal: Increase HIV-positive clients' access to and engagement with support and medical services.					
Objectives	**Activities/Action Step**	**Person (s) responsible**	**Measures/Indicators**	**Evaluation Methods**	**Outcomes**
1.1 Provide at least 2000 outreach encounters to at-risk HIV-positive individuals targeting substance users, homeless persons, MSM, women, and communities of color	• Conduct at least 8 education and outreach activities at the agency and in the community per week. • Identify and build relationships with at least 8 other social service agencies (food agencies, housing organizations, substance treatment providers, etc) to outreach to at-risk populations. • Refer at-risk individuals to HIV counseling & testing at the clinic	Prevention Education coordinator and outreach workers	• Number of prevention education activities • Number and demographics of outreach encounters • Number of partner agencies conducting monthly prevention/ education sessions • Number of referrals to counseling & testing at the clinic	Process: • Encounter forms (see Sample forms for documenting peer work in Program Resources.) • Referral logs	• Reduced unmet need

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: INCREASE ACCESS TO SERVICES

Goal: Increase HIV-positive clients' access to and engagement with support and medical services.					
Objectives	**Activities/Action Step**	**Person (s) responsible**	**Measures/Indicators**	**Evaluation Methods**	**Outcomes**
1.2 Provide at least monthly case management services to 100% of HIV-positive newly diagnosed or lost-to-follow up individuals referred from the clinic	Hold monthly meetings with clinic staff to identify newly diagnosed or lost-to-follow-up HIV-positive clients.	• HIV case management supervisor • Peer • Case manager • Clinic staff	• Number/ demographics of HIV-positive clients referred and enrolled in HIV case management services • Number of HIV-positive clients with case management plans and service goals • Number/types of services provided	• Case manager treatment plans completed	• Reduced barriers to care for newly diagnosed & lost-to follow-up
1.3 Provide weekly support groups to 80% of HIV-positive clients	• Conduct at least 2 groups/week around HIV care and treatment adherence, positive living, resources, and other consumer-identified topics • Recruit HIV-positive clients into support groups	• Peer leader • Staff support group leader • Program Manager	• Number and topics of support groups • Number of HIV-positive clients who attend support groups	• Client surveys (see HIV patient satisfaction survey in Program Resources.) • Focus groups • Attendance lists	• Improvement in self-reported quality of life

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: INCREASE ACCESS TO SERVICES

Goal: Increase HIV-positive clients' access to and engagement with support and medical services.					
Objectives	**Activities/Action Step**	**Person (s) responsible**	**Measures/Indicators**	**Evaluation Methods**	**Outcomes**
1.4 Link 80% of HIV-positive clients into medical and social support services	• Conduct reminder and follow-up phone calls regarding medical and social service appts • Accompany HIV-positive clients to medical & social service appts	• Peers • Case Managers • Clinic staff	• Number of HIV-positive case-managed clients with at least 2 medical visits in measurement year • Number of clients with CD4 & VL tests	• Chart audits • Client surveys • Peer Educator Encounter forms • Treatment plans completed	• Increase in number of clients with 2 or more medical visits in a 12-month period • Increase in number of clients with CD4 & VL tests

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

7.2 EVALUATING PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

"It may be a model, Captain, but it's highly illogical."

www.FieldstoneAlliance.org

Logic Models: What are they and why would anyone besides Mr. Spock care? on http://www.fieldstoneAlliance.org

Many public service programs rely on logic models for program planning. Logic models are particularly useful for focusing evaluation activities and identifying program indicators to be measured, because they present a systematic, graphic representation of program resources, activities, and outcomes, and articulate the intended links among these program components.

While the visual scheme of a logic model may vary, it will always contain the following core components:

Inputs are the resources necessary to undertake program activities. Inputs are primarily material and human resources; non-material factors that enhance a program's ability to fulfill its goals may also be included in resources. Examples of non-material inputs include public support for a program from a Ryan White Planning Council or consumer advisory board; long-standing referral networks that facilitate case management; or a series of public presentations to build support for a new initiative.

Activities include the necessary steps of all phases of program implementation and the types of services provided. Hiring processes and the establishment of community partnerships are crucial activities in early phases of program development, as are providing adequate training and supervision of staff. Service-provision activities include conducting education and outreach, building relationships with social services agencies, referring at-risk individuals to HIV counseling and testing, and holding support groups on HIV care and treatment and positive living. Collecting data about program objectives, disseminating program results, and expanding the funding base are more significant activities during the evaluation phase of a mature program.

Outputs are the direct results of program activities, such as services delivered or tasks completed, which provide evidence of service delivery to the target audience as intended. Outputs may also be evidence of program development or structure, such as number of people hired, trained and supervised.

EVALUATING PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

Outcomes are specific, measurable changes that are linked to program activities and outputs. Such changes may occur in knowledge, skills, or behaviors of a program's target population. Outcomes are often measured as:

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

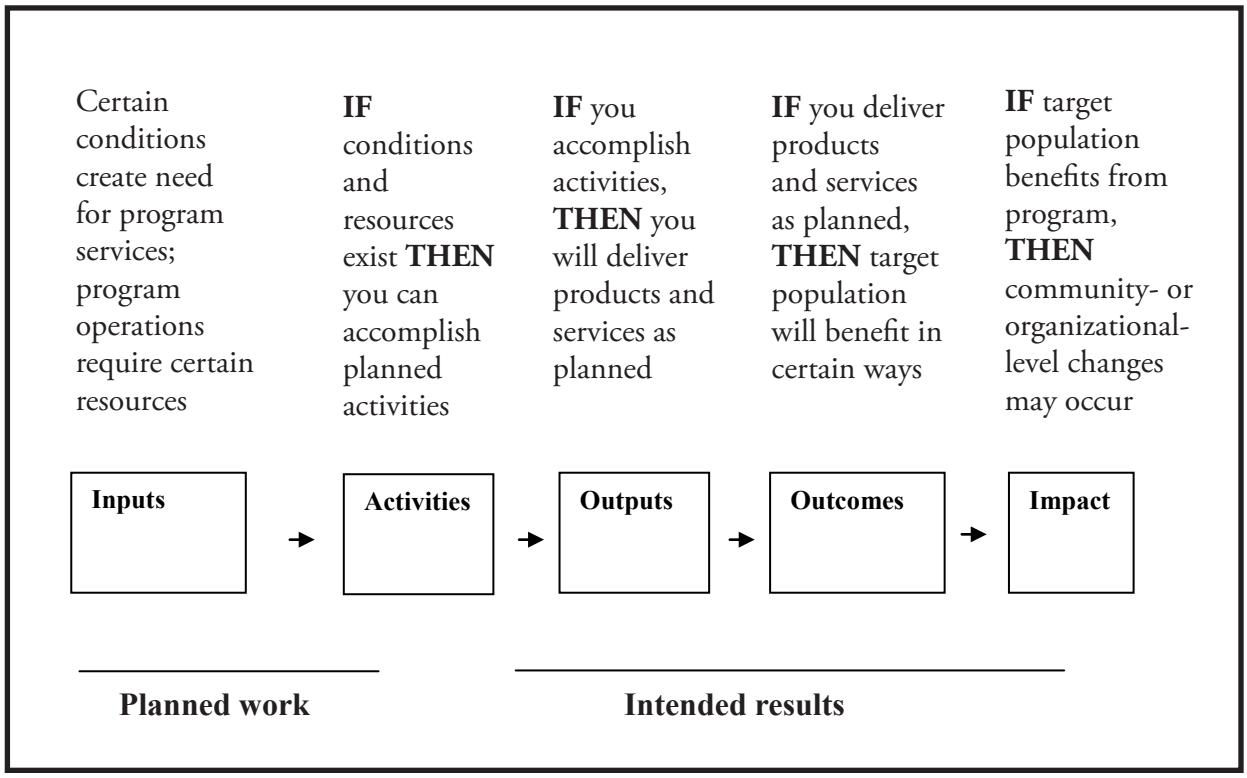
Outcomes reflect a program's objectives.

Impact is closely related to a program's ultimate goal, and identifies broad-ranging, fundamental changes linked to program efforts. Impact is felt only after short- and long-term outcomes have taken effect and may be dependent on factors beyond program outcomes or objectives.

The W.K. Kellogg Foundation describes the logic model as a series of "if – then" statements that map the intended road from program efforts to program results.

Process Evaluation and Logic Models

Creating a logic model helps inform and map out your program's evaluation plan by more clearly defining the goals, outcomes, and indicators of your program. Logic models create a link between outcomes evaluation and process or implementation evaluation. Process or implementation evaluations are used to document and assess the intended links between components



The logic model is a series of "if-then" statements that map the intended road from program efforts to program results.

Adapted from W.K. Kellogg Foundation, *Logic Model Development Guide* (Battle Creek, MI, 2004), p. 3

EVALUATING PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

of the logic model, and to help refine the list of indicators created during the outcomes evaluation. Process or implementation evaluation uses the logic model to assess:

- How resources are invested in activities.
- How activities result in outputs.
- How outputs promote intended short- and long-term outcomes.

Information generated by process-evaluation efforts highlights where the intended links among program components are weak or broken.

Below is a sample logic model for a clinic who wanted to implement a peer program to improve client engagement in care and adherence to HIV treatment.

Logic Model of the Smith County Service Program

Inputs	Activities	Outputs	Initial Outcomes	Intermediate Outcomes	Long-term Outcomes
Program space and supplies	Build relationships w/ community partners	Effective community partnerships	Increased testing opportunies	Reduced barriers to testing & care	Reduction in unmet need
Prevention educators and outreach workers	Conduct outreach & community education activities	Prevention education activities	At-risk ind'ls receive HRT		
	Refer at-risk ind'ls for counseling & testing				
Clinic staff	Identify lost-to-follow-up clinic pts. for outreach efforts	Referrals made	At-risk ind'ls use program services		Improved HIV medical outcomes
Case management team	Link clients to program case mgrs & peers	Clients linked to case management	At-risk ind'ls access medical & social services	Increased proportion of HIV-positive ind'ls within target area engaged in care	
	Provide case mgt for entry & re-entry into care				Increase in social service needs met
	Make follow-up reminder calls for medical & social service appts; accompany pts to appts	Follow-up services provided	At-risk ind'ls access medical & social services		
Peers	Facilitate support groups	Support groups held	Support group participants experience changes in knowledge & perceived social support	Support group participants experience changes in quality of life	Reduced experience of HIV-related stigma & discrimination
Evaluation team	Collect data related to program activities and outcomes	Program evaluation data collected	Program monitors activities	Program assesses outcomes toward stated outcomes or objectives	Evaluation of program success in meeting stated outcomes or program objectives

EVALUATION PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

▶ FOR MORE INFORMATION

Additional Evaluation Sections

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

Resources

- Sample forms for documenting peer work
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- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
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7.3 EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Two peers at Christie's Place

"You can't just use quantitative data to evaluate the impact of peers. You have to use more qualitative data... It's not just about T cells, CD4 count, making it to your doctors' appointments on time. That's a big part of it, but what are the other quality-of-life measures we can look at to talk about the impact of this work on women who are positive?"

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

Getting Started: Monitoring and Documenting Peer Work

Documenting peer work with clients can help the program understand how peers are contributing to the success of HIV services. Integrating documentation of peer work with existing documentation processes can facilitate tracking and monitoring of peer work and program evaluation. Whether the current processes are paper charts or electronic medical records or databases, investigating the feasibility of peers documenting their work directly into those systems can save time and resources. It also increases the likelihood that the work peers do will be utilized by other members of the multidisciplinary team and helps to integrate the peers into the team. This can be a challenging process. Issues related to 'ownership' of the data in the record (electronic or paper) will have to be addressed, as will issues surrounding confidentiality, HIPAA compliance and patient privacy. (See Subsection 7.6, Protection of Human Subjects and Evaluation.) Resolution of these challenges will depend upon many factors within the agency and program.

If documentation of peer work cannot be integrated into the existing process, then developing simple tools for peers is important. The design of these tools and the data collected will depend upon the work peers are doing and the outcome measures for the program. For example, peers who help with support groups may want to keep attendance or sign-in sheets to document the number of persons, their gender, and the topic discussed. Peers who work individually with clients may want to use a contact sheet that can be filed to document the activities the peer did with the clients, any referrals that were made, and the length of time spent on the activity. For peers who are working with clients around treatment adherence, maintaining logs or sheets that describe their work and the progress made with a client is another valuable data-collection tool. This information can then be collected on a monthly or quarterly basis to describe the type of work peers are doing with clients and identify areas that could be improved The Program Resources for Section 7 Evaluating Peer Programs provides data collection tools.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Data collection is an important aspect of peer program evaluation. Inaccurate data collection can impact the validity of the results of the project. Encouraging and training peers to consistently and accurately document their work with clients aids in the data-collection process. As peers work with clients, details of their work can be logged, either quantitatively or qualitatively, and this data can be monitored and compiled later on for analysis.

Data-Collection Methods: Qualitative vs. Quantitative

The first step is to decide the appropriate data collection method(s) for documenting and evaluating the peer program. Some methods assess how the peer program is contributing to overall HIV services at the agency. Other methods are more appropriate for identifying the impact of the program on peers and clients. Depending on the evaluation needs of the program, two types of data methods can be employed:

Qualitative Methods

Qualitative methods uses scientific procedures to collect non-numerical, in-depth responses about what people think and how they feel. Qualitative data is often gathered during in-person interviews, written questionnaires, or observation. These methods often involve purposefully selecting participants from a larger population to examine a specific question. The participants are not randomly selected. This method can give outside audiences a real, personal understanding of the difference that the peer program makes in the lives of people. These methods provide valuable insight into attitudes, beliefs, motives and behaviors that can help to determine areas for quality improvement and program development. Qualitative data can be used as a formative process prior to collect quantitative data and to serve as a guide to direct the evaluation process. Qualitative data can also be a stand alone method for program evaluation.

Examples of Qualitative Methods

Case Studies are detailed studies that document and present information on a particular participant or small group and frequently include the accounts of clients or peers themselves. The case study looks intensely at an individual or small participant pool, drawing conclusions only about that participant or group and only in that specific context. Emphasis is placed on exploration and description.

Advantages: Case studies fully depict the client's experience in the program process and results, and are a powerful means to portray the peer program to outsiders. For example, case studies may be useful for sharing and disseminating stories about how peers have helped clients with HIV medications.

Challenges: Case studies can be time consuming to collect, organize, and present. They represent a depth of information rather that a breadth of information.

Example: A program interviews a client of a peer to understand the client's experience with HIV care and treatment prior to working a peer, the motivation for seeking and working with a peer, and the impact the peer has had on the client's knowledge, attitudes and practices about HIV care and treatment.

Focus Groups are small groups (usually 6 to 10 members) brought together for guided discussions of a particular subject. The session usually lasts for 1 to 2 hours. A facilitator guides the group through a discussion that probes attitudes about client services. The discussion is loosely structured to allow for an open, in-depth examination of the thoughts and feelings of the clients. The facilitator is typically given a list of objectives or an anticipated outline to help guide the discussion. He or she will generally have only a few specific questions prepared prior to the focus group,

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Typically, for a new person, I give out a survey so I know a little bit about how much they know about the disease. We do that every three months so we can see what they have learned that they didn't know before.

Fred Glick
Peer Educator
Truman Medical Center,
Kansas City, MO

and these questions will serve to initiate open-ended discussions. Typically, a note taker is also present to record information by hand or with a tape recorder.

Advantages: Focus groups are a quick and reliable way to collect shared attitudes and feelings. They can be an efficient way to get a range and depth of information in a short amount of time and allow you to convey key information about the peer program.

Challenges: Information collected during focus groups can be difficult to analyze. A good facilitator is required to keep the group on track and for safety/closure. Also, participants of focus groups can be swayed by the comments made by other participants during the discussion, and therefore, data collected from focus groups may be more biased than interviews

Example: An agency that is just starting to design a peer program, invites and convenes a focus groups of 6-8 HIV-positive clients to learn about the strengths and challenges of peer programs and to collect ideas for peer roles that can help to improve the quality and efficiency of services.

Alternatively, a program may want to conduct a focus group with clients to identify successes and challenges in working with peers. The Program Resources for Section 7, Evaluating Peer Programs contain Focus Group Guidelines from the Kansas City Free Health Clinic and a Peer Focus Group Guide from the Massachusetts Department of Public Health.

Key Informant Interviews are in-depth interviews with people who have direct, personal experience with the program, such as peers or clients of peers. Many CARE Act grantees and planning groups use key informant interviews to obtain feedback on the adequacy of HIV services, gaps in care, and service barriers faced by different populations.

Advantages: Key informant interviews provide a full range and depth of information as well as help to develop a relationship with the interviewee. Additionally, follow-up questions can be included to clarify responses or to obtain additional details. Compared to focus groups, key informant interviews may yield more accurate information from participants, because interviews are typically

conducted one-on-one and in private, confidential settings. As a result, participants may be more willing to share their perceptions, knowledge and opinions.

Challenges: In-person key informant interviews can be time consuming and costly. It can be difficult to analyze and compare responses across interviews, and the potential exists for the interviewer to bias the information collected with his or her own perceptions or opinions.

Example: A program uses key informant interviews with clients to asses the role a peer played in a client's adherence to HIV care and treatment. The Program Resources for Section 7, Evaluating Peer Programs provides an Example of a Qualitative Study Design and Interview Guide.

Quantitative Methods

Quantitative methods use scientific procedures to obtain counts, percentages, and other forms of measurement data that can be subject to descriptive analysis or more rigorous statistical analysis. Quantitative data is often collected through closed-ended questions that require participants to count how many times an event has occurred or to rate their satisfaction using a numerical scale. These methods can gather data on a large, random sample of participants. This allows the data to be generalized to larger populations. However, quantitative methods often cannot collect in-depth, descriptive details on knowledge, attitudes, and beliefs of participants.

Examples of Quantitative Methods

Medical Record Reviews can be used to collect specific, predetermined data from medical / service records. Usually a pre-coded, medical record abstraction form is used to aid the review. This method is useful when a program wants to identify the impact of a peer program that works with clients around adherence to treatment or staying engaged in medical care. This program could examine the medical records of clients of peers every 6 months and see how many medical visits and CD4 and HIV RNA tests they have had since working with peers. This may be an appropriate method for clinic-based peer services. For peers in a community-based setting, obtaining client medical records requires additional work and must ensure that appropriate client consents are in place. For more information, refer to Subsection 7.6, Human Subjects Protection and Evaluation.

Advantages: Medical record reviews allow for comprehensive and historical information collection. In addition, the review does not interrupt the program or clients' routine by requiring them to answer questions. The systematic methodology of this data collection technique helps to avoid biases in the data collection process.

Challenges: Medical record reviews can be time-consuming and often information is incomplete. Sometimes it can be difficult to read medical records, and trained personnel may be needed to perform abstractions.

Example: At the Kansas City Free Health Clinic, 25-30 patient charts are randomly selected each month. The evaluation team reviews the charts and documents whether the client is in compliance with a specific indicator for engaging in medical care. Charts are examined to see if a client on ARV has had a primary care visit and a viral load and CD4 test in the past 4 months. This information is entered into a spreadsheet and submitted to the Manager or Director of the clinic department for quality management.

Written Questionnaires are documents containing a set of predetermined questions and other types of items (e.g., demographic information) designed to solicit information appropriate for analysis. Surveys often collect information on demographics and how many times services are used.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Advantages: Data retrieved from questionnaires can be compared much more easily across a large number of participants than data collected from interviews. Responses can be obtained in numerical form which makes statistical analysis possible. Most people are familiar with completing questionnaires, but skill is needed to design a good questionnaire that will result in reliable responses and ultimately provide valid results.

Challenges: Individuals are often not accustomed to communicating information through a questionnaire. Additionally, the questionnaire must be written at a literacy level that every respondent can understand and needs to be provided in the native language of the respondents.

Example: The Program Resources for Section 7 Evaluating Peer Programs provide an HIV Patient Satisfaction Survey for assessing client satisfaction with HIV services.

Face-to-Face questionnaires/Telephone questionnaires are structured conversations between two or more people (the interviewer and the interviewee(s)) where closed-ended questions are asked. Open-ended questions may be asked as well.

Advantages: Follow-up questions can be included in face-to-face and telephone questionnaires to clarify responses or to obtain additional details. Literacy may not be as great an issue as with a written questionnaire. Importantly, data from individual responses can easily be used to generate group-level summary statistics.

Challenges: Interviewers should be trained in appropriate, non-biased interviewing skills. In addition to training interviewers, designing an interview tool can be time-intensive. Sufficient time should be given to survey methodology.

Example: The Program Resources for Section 7, Evaluating Peer Programs provide an HIV Treatment and Adherence Survey that can be given to clients of peers who are involved in HIV treatment support groups or individual counseling sessions. These surveys may be administered quarterly or semiannually.

Management Information Systems (MIS) are the processes in place to systematically collect and assess data to assist with program quality improvement. For example, questionnaires and forms can be used to document the work completed by a peer with a client. The information can then be entered into an electronic database to track the services each client receives. Periodic reports (monthly or quarterly) on the data are run and submitted to a manager/director who may use the data to distinguish the types of activities conducted by peers, make adjustments to peer workloads, and detect gaps and additional service needs. In some places, peers may enter their work with clients directly into the client's electronic record or chart. In other cases, to protect confidentiality of the client, the data collected by the peer is entered into a separate database and then later linked with other client information.

Advantages: Utilizing a MIS system can help facilitate program quality monitoring and management. A MIS helps to process and assess the peer work and isolate areas for improvements.

Challenges: Peers will need to be trained to document their work and will require supervision to ensure the data is collected and submitted in a timely fashion. Maintaining a MIS may be time consuming and costly for peers and staff.

Example: The example in the box below describes one clinic's MIS for its peer program on treatment adherence.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

MANAGEMENT INFORMATION SYSTEMS (MIS) EXAMPLE

In a multidisciplinary, clinic-based ART-adherence-support program, peers actively reach out to their caseload of about 15 clients each in order to engage clients in care, help them identify and resolve barriers to becoming adherent, and help them build long-term adherence skills. Peers work collaboratively with the program case manager and health educator. Peers use a contact form to document all aspects of their work with clients in a user-friendly format. Refer to the Sample Forms for Documenting Peer Work in the Program Resources for Section 7 Evaluating Peer Programs for an example of a peer contact form.

- Date of contact
- Client code and peer code (using codes instead of names enables the system to merge peer-entered information with the larger database of client information while maintaining confidentiality)
- Type of contact
- Location of contact
- Life stressors addressed
- Referrals made
- Adherence questions addressed

Peers complete the form as soon as possible following each contact. The program coordinator reviews the contact forms weekly for completeness and discusses issues documented in the 'notes' section during bi-weekly individual peer supervision sessions.

The program's funding source requires that it report the number of peer-client contacts each month, along with other client indicators such as the number of HIV primary care and case management appointments kept, the most recent CD4 and HIV RNA measures, and any new diagnoses. Peer-client contacts are abstracted from peer contact forms each month and entered into the clinic's electronic information reporting system according to client ID. Monthly reports of patient-level program data are generated through the electronic system and submitted to the funder in accordance with funding requirements. Peer-client contacts become part of the client's chart and are reviewed by clinic staff as part of quality assurance and quality improvement efforts.

In addition to required reporting, the program evaluation team has determined to answer several program-specific evaluation questions and has identified corresponding indicators, collected from the peer contact form, that the program will track. The evaluation questions and indicators are:

Evaluation Questions	Evaluation Indicators
Do peers successfully reach program clients?	Ratio of successful contacts to attempted contacts
Do peer services address potential barriers to adherence?	Life stressors addressed
Do peers contribute to comprehensive service provision?	Referrals to program, hospital, and outside service providers
Do peers address adherence behavior in their interactions with clients?	Adherence questions addressed

The program case manager and health educator are responsible for entering evaluation indicators into a program evaluation database every week. The program coordinator generates reports summarizing the indicators every month and presents them to the evaluation team at monthly evaluation meetings. The evaluation team presents results at annual meetings with the program's stakeholders and advisors.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Anonymity and Confidentiality

During data collection, an individual's identity must be protected in order to prevent unintended risks or harm to the individual. Two techniques that are used to protect an individual's identity are anonymity and confidentiality.

Anonymity

A survey or questionnaire is anonymous when the survey administrator or evaluator cannot identify a survey respondent based on his or her responses to survey questions. For example, a mailed survey can be considered anonymous if the survey does not ask for personally identifying information, such as respondent name, and if it is sent without any personally identifying information on the survey or envelope. Anonymity makes it difficult to follow up with respondents who did not complete the survey, since there is no process to identify who has returned the survey/questionnaire. However, anonymity allows the respondents to feel more comfortable answering the survey, and in turn, provide more honest and accurate information.

Confidentiality

A confidential survey/questionnaire collects personally identifying information, but this information is not shared with anyone outside of the peer program. In other words, information from confidential surveys is presented anonymously, but not collected anonymously. For example, a respondent's response to missing their medication can be made public, but the individual respondent information remains private. This type of information is reported as aggregate data, or group data, but not by individual.

To ensure confidentiality, a number of procedures can be followed. First, individuals administering protocols and/or who have access to identifying information should be trained in their ethical responsibilities. (Refer to Subsection 7.6, Protection of Human Subjects and Evaluation for more information on training.) Second, all names, addresses, and any other personally identifying information should be removed from the questionnaires and replaced with an identification number or code. A master identification list should be created linking the identification number or code to the names and only used as necessary. For example, the master identification list can be used to correct missing or questionable information, or to send a follow-up questionnaire. This allows you to track down individuals who have not yet completed the survey or who have left parts of the survey incomplete or ambiguous.

It is important to inform the individuals participating in any form of evaluation whether their information is confidential rather than anonymous.

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- Validated evaluation instruments

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7.4 EVALUATING PEER PROGRAMS: ANALYZING AND DISSEMINATING EVALUATION RESULTS

Due to our peer navigators' assistance with contacting our no-show clients, our no-show rate is stable at 29%, which is a 10% improvement. Making sure that the majority of our clients are in here and receiving health care on an ongoing basis--that's success to us.

Lucy Wells
Business Manager/Ryan White Project Director
Boulevard Comprehensive Care Center
Jacksonville, FL

Once an evaluation design has been chosen, a logic model developed, and data collection strategies and continuous quality control methods are in place, the program can begin to explore the meaning of the information. The plan for the use of the data influences the type of analysis. Data analysis also depends on available resources such as staff with expertise and software for analysis. Data analysis can be as simple or rigorous as necessary to meet the needs of the program. Many programs conduct data analysis for internal purposes (quality management and program improvement) and reporting to funders. Others are interested in disseminating the results through publications and presentations to share results with the broader community. It's important to have a clear understanding of the use of the data prior to data analysis.

Data Preparation: Coding and Cleaning

Before beginning analysis, it is important to prepare the data. For quantitative data, an important first step in this process is data coding. If statistical software is available, it is necessary to assign numeric values to each response. For example, a "Yes" response can be assigned the number "1" and a "No" response can be assigned the number "0." Assigning numbers to character responses will aid the data entry process and will allow the software to run frequency counts more easily and efficiently. The end product is a codebook that will be used for labeling and tracking variables.

For all software programs, it is important to thoroughly check the data to ensure that it's free of errors after it has been entered. This process is called **data cleaning**. Cleaning data is usually conducted by someone other than the person who entered the data and involves running frequencies to identify responses that seem out of the ordinary or missing data. In continuous quality improvement, cleaning data involves conducting a random audit by comparing information on the reporting form with the entered data.

If a program is analyzing qualitative data, data preparation involves organizing the documents for review or transcribing text from interviews and observations into a word-processing file.

EVALUATING PEER PROGRAMS: ANALYZING & DISSEMINATING EVALUATION RESULTS

Preliminary Data Analysis

Once the data has been properly entered and cleaned, the next step is to run preliminary analyses to gain understanding of the data and recognize any simple trends. For quantitative analysis, the program should begin with a descriptive analysis. Descriptive analyses involve calculating the mean, median, and variation in responses to determine the general trends in the data. In qualitative analysis, exploring the data involves reading through all the data to develop a general understanding of the database while recording initial thoughts in the margins of the transcript or field notes.

Unless the organization has invested in statistical software such as SPSS (http://www.spss.com) or SAS (http://www.sas.com), the program will be limited to conducting analyses by hand. For example, the Smith County program, described in Read More C: Sample Evaluation Plan found in Subsection 7.1, tabulated frequencies of the number of community partner testing opportunities before the program started and compared them with the number of community partner testing opportunities at the end of the program period in order to measure the number of increased testing opportunities. Frequencies, or counting the number of recurring events, are the most common analytical tests of measurement. Frequencies will not reveal the cause for the number of recurring events, but instead will clearly provide information on how many times an event happens in a specific time period. Frequencies can be used to recognize trends in peer work, changes in clients' access to services, and other peer program outcomes.

Microsoft Excel can also be used to conduct preliminary data analyses. The program can be used to run frequencies, calculate means and medians, and create charts to visualize your data. Data entered into Excel can be imported into both SPSS and SAS for further, more advanced analyses. For more information on how to import Excel spreadsheets, visit the Help sections in SPSS or SAS or their websites at http://www.spss.com/ and http://www.sas.com/technologies/analytics/statistics/stat/ , respectively.

Advanced Data Analysis

Quantitative Data

With quantitative data, advanced analysis uses appropriate statistical tests to address the questions, objectives or hypotheses that were established early in the planning or design process of the peer program. Statistical tests might include generating cross-tabulations to compare two different variables or running t-tests to determine the statistical significance of responses between two time periods, such as pre- and post-test.

Qualitative Data

Qualitative analysis involves more steps than most quantitative analysis techniques. It begins with coding the data, dividing the text into small units, and assigning a label to each unit or piece of text. Code words are assigned to text segments and then recorded into broader themes.

For example, an excerpt from a client interview may contain the client's thoughts on keeping appointments and adhering to medication. These different paragraphs would be separated into smaller units by placing the text in separate files or index cards. Then, the paragraphs would be labeled separately under the code words "appointments" and "medication," and may ultimately be recorded under a broader theme entitled "Adherence to Care and Treatment."

EVALUATING PEER PROGRAMS: ANALYZING & DISSEMINATING EVALUATION RESULTS

Themes can then be grouped into larger dimensions or perspectives related or compared. The themes or larger perspectives are the findings or results that provide answers to the program's initial objectives or hypotheses. It is a good idea to use a trained evaluator to run the qualitative data analysis process.

Dissemination of Findings

Sharing and disseminating results is an important final step in program evaluation. Dissemination of the results with stakeholders can lead to new programs and policies or improve and change existing ones. Evaluation results can be disseminated outside the program at national, state, or local events through presentations, workshops or posters and through written methods such as publications, review articles, or via the World Wide Web. Program staff can use evaluation results internally to improve systems and practices. Deciding a dissemination strategy during the design of the evaluation plan can help to facilitate data analysis and dissemination.

One of the most effective ways to increase the utilization of data analysis findings is to present the findings in a way that are of direct practical use to the program stakeholders. Depending on the audience, a program may want to present only a summary of the findings or provide a full report of the findings. In either situation, it is important to keep the presentation focused on the key findings. Ideally, the program should bring together evaluators with key program staff to determine what key findings they want to present. A joint meeting is an effective way to discuss the meaning of the data from the program staff perspective. This tandem team strategy also can be helpful for deciding appropriate recommendations to assure practicality while staying true to the data. Plan the written report to make it simple, attractive, and user-friendly. Often, the best way to communicate the results is through narratives that reference tables and charts. Whether the findings are based on quantitative or qualitative methodologies, the use of visual or verbal presentations to complement written reports is universally accepted.

Some of the valuable uses of evaluation findings include:

- To improve/enhance programs or create new ones.
- To report/validate program effectiveness to current or potential funders, grantors, etc.
- To effect policy changes.
- To share positive findings with others through oral presentations, professional journal articles, etc.

The Communicating and Reporting Plan in Program Resources for Section 7, Evaluating Peer Programs provides steps to developing a plan for disseminating the results of a peer program evaluation.

[1]Norušis, M. J. and SPSS Inc. 2000. The SPSS Guide to Data Analysis for Release 4. Chicago: SPSS

EVALUATING PEER PROGRAMS: ANALYZING & DISSEMINATING EVALUATION RESULTS

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- Validated evaluation instruments

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7.5 EVALUATING PEER PROGRAMS: EVALUATION AND RESOURCE PLANNING

Engaging peers in evaluating peer program effectiveness provides peer insight by accessing input from their role as both consumer and provider. By virtue of this distinct role, peer contributions at every point of program development ensure that programs and evaluation measures are well thought-out.

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Being able to document, monitor, and evaluate the contributions of peer programs requires sufficient financial and human resources. The following are recommended guidelines for evaluation resources and planning:

Incorporate peer perspectives: Peers can be thought of as straddling the often disparate worlds of program staff and program clients. They share many experiences with a program's clients or target community, and at the same time understand the program's activities, objectives, and goals from a staff or 'insider' perspective. Thus peers can make a unique contribution at every stage of evaluation planning, implementation, and analysis. Peers may understand more clearly than staff which evaluation questions are meaningful to the population they serve. They may also be effective in getting frank feedback from community advisory boards and other community stakeholders about program evaluation. Peers can also provide insight into what data collection methods would be more acceptable to a particular population and how best to engage clients in the data collection effort. To the extent that they are representative of the population receiving program services, they can also pilot or 'test-drive' data collection instruments to ensure that they are comprehensible and culturally appropriate. With proper training and supervision, peers can also be engaged in data collection efforts. Finally, whether or not peers are involved in conducting the analysis of evaluation data, their perspective on the implications of the evaluation results for the community is invaluable. Peers can also suggest means of making the evaluation results known, such as local TV and radio programs, community events, and consumer-oriented publications, that program staff are not aware of.

Identify evaluation staff: It is recommended that 10% of the program budget be set aside for staff who will be responsible for program monitoring and evaluation, reporting key successes to the entire program or agency staff on a regular basis, and identifying areas for improvement for the program. It is recommended that evaluation staff not hold responsibilities related to the delivery of program services so as to remain objective and fair in reporting results and outcomes of the program.

Consultants: Another option is working with a consultant on a periodic basis to assist the staff with documenting and monitoring program progress. A consultant can be contracted at various time periods to work with staff on:

- Designing an evaluation of services,
- Training staff to collect data to monitor program activities, and
- Analyzing data collected by the agency to identify program challenges and progress towards performance indicators and program outcomes.

Travel: In some cases, a program may want to include travel or transportation costs for evaluation activities. For example, if a clinic or organization would like to implement client focus groups on a semiannual basis to assess program impact on treatment adherence, providing a stipend or travel reimbursement for participants is likely to enhance participation in the group. Additionally, peers may need to visit clients at their home or accompany clients to appointments, depending on their scope of work. Therefore, it may be necessary to reimburse the peer for transportation costs.

Communications: Having resources allocated for postage and phone communications can help a peer program document its activities. For example, an organization may want to provide the program with funds for sending out client satisfactions surveys to participants in support groups or conducting follow-up phone calls with clients to understand and document why a medical appointment was missed.

Training costs: If peers will be required to document their work, program supervisors and managers should set aside resources to train peers on how to document their activities with client, either electronically or on paper, so that the data can later be entered by other staff members. In addition, a program may want to set aside some funds for future trainings on documentation.

Printing and duplication of forms: For programs that do not use electronic data systems or decide they do not want peers to enter their work directly into an electronic system, it may be necessary to print forms that peers and supervisors will use to track their work. An organization may want to consider printing forms in duplicate so that the peer and supervisor can keep one copy for their records and another can be entered as part of the client's official medical or program chart.

Equipment and software: Deciding how to store and analyze the data for the program is important. Even if the peers are tracking activities on paper, it is recommended that an organization use a software package such as MS Access or Excel to store data for ease of data management and analysis. For in-depth analysis, the organization may want to purchase software packages such as SPSS or SAS for quantitative data or Nvivo for qualitative data.

Supplies and materials: Depending on the evaluation plan, a program may want to allocate funds for purchasing notebooks, pens, pencils, and carrying cases for peers to use in the documentation of their work with clients. In addition, the program should consider purchasing supplies to support the facilitation of focus groups and client surveys. This may include purchasing food, drinks, reading materials, and things to entertain children. Creating incentives and reducing barriers to a client's participation in a study can help facilitate the data collection process.

EVALUATING PEER PROGRAMS: EVALUATION & RESOURCE PLANNING

▶ FOR MORE INFORMATION

Additional Evaluation Subsections

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

Resources for Section 7

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

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

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7.6 EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

IRB RESOURCES ON THE WEB

The role of the Institutional Review Board (IRB) is to ensure that human subjects involved in research and evaluation activities are not placed at undue risk or coerced into participating.

http://www.hhs.gov/ohrp/archive/irb/irb_guidebook.htm : Use the IRB Guidebook, produced by the federal department of Health and Human Services (HHS), to become familiar with the issues and concepts that underlie IRB regulations.

http://www.hhs.gov/ohrp/policy/faq/ : This website has a list of frequently asked questions that describes HHS/OHRP's thinking on quality improvement activities and human subjects research

http://www.hhs.gov/ohrp/assurances/ : Use this HHS website to search for a local registered IRB or to consult a list of frequently asked questions about IRB registration

http://phrp.nihtraining.com : Use this National Institutes of Health online training to become certified in human subjects protection

The role of the HIPAA is to ensure patient confidentiality.

ftp://ftp.hrsa.gov/hab/hipaa04.pdf : Use this resource guide for HIV services providers to become familiar with the Privacy Rule as it pertains to CARE Act grantees.

A crucial step in developing a peer program is to secure necessary approval for all phases of program implementation, evaluation, data collection, and data analysis. Obtaining approval from an Institutional Review Board (IRB) may be necessary depending on the design of the evaluation, the type of data that is being collected and analyzed, how the results will be used, and who is participating in the evaluation. The purpose of an IRB is to ensure that human subjects who are involved in research and evaluation activities are not placed at undue risk and are participating in activities with informed consent and without coercion. This section describes the role of the IRB and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in the protection of human subjects and patient confidentiality.

Some evaluation activities may be considered quality improvement (QI). QI refers to measures to continuously monitor and improve the quality and efficiency of services by systematically assessing program components. QI is built into routine program activities, so that service providers and administrators are engaged in monitoring and improving progress toward program objectives and goals. QI typically involves the review of patient or client records and/or anonymous surveys.

All staff members, including peer workers, who are involved in the collection, storage, or analysis of QI data must be trained to understand and comply with all guidelines concerning patient/client confidentiality, the Health Insurance Portability and Accountability Act (HIPAA), and the protection of human subjects in research (see below).

Although QI shares many characteristics with research, the two endeavors are essentially distinct. QI initiatives generally examine internal processes and work to generate solutions to process-type problems, and often have a limited, internal audience. Another criterion of QI initiatives is that the majority of clients are likely to benefit from the knowledge gained, and the clients are not subjected to additional risks or burdens beyond general clinical practice. QI initiatives may not typically be seen as research. Helpful criteria have been proposed for differentiating **QI and research** (Reinhardt, 2003)

EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

The table below helps to outline these distinctions.

Institutional Review Board (IRB)

In the United States, IRBs are governed by Title 45 CFR (Code of Federal Regulations) Part 46. Legislation in the mid-1970's provided the guidelines for IRBs and defined their roles and responsibilities for the review of research activities subject to regulation by the federal Department of Health and Human Services (HHS). The Office for Human Research Protections in HHS regulates and oversees IRBs. For more information see: http://www.hhs.gov/ohrp/archive/irb/irb_guidebook.htm

To determine whether IRB regulations apply to an evaluation program, two questions need to be answered: 1) do the evaluation activities constitute research; and 2) do the activities involve human subjects. Each term has a technical definition within OHRP. For example, research means "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities."[1]

Human subjects means "a living individual about whom an investigator (whether professional or student) conducting research obtains 1) data through intervention or interaction with the individual, or 2) identifiable private information."[1]

IIt is possible that some evaluation projects will require an IRB approval, while others may not. Likewise,

DIFFERENCE BETWEEN QI AND RESEARCH

Criteria	Quality Improvement	Research
Intervention	Accepted practice or treatment intervention not previously implemented	New, untried practice or treatment intervention
Risk	Absence of risk to participants	Presence of risk, however slight, to participants
Audience	Primary audience is the organization Information is applicable only to the organization	Primary audience is the scientific community and consumers Information is generalizable

[1] http://www.hhs.gov/ohrp/policy/engage08.html

EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

HIPAA RESOURCES ON THE WEB

The role of the HIPAA is to ensure patient confidentiality.

ftp://ftp.hrsa.gov/hab/hipaa04.pdf
Use this resource guide for HIV services providers to become familiar with the Privacy Rule as it pertains to CARE Act grantees.

http://privacyruleandresearch.nih.gov/
This HHS National Institutes of Health website provides HIPAA resources and educational materials.

some research projects will need IRB oversight while others may not. The best way to address the issue, again, is to contact an IRB representative and discuss the proposed project activities to determine if they meet the definitions of "research" and "human subjects."

Where are IRBs and who serves on them?

Most colleges and universities maintain IRBs, since these institutions routinely implement research funded by federal agencies involving human subjects. IRBs can also be found in most state and county health offices, and within medical clinics and social service agencies. There also are private IRBs that charge a fee for the review process. IRBs have guidelines about the types of applications they will accept for review. For example, universities may not review an application if it does not involve any of their staff, faculty, or students. The composition of an IRB is outlined in federal regulations. An IRB must have at least five members—some with and some without research expertise. IRBs should also include men and women from diverse professional fields and there should be at least one scientist and one non-scientist. At least one non scientist member is not affiliated with the organization. The goal is to have a diverse board that understands research as well as local community standards and conditions. To find a local IRB, visit the Department of Health and Human Services website at http://www.hhs.gov/ohrp/assurances/

Criteria for IRB approval of research

An IRB representative can help determine if the evaluation activities meet the criteria for IRB review. If an application to a local IRB is required, the board members will consider whether all of the following conditions are met in the proposed activities: 1) risks to subjects are minimized, 2) risks to subjects are reasonable in relation to anticipated benefits (to participants or society), 3) selection of subjects is equitable, 4) informed consent will be sought from each prospective subject or the subject's legally authorized representative, 5) informed consent is appropriately

documented, 6) the research plan provides for monitoring the data collection process to ensure the safety of participants, and 7) there are adequate provisions to protect subject privacy and maintain confidentiality of data collected.

Training in the Protection of Human Subjects

Regardless of whether evaluation efforts qualify as research, it may be helpful to have all parties that are involved in evaluation certified in human subjects protection. Check with a local IRB and ask about completing human subjects protection training. Most trainings, if not all, can be completed online. A curriculum offered by the National Institutes of Health (NIH) takes about 90-120 minutes to complete. It includes reading materials and a number of quiz questions. Successfully completing the quiz questions allows the participant to print a certificate documenting completion of the curriculum. The course can be found at: http://phrp.nihtraining.com

HIPAA Guidelines

In all aspects of evaluation, patient confidentiality must be maintained and the Health Insurance Portability and Accountability Act (HIPAA) guidelines need to be followed carefully. The HIPAA privacy rule covers all protected, personally identifying health information.

The HIPAA privacy rule covers **individually identified health information** which is any health information that can be used to identify an individual. **De-identified information** is not covered by the privacy rule.

There are 18 identifiers that must be removed from data (such as medical record data) in order for it to be considered de-identified. These include name, social security number, dates of service and medical record number, among others. The organization should review the HIPAA guidelines put out by HRSA at the following site: ftp://ftp.hrsa.gov/hab/hipaa04.pdf

This information will help determine if the program is in compliance with HIPAA regulations. It may also be necessary to also discuss this with a project officer.

EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

▶ FOR MORE INFORMATION

Additional Evaluation Sections

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Resources

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