

7.3 EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS



Two peers at Christie's Place

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 [Section 7.6 Human Subjects Protection 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.

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

Data-Collection Methods: Qualitative vs. Quantitative

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

Qualitative Methods

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

the evaluation process. Qualitative data can also be a stand alone method for program evaluation.

Examples of Qualitative Methods

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

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

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

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

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

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“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

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

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

Example: A program uses key informant interviews with clients to assess the role a peer played in a client's adherence to HIV care and treatment. The [Program Resources](#) for section 7 Evaluating Peers 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 [Section 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.

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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.

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► 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.

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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 [Section 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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► FOR MORE INFORMATION

Additional Evaluation Section

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

Resources

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

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