

# 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.

<b>Goal:</b> Increase HIV-positive clients' access to and engagement with support and medical services.					
<b>Objectives</b>	<b>Activities/Action Step</b>	<b>Person (s) responsible</b>	<b>Measures/Indicators</b>	<b>Evaluation Methods</b>	<b>Outcomes</b>
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	<ul style="list-style-type: none"> <li>• Conduct at least 8 education and outreach activities at the agency and in the community per week.</li> <li>• 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.</li> <li>• Refer at-risk individuals to HIV counseling &amp; testing at the clinic</li> </ul>	Prevention Education coordinator and outreach workers	<ul style="list-style-type: none"> <li>• Number of prevention education activities</li> <li>• Number and demographics of outreach encounters</li> <li>• Number of partner agencies conducting monthly prevention/ education sessions</li> <li>• Number of referrals to counseling &amp; testing at the clinic</li> </ul>	Process: <ul style="list-style-type: none"> <li>• Encounter forms (see <a href="#">Sample forms for documenting peer work in Program Resources.</a>)</li> <li>• Referral logs</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced unmet need</li> </ul>

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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.	<ul style="list-style-type: none"> <li>• HIV case management supervisor</li> <li>• Peer</li> <li>• Case manager</li> <li>• Clinic staff</li> </ul>	<ul style="list-style-type: none"> <li>• Number/ demographics of HIV-positive clients referred and enrolled in HIV case management services</li> <li>• Number of HIV-positive clients with case management plans and service goals</li> <li>• Number/types of services provided</li> </ul>	<ul style="list-style-type: none"> <li>• Case manager treatment plans completed</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced barriers to care for newly diagnosed &amp; lost-to follow-up</li> </ul>
1.3 Provide weekly support groups to 80% of HIV-positive clients	<ul style="list-style-type: none"> <li>• Conduct at least 2 groups/week around HIV care and treatment adherence, positive living, resources, and other consumer-identified topics</li> <li>• Recruit HIV-positive clients into support groups</li> </ul>	<ul style="list-style-type: none"> <li>• Peer leader</li> <li>• Staff support group leader</li> <li>• Program Manager</li> </ul>	<ul style="list-style-type: none"> <li>• Number and topics of support groups</li> <li>• Number of HIV-positive clients who attend support groups</li> </ul>	<ul style="list-style-type: none"> <li>• Client surveys (<a href="#">see HIV patient satisfaction survey in Program Resources.</a>)</li> <li>• Focus groups</li> <li>• Attendance lists</li> </ul>	<ul style="list-style-type: none"> <li>• Improvement in self-reported quality of life</li> </ul>

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1.4 Link 80% of HIV-positive clients into medical and social support services	<ul style="list-style-type: none"> <li>• Conduct reminder and follow-up phone calls regarding medical and social service appts</li> <li>• Accompany HIV-positive clients to medical &amp; social service appts</li> </ul>	<ul style="list-style-type: none"> <li>• Peers</li> <li>• Case Managers</li> <li>• Clinic staff</li> </ul>	<ul style="list-style-type: none"> <li>• Number of HIV-positive case-managed clients with at least 2 medical visits in measurement year</li> <li>• Number of clients with CD4 &amp; VL tests</li> </ul>	<ul style="list-style-type: none"> <li>• Chart audits</li> <li>• Client surveys</li> <li>• Peer Educator Encounter forms</li> <li>• Treatment plans completed</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in number of clients with 2 or more medical visits in a 12-month period</li> <li>• Increase in number of clients with CD4 &amp; VL tests</li> </ul>

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://www.hdwg.org/peer\\_center/program\\_dev](http://www.hdwg.org/peer_center/program_dev).