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

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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

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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