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Assessing Peer Advisor Intervention Fidelity Using Video Skits in a Peer Support Implementation Trial

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Abstract

In community-based interventions involving lay health workers, or “community health workers,” peer-client interactions are not typically observed by investigators, creating challenges in assessing intervention fidelity. In the context of a community-based randomized controlled trial of the effectiveness of peer support on diabetes outcomes of people with diabetes in rural Alabama, a region characterized by poverty and low literacy, we developed a video assessment tool that assessed participant perceptions of peer–client interactions. The video assessment consisted of four short skits on areas of emphasis during peer training: directive versus nondirective counseling style and setting a specific versus a more general goal. The video tool was evaluated for association with questionnaire-derived measures of counseling style and goal setting among 102 participants. For counseling style, 44% of participants reported that their peer advisor was most similar to the nondirective skit. For goal setting, 42% reported that their peer advisor was most similar to the specific goal skit. There was no statistically significant relationship between skit selection and questionnaire-derived measures. The video assessment was feasible, but results suggest that video and questionnaire assessments in this population yield different results. Further validation to better understand the differences between questionnaire reports and video assessment is warranted.

Keywords

Diabetes; Community Intervention; Health Disparities; Community-Based Participatory Research; Evaluation Methods; Rural Health

INTRODUCTION

Intervention fidelity is a term used to reflect the degree to which an intervention was implemented as specified in the study protocol, including all the components of programming that can affect the intervention outcomes and the implementation of program delivery (Bellg et al., 2004; Dane & Schneider, 1998; Dusenbury, Brannigan, Falco, & Hansen, 2003; Hardeman et al., 2008; Hill, Maucione, & Hood, 2007). Intervention fidelity

is especially critical in peer support interventions, which match trained community members with others in the same community in the management and support of a chronic medical condition. Peer support interventions are gaining traction in minority communities, which are often geographically or culturally remote from the mainstream and in which residents are often challenged by high risks for poor health outcomes but scarce medical resources. Peer supporters, community health supporters or *promotoras* (hereafter referred to in this article as community health workers [CHWs]) have an ongoing flexible partnership with individuals living with a chronic medical condition, and CHWs often have this condition themselves, providing an in-depth understanding of the challenges to succeeding at self-management. Since CHWs typically receive varied degrees of training, assessment of intervention fidelity is particularly important to enable investigators to identify areas where the protocol was applied inconsistently by the program facilitators (Hill et al., 2007). Measuring CHWs adherence to the protocol permits the investigators to understand how well the program “fits” into a particular community (Dusenbury et al., 2003), and permits comparison of critical features of implementation across multiple sites (Bellg et al., 2004; Hill et al., 2007).

Previous studies have investigated various methods of assessing intervention fidelity. These include trainer or instructor observations (Hill et al., 2007), peer reviews (Moorer-Whitehead, 2010), facilitator self-assessments, or behavioral checklists (Hardeman et al., 2008). Particularly, video recordings and supervised phone calls (Byrnes, Miller, Aalborg, Plasencia, & Keagy, 2010) can monitor overall CHWs’ performance and audit skill competency. However, these strategies require scoring, which is time intensive and burdensome for CHWs and study staff and could be perceived as intrusive by the CHW and potentially alter the relationship with their client. Byrnes et al. (2010) used video tapings of parent/youth/health educator interactive sessions to assess health educators delivering a family-based drug prevention program, reporting that mean adherence to program delivery per protocol was 78%. However, it is not clear how well the recorded sessions reflect unrecorded interactions. Hardeman et al. (2008) found that although facilitators delivering a physical activity intervention self-reported 100% adherence, study staff who observed the facilitators measured adherence to the program’s critical features at 25% to 66%. Although most study sites employ multiple means of measuring intervention fidelity, cost and reliability must be taken into consideration when developing and using such intervention measurements. To date there is no widely used standardized method to measure intervention fidelity in community-based interventions using the peer support model (Waltz, Addis, Koerner, & Jacobson, 1993).

We studied a novel approach to assessing intervention fidelity in a community-based trial testing the effectiveness of a peer support model to improve diabetes outcomes among residents of the rural Black Belt of Alabama. With the highest prevalence of diabetes in the United States, this region is characterized by steep poverty, high functional illiteracy, and very scarce medical resources. The area’s mostly African American residents face very high risks of poor health outcomes. Intervention participants were paired with CHWs from the community called “peer advisors.” A 2-day peer advisor training included skills in delivering nondirective, empowering, and activating support based on the tenets of

motivational interviewing (MI), emphasizing the use of open-ended questions, affirmations, reflections, and summaries. Training also included how to set goals that were specific, measurable, achievable, realistic, and time oriented (SMART). Peer advisors were encouraged to build informal relationships with diabetic clients while adhering to a telephone contact schedule and operating as activating advisors in an unsupervised setting.

In the context of this larger trial, the aim of this study was to develop a video assessment tool to measure the participants' perception of their interactions with their peer, thus developing an alternative method of measuring intervention fidelity in community-based peer support studies. Video skits were developed to evaluate participant perceptions of the peer advisor's counseling style and approach to goal setting. Thus, we aimed to assess intervention fidelity from the client's perspective, which to our knowledge has not been investigated.

METHODS

Study Context: The ENCOURAGE study

ENCOURAGE was a community-based participatory research study that recruited 424 diabetic residents from nine counties of the rural Black Belt of Alabama, where 12% to 15% of the adult population has diabetes (Centers for Disease Control and Prevention, 2005). Details of the study are available elsewhere (Andreae, Halanych, Cherrington, & Safford, 2012; Cherrington et al., 2012). Briefly, the intervention was based on social cognitive theory (Bandura, 1986) and adult learning theory (Boxer et al., 2009). Data collection was conducted at baseline, 6 months, and 12 months. At baseline, participants received a 1-hour diabetes education class, educational materials, and their personalized diabetes report card; 200 intervention arm participants were also assigned a peer advisor. Peer advisors underwent 2 days of training that included instruction on MI supportive counseling techniques and "SMART" goal setting. MI is a client-centered counseling technique (Miller & Rollnick, 1991; Rollnick & Allison, 2002) that is designed to support clients in overcoming ambivalence. Recipients of MI are encouraged to identify their own barriers that cause them to resist behavioral change. At the conclusion of training, peer advisors were certified to achieve a uniform minimum level of competency.

Certified peer advisors volunteered to advise 5 to 10 clients over the course of a year according to a specific schedule of telephone calls. At the initial 45-minute meeting, using their individualized report card, a list of current medications, and feedback from their previous physician visit; peer advisors encouraged their clients to think about areas of their diabetes management that needed improvement. They then selected an area of initial focus and set a SMART goal to work on over the next week. Follow-up calls were designed to be about 15 minutes in length and occurred weekly for the first 2 months, then every 3 to 4 weeks over the year. Peer advisors recorded all contacts with the client in the contact log, whether scheduled or not. The contact log recorded each client's plan of action to accomplish a short-term goal using the SMART goal framework; contact logs were therefore designed as both tools for the peer advisor to track progress with each of their clients and as a process evaluation assessment for the study that recorded both the frequency of contacts and the characteristics of the goal the peer-client pair were following.

Video Assessment Tool Design

The video tool was designed to assess two elements emphasized in peer advisor training: counseling style and SMART goal setting. We developed two skits for each of these two elements consisting of mock interviews between a client and the peer advisor. Figure 1 shows a diagram of the video layout. The first video set consisted of two skits that focused on the peer advisor's counseling style. The first skit showed a peer advisor using directive counseling techniques lacking MI skills without open-ended questions, affirmative statements, reflective listening, or summarization (OARS). The second skit showed the peer advisor using nondirective counseling and numerous OARS strategies. The second video set consisted of two skits focused on goal setting. In the first skit of this set, the peer advisor and the client worked together to set a SMART goal and the second skit they set a more general goal. The skits were designed to be equally appealing, differing only on use of targeted skills, to avoid participants selecting the skit in which the peer advisor was "nicer." To measure the success of achieving this goal, we asked clients to indicate whether they liked the peer advisor in one of the pairs of skits better than the other or if they liked the peer advisor in both skits about the same. The video assessment tool took on average 10 minutes to complete.

Video Assessment Procedure

This cross sectional study was conducted at the 6 month follow-up visit at a time when they were interacting with their peer advisor every 1 to 3 weeks. Study participants watched the video on a laptop computer while listening with individually volume-adjusted headsets. Study staff explained the purpose of the video before the clients viewed the video and monitored each client's progress and comprehension of the assessment. All clients received a Video Assessment Questionnaire preprinted with their peer advisor's name (see Figure 2). Participants with physical limitations such as impaired hearing or vision or unable to fully understand the assessment (e.g., completing the form before the video concluded or not completing questions when prompted) received assistance from study staff, who reviewed the video individually with the client using a One-on-One Video Assessment Questionnaire modeled on the Video Assessment Questionnaire in which staff completed the questionnaire for the client.

Statistical Methods

The trial data collection included interview data on quality of life, diabetes management, and quality of relationship with the peer advisor at the 6-month follow-up. Within this interview, the eight-item Nondirective Versus Directive Support scale was used to assess the nondirective or directive counseling style of the client's peer advisor (Fisher, Earp, Maman, & Zolotor, 2010). The eight-item support scale is a self-report measure of peer support. These questions used a Likert-type scale response option ranging from 1 (*not at all typical*) to 5 (*very typical*). Five of the eight questions were reverse coded, that is, a response of 4 or 5 may describe a nondirective counseling skill for one question while the response of 1 or 2 may describe a nondirective skill for the proceeding question. The associations between responses to Question 1 (Q1) of the Video Assessment Questionnaire and of the eight-item support scale were assessed using logistic regression. Contact logs were reviewed and

scored to ascertain the number of SMART goal elements. A goal was considered SMART if it had at least four of the five SMART elements. Chi-square tests of association between the responses of Question 3 (Q3) of the Video Assessment Questionnaire (assessing whether the goal was SMART or more general; Figure 2) and the participant's goals as recorded on the contact logs. A two-tailed p value of $<.05$ was considered statistically significant. All analyses were carried out using SAS Version 9.2 (Cary, NC). The University of Alabama Birmingham Institutional Review Board approved this research.

RESULTS

Participant Characteristics and Feasibility of Assessment

In all, 200 intervention arm participants enrolled in the study; however, only 108 intervention arm participants completed the follow-up that included the video assessment. A shorter follow-up assessment option that did not include the video assessment was offered to all ENCOURAGE participants who had difficulties coming to larger data collection sites. Of the 108 participants who viewed the video assessment, 102 (94%) completed the corresponding questionnaire and their characteristics are shown in Table 1. The majority of the respondents were Black women of average age 61 years; most had a high school education or less and an average household income of \$20,000 or less. Of the six incomplete video assessments, reasons for failing to complete included: infrequent contact with their peer advisor, missing answers, or multiple answers to questions where a single answer was requested. Only one participant was unable to understand the video assessment instructions in spite of assistance from study staff. A majority of the participants (91% of 108 respondents) were able to view the video assessment without the assistance of study staff and the One-on-One Video Questionnaire.

Video Assessment Responses

Table 2 shows the results of the Video Assessment responses. For the video set assessing perceptions of counseling style, 45 of the 102 (44%) participants who completed the assessment perceived their peer advisor to be most similar to the nondirective peer advisor; 70 of the 105 (67%) who completed the preference assessment expressed no preference for either video clip. For the video set assessing goal setting, 43 of 102 participants (42%) perceived their peer advisor to be most similar to the peer advisor who helped their client to set a SMART goal. Out of the 107 participants who expressed their preferences between these two skits, 81 (75%), expressed no preference for either skit.

Association With Questionnaire Responses and Contact Logs

Ninety-two intervention participants completed both the eight-item support scale and the video assessment. Forty-one percent of these participants perceived their peer advisor to be most similar to the nondirective peer advisor in the video skit and the median score of the eight-item support score was 22 (interquartile range 20–24, range 15–32 with possible range 15–40). Notably, 18 (20%) respondents answered all eight questions using a single response, either 1 or 5. There was no statistically significant relationship between the video assessment response to Q1 and the score on the nondirective/directive peer support scale (odds ratio = 1.16, 95% confidence interval = 0.38, 3.54).

One hundred one participants completed the video assessment of goal setting and had contact logs available. The median number of peer contacts was 14.5 (25th: 8.5, 18.0; range 1–58) and 68% of participants ($n = 63$) set goals with their peers and were assessed to be SMART goals. There was no statistically significant association between the presence of a SMART goal on the contact logs and participant ratings of whether their peer advisor helped them set SMART goals ($\chi^2 = 0.24$; $p = .63$).

DISCUSSION

We demonstrated that a video assessment of participant perceptions of selected elements of motivational interviewing and SMART goal setting is a novel and feasible approach in underserved communities with high functional illiteracy. The findings of this study suggest that participant perceptions based on video skits differ from other assessment approaches such as questionnaire responses or measures derived from the contact log entries used. Further work is needed to better understand the optimal approach to assessing intervention fidelity in community-based studies of peer support interventions.

It is important to note that the eight-item Nondirective Versus Directive Support scale has not been validated in a population similar to the ENCOURAGE population. One in five participants selected a single response, such as all 1s or all 5s, in the 8-point Likert-type scale; suggesting that the reverse coding may lead to measurement error in this population. The eight-item support scale was tested at 14 demonstration project sites across the country that partnered for The Diabetes Initiative of The Robert Wood Johnson Foundation. None of the sites chosen for this initiative were in rural, southern, predominately African American communities similar to the Alabama Black Belt (Fisher et al., 2007; Fisher et al., 2010). Second, Lee, Jones, Mineyama, and Zhang (2002) have shown that Likert-type scales might have a cultural bias, such as individuals of a particular ethnicity consistently ignoring the “continuum of responses” that characterizes the scale and often preferring a more dichotomous response. Skelly et al. (2000) reported that low-literate Hispanics and African Americans found a 6-point scale more difficult to interpret than a 4-point scale of the same measure. Additionally, reverse coding is not only problematic to calculate for the scorer, but it is also challenging to interpret by the responder. Reverse coding has been shown to reduce reliability, reduce interitem correlation (Barnette, 2000; Carlson et al., 2011; Woods, 2006), and even measure other constructs (Rodebaugh, Woods, & Heimberg, 2007). Carlson et al. (2011) specifically investigated the challenges that adults older than 60 years face with reverse-coded items. Older adults challenged by the alternating format of reverse-scored items are likely to give erroneous responses that are not consistent and careless. Woods (2006) reported that if as few as 10% of the respondents are careless on a questionnaire with 10 out of 23 reverse-worded items, this prevalence can “detrimentally” affect the results of a one-factor scale. In the scope of this current study, almost 20% (18 out of 92 respondents) of the analyzed intervention participants showed no variation in their responses, with most responses concentrated on the highest value (5).

Using the SMART framework provided on each contact log, peer advisors were trained to develop a SMART goal from a general goal suggested by their client, such as “I want to lose weight.” It is worth noting that clients were not required to document their own goals but

were encouraged to maintain each goal on their own between contacts with their peer advisor. We believe that many of the diabetic clients had very little to no exposure to goal setting prior to this study, thus limiting their ability to identify a general goal from a SMART goal. In future studies, we will use a Think Aloud Protocol to investigate client's perception of each video skit, specifically the differences between each mock conversation; however, this was beyond the scope of this project.

An important aspect of our approach was the assessment of preference for one video segment relative to the other. We designed the skits so that the peer advisor was friendly in both options, reflecting the nature of all of the peer advisors in the program. This assessment served to confirm that the video had been successful at depicting two equally pleasant options, differing only on the skill being used. It is noteworthy that a sizable minority did have a preference for directive counseling, suggesting that some participants may prefer to work with more directive peer advisors. Consistent with this observation, West, DiLillo, Bursac, Gore, and Greene (2007) added MI to a weight loss program for women with Type 2 diabetes. They found increased weight loss in diabetic women overall with MI, but African American women weight loss was less than White women, suggesting that MI has a decreased benefit for African Americans.

The findings demonstrate that a video assessment can be an acceptable and novel method of evaluation in a community-based peer support intervention in our partnering communities. This finding is supported by the very few (<1%) participants who were unable to understand the requirements of the assessment in spite of study staff assistance. Furthermore, more than 90% of individuals were able to complete the assessment independently, suggesting that well-designed instructions and the visual approach we used were acceptable for these participants.

In contrast to other methods used to assess intervention fidelity in a community intervention, assessing the participant's perception of targeted skills can be useful for interventions that lack the resources to record and score individual conversations. This is especially true when investigators are not located at the site of the intervention. Furthermore, the lack of observed interactions allows the peer and client to bond without the presence of an interviewer. Evaluating the participants' perception of their peer-client interaction provides a unique perspective and can aid in developing a cost-effective patient-centered means of assessing a peer support training curriculum (McMurran, Cox, Coupe, Whitham, & Hedges, 2010). Further study examining the association of study outcomes with each of the measures of intervention fidelity will shed light on which approach has greater utility.

Limitations

This study has a number of limitations that should be considered when interpreting and generalizing the results. First, the study was modest in size, limiting the ability to detect potentially important effect sizes. Participants were from a single region in rural Alabama, potentially limiting the generalizability of our findings. Second, participants were asked to rate their peer advisor at a time when they were asked to the interaction only every 3 to 4 weeks; therefore, both the video assessment and questionnaire responses are subject to recall biases. Also, we had no way to validate the information recorded on the peer contact logs.

As mentioned above, additional resources would have permitted additional qualitative assessment of participants' interpretations of the skits, but this was not feasible.

CONCLUSIONS

Video assessment using skits incorporating community member actors modeling the use of targeted skills may be a promising approach to assessing intervention fidelity from the participants' perspective. The findings of this study suggests that evaluating via a video assessment tool the participants' preference of video skits maybe an attractive approach as a complement or alternative to other assessment methods.

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Video Assessment Survey

Pre-printed Label

You have worked with your Peer Advisor for several months now. By using short videos, we would like to get an idea of how your Peer Advisor helped you. First, you will watch the videos, and then you will answer some questions. There is no right or wrong answer. Do not share your ideas or answers with anyone else. Please let me know if you have any problems with the video.

You will watch 2 short conversations and then answer questions 1 and 2. Followed by 2 more short conversations and then answer questions 3 and 4.

Okay you may now put on your headsets.

1. In which video was the way Tawny helped Ms. CY most like the way **your** Peer Advisor helped **you**? Please check either A or B.

A ☐ B ☐

2. You may have liked the way Tawny helped Ms. CY in one video more than the other. Which video did you **like better**? Please check either A, B or C.

A ☐ B ☐ C ☐ I liked A and B the same

3. In which video was the way Tawny helped Ms. CY most like the way **your** Peer Advisor helped **you**? Please check either A or B.

A ☐ B ☐

4. You may have liked the way Tawny helped Ms. CY in one video more than the other. Which video did you **like better**? Please check either A, B or C.

A ☐ B ☐ C ☐ I liked A and B the same

FIGURE 1.
Video Assessment Questionnaire Used After Viewing Video Skits of a Peer Supporter (Tawny) and Her Participant (Ms. CY)

Video Set 1 - Counseling Style		Video Set 2 - Goal Setting	
Skit A	Skit B	Skit A	Skit B
Directive counseling	Non-directive counseling	SMART* goal	More general goal
Video Set 1 assessment questions		Video set 2 assessment questions	

FIGURE 2.

Video Assessment Tool Schematic of the Two Sets of Videos

*SMART = specific, measurable, achievable, realistic, time-oriented.

TABLE 1

Demographic Characteristics of Participants Who Completed the Video Assessment Questionnaire

	Overall (n = 94), n (%)	Perceived directive peer support (n = 51), n (%)	Perceived nondirective peer support (n = 43), n (%)
Mean age years (<i>SD</i>)	60.8 (11.5)	61.7 (10.5)	59.8 (12.6)
African American	90 (95.6)	50 (98)	40 (93)
Female	75 (80)	44 (86)	31 (72)
Male	19 (20)	7 (14)	12 (28)
Education			
Less than high school education	31 (33)	17 (33)	14 (33)
High school education	44 (47)	21 (41)	23 (55)
Post-secondary education	18 (19)	13 (26)	5 (12)
Income, \$			
< 10,000	24 (26)	12 (24)	12 (28)
10,000–20,000	38 (40)	24 (47)	14 (33)
20,000–30,000	10 (11)	5 (10)	5 (12)
30,000	22 (23)	10 (20)	12 (28)

TABLE 2**Participant Responses to the Videos Assessing Counseling Style and Goal Setting**

Participant Answers to Video Set 1 (Counseling)	Assessment of Their Peer (<i>n</i> = 102)^a		Preference (<i>n</i> = 105)^a	
	N	%	N	%
Directive counseling	57	56	11	10
Non-Directive counseling ^b	45	44	24	23
No Preference for either Video Clip A or Video Clip B			70	67

Participant Answers to Video Set S (Goal Setting)	Assessment of Their Peer (<i>n</i> = 102)^a		Preference (<i>n</i> = 107)^a	
	N	%	N	%
Set general goal	59	58%	17	16%
Set SMART goal ^b	43	42%	10	9%
No preference for either Video Clip A or Video Clip B			81	75%

^aSome participants had incomplete questionnaires.

^bPeer training targeted client-centered skills.