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I DON'T WANT THE TRAY TO TIP: EXPERIENCES OF PEER EVALUATORS IN A MULTISITE HIV RETENTION IN CARE STUDY

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Abstract

Numerous studies demonstrate the efficacy of peer-delivered interventions to improve HIV prevention and care outcomes, yet few explore the role of peers in evaluation and data collection. We conducted qualitative interviews with providers in a multisite HIV Retention in Care initiative to explore peers' evaluation roles, challenges, and strategies for success. We found peers' responsibilities included data collection, client assessments, and data entry. Their rapport with clients was considered an evaluation asset. However, peers struggled with balancing rigorous evaluation and data collection demands with the needs and comfort of clients. Recommendations for peer-based evaluation include ensuring self-care, streamlining workflow, and involving peers in evaluation development and reporting processes. Additional research is needed to explore the extent to which peers participate in evaluation activities and to ensure rigor in peer-based evaluation. Given that peers are well-positioned to collect client-level data, best practices, standards, and trainings for peer-based evaluation should be developed.

Keywords

peers; evaluation; HIV

Numerous interventions to reduce HIV risk and improve health outcomes for marginalized populations rely on peers to establish rapport and deliver culturally relevant information to clients who are members of their own communities (Webel, Okonsky, Trompeta, & Holzemer, 2010). Peers can be described as individuals who share "... key personal characteristics, circumstances, or experiences ..." with their clients, and these shared experiences create foundations for interventions (Simoni, Nelson, Franks, Yard, & Lehavot, 2011). Peer-based behavioral change interventions have been shown to effectively engage target populations and provide them with education and social support (Dutcher et al., 2011; Enriquez, Farnan, & Neville, 2013; Marino, Simoni, & Silverstein, 2007), and have helped

participants reduce sexual risk behaviors, improve attitudes and knowledge about HIV risk (Simoni et al., 2011), and increase treatment adherence (Marino et al., 2007). These approaches are premised on the idea that peers are culturally and ethnically similar to their target populations, are able to establish rapport because of these similarities, and can rely on established peer networks to recruit and share information (Dickson-Gomez, Weeks, Martinez, & Convey, 2006).

The value of peers in improving health outcomes for people living with HIV (PLWH) has been documented in both research and applied settings. Peer outreach can strengthen participant recruitment, especially for often-marginalized and poorly engaged populations. For example, people with histories of substance use can effectively deliver harm reduction interventions to reduce disease transmission among injection drug users. The rapport generated by peer workers can improve follow-up efforts and participants' understanding of study aims (Arayasirikul, Cai, & Wilson, 2015; Hawk, 2014). Programs to improve health outcomes for PLWH are a necessary component of the Undetectable = Untransmissible (U = U) campaign, which builds on the fact that those with suppressed viral load are unable to infect others (Hayward, 2017).

As front-line workers, peers are well-positioned to collect data and conduct assessments yet few studies have examined peer-based evaluation. Some studies describe the involvement of peers in process measures, such as tracking the number of contacts made through their work activities (Dickson-Gomez et al., 2006; Hawk, 2014), and one study described the use of peers to collect outcomes data via participant surveys (Hawk, 2014). Community stakeholder literature underscores the importance of peers in designing evaluation plans for health promotion or social improvement (Brandon, 2011; Chen & Garbe, 2011). However, a comprehensive description of peer-based evaluation activities and methods is not represented in the literature. The current article seeks to address this gap by describing ways that peers in one multisite study participated in evaluation activities. Our aim is to advance discussion about how to best employ and support peers in evaluation research and practice settings.

AIDS United's Retention in Care (RiC) Initiative was a 3-year partnership with the M·A·C AIDS Fund to identify, document, and evaluate innovative models for improving retention in care for PLWH in the United States. AIDS United is a grantmaking and advocacy organization whose mission is to end the AIDS epidemic (AIDS United, 2018), while the M·A·C AIDS Fund supports "... innovative programs that deal directly with the most marginalized, stigmatized, and under-heard victims" (M·A·C AIDS Fund, 2018). By funding and evaluating seven innovative and community-based approaches to care, these grantmakers sought to explore methods of addressing stigma, discrimination, and social determinants of health to improve health outcomes among marginalized PLWH as well as to demonstrate novel and promising practices.

Through grantee cohort conference calls, the framework of which focused on program evaluation and provided feedback to the national evaluation, it became apparent that many grantee sites were engaging peers in evaluation and data collection efforts and that there were a number of shared challenges, particularly with administration of a self-assessment tool. This article presents findings from qualitative interviews that were conducted with RiC

peers and program managers to understand the ways that peers participated in evaluation and data collection activities, challenges they experienced, and strategies they used to overcome them.

METHODS

Seven sites RiC were funded to implement and evaluate innovative or promising models to improve health outcomes for PLWH. Six sites relied on peers to deliver program components, primarily focusing on health navigation, referral activities, and the provision of informal support, and five of these six also used peers in evaluation tasks and activities. Staff from these five sites participated in qualitative interviews for this study (Table 1).

The RiC initiative used a national evaluation framework led by researchers from a large academic institution (the “evaluation team”) in cooperation with local evaluators to document improvements in participants’ health, assess systems change, and measure cost effectiveness. The framework was developed by the evaluation team in collaboration with project officers from AIDS United. It incorporated data collected from electronic health records (CD4 and viral load counts, appointment adherence) and participants’ self-reports. Self-report data were collected via an assessment tool developed specifically for this study by the evaluation team based on a review of the literature. The tool incorporated multiple evaluation constructs, many of which were previously validated in other studies, encompassing more than forty questions collecting demographic information, HIV history, housing status, substance use history, mental health status, experiences of stigma, disclosure of HIV status, exposure to services, client needs, barriers to care, and clinical adherence. Data were collected at baseline and at 6-month intervals. Though the evaluation methods were rigorous, it is important to emphasize that RiC grantee sites were community-based organizations seeking to improve care outcomes for PLWH, not research sites aiming to produce generalizable knowledge.

The local evaluator for one of the RiC sites served as the qualitative researcher and conducted interviews with peers and program managers from the five target sites. Program directors and evaluators from each of the sites had previously participated in grantee cohort conference calls, so the researcher was known to the participating sites and this relationship formed the basis for recruitment of this convenience sample. The researcher invited each site to participate via email. Funded programs varied in the size of their funded activities and related staff positions so there was a range in the number of people able to be interviewed at each site. Interviews were requested with all RiC-funded peers and their direct supervisors in order to gain multiple perspectives. Project directors then set up in-person meetings between the researcher and RiC peers and program managers. These roles were distinct in that none of the peers also served as program managers.

All interviews were conducted in-person by the qualitative researcher from May through September 2015, the final year of the RiC funding initiative. A semistructured interview protocol was developed and discussed by the qualitative researcher, AIDS United project officers, and the evaluation team from the multisite study to not only identify domains of interest but also to ensure the interviewer was prepared to conduct the interviews with rigor

and consistency across sites (Table 2). The qualitative researcher is a mixed methodologist from an academic institution with formal qualitative training and experience conducting mixed-methods research including qualitative interviews. This individual led the qualitative team, which included two research assistants, both of whom had foundational training in qualitative methods and applied training by the qualitative researcher leading this portion of the study. Qualitative analysis was conducted in NVivo 11 (QSR International, 2012) using contextualizing and categorizing strategies (Strauss & Corbin, 1990). First, the qualitative team reviewed each of the transcribed interviews to explore major themes and contextualize the data. Next, a set of analytic codes was developed, derived from the exploration of themes as well as assessment domains identified during the development of the interview guide. All of the interviews were coded by two research assistants. Three of the transcripts were triple-coded by the interviewer and both research assistants to ensure consistent code use and ensure analytic rigor (Barbour, 2001), and when divergence occurred the codes were discussed until there was category agreement. After all of the transcripts were coded they were reviewed for emerging themes by the qualitative team then discussed with the national evaluation lead and representatives from AIDS United. The study was determined to be exempt from review by the University of Pittsburgh Institutional Review Board.

RESULTS

Twenty-one qualitative interviews were conducted across five grantee sites. Participants comprised 8 program managers and 13 peer community health navigators or outreach specialists (Table 1). At every site the peers were paid staff members employed to help retain PLWH in care. Most programs employed PLWH as peers though some sites specifically employed peers that were part of other underserved networks such as Latino or substance-using communities. Many peers became involved in programs first as clients and were subsequently recruited to serve as peer workers. Few peers described previous experience in administration or data management and were recruited because of their interest in helping others, ability to establish rapport with clients, history of shared experiences, and ability to serve as role models for others in navigating the health care systems. One peer indicated that:

They [clients] want some of what we have. They want some of what we were able to acquire. And so it makes them easier to talk to. They also know that we've been some-where else.

(Peer 57)

A program manager also noted that:

We always say our peer navigators are sort of triple peer navigators in a way because they're living with HIV, they have histories of trauma, and histories of substance abuse. All that, they've overcome, and they're living very well with.

(Program Manager 301)

Some peers spoke explicitly about working in this capacity as part of their own growth experience or to give back to a system that had helped them.

And so now it's been ... 5 years and I think I really have grown a lot, you know. Not only with the learning how to move a computer [laughter] but ... you know, for me, giving me the opportunity to work, to help others, you know. I wish, in my time, when I was diagnosed, I could have had an agency or a peer.

(Peer 35)

PEER RESPONSIBILITIES AND ROLES

The direct service responsibilities of peers included transporting clients, providing general support and encouragement, modeling engagement in care, placing referrals, and linking clients to care. Evaluation-specific activities included client assessments, finding and engaging clients for follow-up assessments, and data entry, even though most peers did not have prior experience in these areas. It became clear through interviews that assessments were conducted not just for the purpose of data collection and evaluation but also as part of the service delivery process.

Yeah, well we have our screening forms and then we have the intake. So the peers are responsible for that information. And that takes about 45 minutes. And we ask questions about where they live, who they live with, who knows about their information, where they get their treatment, if they're taking their treatment. And we ask them if they're keeping their appointments and if they don't, since we're concerned about retention in care, we try to find out why they're not keeping their appointments and try to kind of bridge that gap so they can keep their appointments.

(Peer 87)

Program evaluation often overlapped with service delivery. Even when peers carved out time specifically to conduct follow-up assessments in keeping with grant expectations, the assessment questions often prompted problem-solving discussions with clients and the need for immediate services. Some peers reported transporting clients while conducting assessments to make the most of their time together and because their clients felt more comfortable talking during a car ride than in more formal settings.

Taking on multiple and overlapping roles was at times difficult. Peers reported that working with clients was energizing but data collection and data entry were draining. Juggling multiple responsibilities was an often-repeated theme:

I think about all the Retention in Care grantees out there; we're collecting this data as a group, but we don't see each other. But we're all pulling at the same place and it will improve the field overall. ... there's an image [in my head] of peers with a beautiful silver tray, and on that tray they're carrying all of the roles that they give to people ... except it's reversed. So they're not giving things off their tray, they're taking things on their tray. So you're supporting people in crisis and you're helping them adapt emotionally and you're helping them get to their appointments and then at the very top of the tray now you're collecting data. And I don't want the tray to tip.

(Peer 8)

CHALLENGES

Many of the conversations about evaluation activities quickly became focused on the self assessment tool. While the assessment of clients as part of a service delivery was an essential part of the peer role, the self-assessment tool itself could be problematic and time-consuming.

So we designed this program, this 6-month intervention, and then we learned that you're doing assessments at 12 months ... this national evaluation that requires 12 months, 18-month data collections. You're following these clients 18 months. That's fine if you have an evaluator who's doing data collection. When the [peer] is doing data collection, even though they're supposed to work intensely with that client in 6 months, when they have to call a client at 12 months and 18 months, they're calling that client on a regular basis, so they're working with the client. If that client has fallen out of care, they wanna make sure that person gets back in care. ... 6 months was a farce ... it's like, a never-ending caseload of re-engaged clients.

(Program Manager 74)

Several peers felt the self-assessment tool was separate from service delivery because it did not directly improve client services: "It's not meaningful for [the clients], it's meaningful for us" (Peer 28). Nonetheless, many peers noted the importance of collecting data to ensure continuation of funding and services.

From that process of data collection ... We just learned that that was a major, major need in our city that no one else was providing. And so, you know, it just gave us different means to do different things for clients. So it allowed us to plug some of the major gaps because there were a lot of people that wasn't getting care, period.

(Peer 85)

Both peers and program managers reported clients felt frustrated by the redundancy of the follow-up assessments. It was often difficult to get clients to return for these, especially those who were homeless, living in shelters, or living in remote areas. This challenge was often eased by incorporating incentives for completion of assessments, which varied by site but often included gift cards and food. "The surveys are long. I always make sure I have snacks, water, we have a coffee maker, sometimes we make coffee for them" (Peer 77).

The self-assessment could be painful for clients and peers alike since it incorporated emotionally difficult topics. This was especially true for peers who personally knew their clients from their own communities, who had similar experiences of being marginalized as their clients, or who had histories of substance use disorders and were working with clients struggling with the same. An extension of this issue was that some peers reported frustration working with people who they thought were not taking care of themselves.

Part of the stress associated with adding evaluation to service delivery responsibilities was that peers were hired because of their strengths working with clients but subsequently had evaluation responsibilities added on. Since many peers joined their organizations to give back and improve the lives of PLWH who were struggling with the same challenges they had

personally overcome, performing evaluation functions that seemed distant from the program mission created stress and dissatisfaction.

From my experience with the community health workers, it's distracting for them when they start it ... They wanted to work with the people. Many of them wanted to provide something to the individuals that they themselves did not have. And so to be able to do this work is very important for them. They wanna be there, help someone navigate through the health care system and understand ... Like that's exciting for them, they really wanna do that. The data is distraction from that for them ... It's not even whether or not they can do it. They end up working through it, but they don't really care for it.

(Program Manager 74)

We actually had one [peer worker] when we were first starting to review the tool, who emailed me and said, can I be put on a different project? Cause when I signed up for this, I signed up to do work with clients and do linkage, and I don't wanna do research.

(Program Manager 74)

A challenge consistently reported by participants was that peers' dedication to their clients limited their own self-care. Peers reported working, supporting clients, and taking calls at all hours of the day with no defined boundaries between work and personal time. Though their supervisors clearly tried to protect them from the stress associated with constantly prioritizing clients' needs over their own, peers reported this level of availability to their clients was part of their mission and were reluctant to create rules about when clients could reach them. Evaluation responsibilities added to peers' workloads and escalated this problem due to the added time required to complete these functions, because some peers felt that the assessments took time away from service delivery efforts, and because the in-depth client assessment brought up many issues that peers needed to work through with clients.

HELPFUL STRATEGIES

Participants discussed several strategies for improving evaluation methods and easing the evaluation burden. Involving peers in the evaluation planning phase helped to refine the evaluation questions, made them more client-centered, and improved buy-in.

But yeah, once we were able to revise the tool so it makes sense, it answers the right questions in the right way, once we created a system of checks and balances involving the [peer], the evaluation team, and the site supervisor. It's coming in cleaner with fewer discrepancies.

(Project Manager 74)

Sharing evaluation outcomes with peers throughout the study period helped them understand the importance of their work, which peers could in turn discuss with clients.

Tying everything together ... showing them, and reminding them that we get this transportation bus pass because of all these data that we've collected. Cause sometimes they'll start to miss the 6 month assessment, and you have to be calm.

“Remember, what we asked you, and why it was important? Like, they’re talking about getting rid of the bus passes, we really need you to come back in.” And then they’re like, “Oh, yeah.”

(Peer 37)

Several useful workflow processes were identified. Some peers conducted client assessments one section at a time to reduce the emotional discomfort of clients and peers. A variety of data entry methods were used; some peers collected data on paper then entered them in a database later, while others used tablets to collect data. This entailed a trial-and-error process for many sites; most tried several options before the ideal methods were identified. Creating priority logs to help peers track which clients were due for follow-ups helped peers to feel less overwhelmed by the need to re-assess clients every 6 months.

I keep a little database on every client, so I’ll put them all on one spreadsheet ... so each day that I come in, I’ll usually pull out the folder that has all of the dates of intake, when they are eligible for their follow ups ... I can get a daily glance who’s within a certain bracket.

(Peer 37)

Some peer teams developed a system to provide backup to each other so that they could each dedicate time to complete paperwork and data entry. Professional development was also highly valued.

TRAINING OF PEERS

Cross-training peers on service delivery, client assessments, and tablet or computer skills helped them feel more confident in their roles and in their opportunities for career growth.

Anyone who’s trained in our project can work in diabetes, they could go to a hospital, they can go work at University of [name redacted], they could work wherever else, and have the basic understanding. And it’s not just that they’ve been trained in one tool.

(Program Manager 74)

Training that addressed evaluation or data collection activities largely focused on confidentiality of data and how to administer the self-assessment tool. These trainings as well as using the tool repeatedly over time helped some peers become more comfortable with data collection processes. Reiterating these messages and the importance of data collection as it relates to service delivery was also useful.

Data collection, numbers, anything with numbers, is challenging for many people. Forms, sheets, check marks ... there are a lot of barriers to data collection. But we do find that we have to reinforce that same message over and over and over and over again. In different ways. It’s not the same thing all the time, but explaining, we have to show them the data. “This is what your data shows us. Is that what you see with your clients? If that’s not what you’re seeing then that’s because we don’t have it ‘cause you didn’t write it down [laughter].” We always have to be doing those trainings and providing that insight.

(Program Manager 22)

However, the majority of peer trainings addressed service delivery. Topics included overdose, harm reduction, medication adherence, patient-centered care, stages of change, motivational interviewing, transgender issues, and intimate partner violence. Trainings on trauma-informed care were highly valued by interviewees who saw this as being beneficial to the clients and to the peers. As noted above, client assessments were acknowledged as not only an important evaluation activity but also an important part of service delivery.

So when we were training the CHWs, it wasn't just, here's this data that you need to use. It was also here's this data that's gonna help shape how you work with this client. The information that the client gives is what you are gonna take notes of. The pieces that make you go "hm, interesting," write that down.

(Program Manager 22)

BENEFITS OF PEER-BASED EVALUATION

In spite of these challenges and stressors, both peers and program managers discussed benefits of having peers perform evaluation tasks. Peers were seen as being highly accomplished in building rapport and establishing connections with clients, which in turn increased clients' comfort and trust. Rapport-building and the fact that peers typically maintained connections with clients throughout the grant period facilitated follow-up assessments.

In one of our studies the peer did the baseline and then the evaluation team did the follow up. They couldn't get in contact with the client. Nobody was returning the calls. Whereas if that person was a peer who had also met the client, then that peer has a relationship and there might be a better chance of them getting to do the follow-up.

(Program Manager 74)

Having peers conduct assessments was thought to help eliminate shame and stigma for the clients, especially since many of the evaluation constructs included sensitive information. Participants believed clients were more likely to be honest with peers about their histories and experiences, resulting in improved data accuracy. As one participant noted, peers are better prepared to hear "dark and hurtful" information from clients and help them get through it.

[Peers] take the time to build the relationship with their clients. I think that they have a better chance of getting information than social workers ... we build a trust within them. They talk to us about stuff that they won't talk to a social worker, or they won't say to a nurse, or not even a doctor.

(Peer 8)

So everything that I was asking, I understood or I had been through it myself, and so I could do it in a way that didn't seem like I was probing or was being ... I never had a person ever tell me "I'm not comfortable with that" or not tell me the answer. They were more than willing to let it all out.

(Peer 37)

In addition to these benefits, several participants noted that being involved in evaluation activities helped peers to develop new skills. Focusing on program outcomes helped them to see the importance of the work that they do.

Actually counting our efforts and quantifying how successful we are I think really kind of confirms what our suspicions are and they we're able to kind of think through, "All right, what do we need to be doing differently?"

(Program Manager 22)

DATA VALIDITY

As noted above, participants believed clients would share stigmatizing information with peers more readily than with professional staff members. However, accuracy of data could be threatened if programs did not standardize evaluation processes. Though all acknowledged the need to test questions and ensure internal validity, using validated assessment tools with fidelity in applied settings at times created disconnect.

And it's a weird balance, right? Cause for so much research, the challenge is that it says, you have to use evidence-based format ... These questions came from research that was done before, that shows that the way these questions are asked is valid. So if you tweak a word in that question, you are changing the validity of the question. It's madness. We need to change that.

(Program Manager 74)

... My panties would be in such a bunch because certain questions I know, sound just alike, and you cannot change anything. And by the end they're like, "if you ask me the same question one more time I'm gonna knock you upside the head." [Laughter.] And I know the way I wanna ask it so they can give me the proper answer, but I can't.

(Peer 87)

Some peers admitted that they did not always follow protocol when recording data. They described how they thought they could change their work to be more effective or to increase clients' levels of comfort. Some reported recording answers differently from what they were told by clients when they felt that clients were not being straightforward or were sharing information inconsistently. One peer indicated, "I know what the answer's gonna be. I can pretty much answer for my clients" (Peer 73).

The degree to which interviewer bias is magnified when peers collect data is unknown. It is important to reiterate that the peers demonstrated a firm understanding of the importance of high quality data yet struggled to balance this with the needs and comfort of their clients. Some peers reported the need to balance the emotionally challenging nature of the job with maintaining the rigor needed to achieve optimal program outcomes:

I don't want to get discombobulated because I need to be present and accountable in order to help, in order to get the data and transfer it overs so it can be put in a process because it would defeat the purpose if I'm not present and accountable.

(Peer 21)

DISCUSSION

Six out of the seven Retention in Care grantee sites used peers to deliver interventions and five of these programs also used peers to collect program evaluation data, despite the fact that few peers had administrative or data management experience prior to their roles in these organizations. Other research has documented the frequent use and value of peer-delivered interventions in HIV care and prevention programs (Arayasirikul et al., 2015; Dutcher et al., 2011; Enriquez et al., 2013; Hawk, 2013, 2014; Marino et al., 2007; Simoni et al., 2011). However, few studies have examined the role of peers in evaluation activities. Community-based participatory evaluation has been gaining traction in research settings and emphasizes the need for community stakeholders to identify target outcomes and shape evaluation designs (Braithwaite et al., 2013). In our study, we found that some peers served this purpose but more often their roles were limited to client assessments, follow-up, and data entry, suggesting a much more hands-on role than is currently described in the literature.

Participants in our study valued the role of peers in both service delivery and data management activities but the overlap in these roles was challenging. In addition to overextending peers, some data collection efforts were seen as taking time away from service to clients. This challenge may be mitigated by involving peers in the development of evaluation plans and by providing training that emphasizes the ways that evaluation and data collection protect and improve service delivery. Creating assessment methods that are trauma-informed and client-centered can ensure that the needs of clients and peers are met. Peers in this study were extremely committed to their clients, which at times limited their own self-care. Since most of them became involved in their work as a way of giving back to their communities, data collection responsibilities could be frustrating to them as it took them away from the work that directly benefitted clients. Still, the various training opportunities that peers participated in not only eased these frustrations but also were valued as professional development that was beneficial to the peers themselves.

The fact that people who delivered services also collected client-level data introduces the threat of bias (Davis, Couper, Janz, Caldwell, & Resnicow, 2010). While interviewer bias may be readily controlled in well-funded research projects by separating those who deliver services from data collection activities, our findings suggest that in applied, real-world program monitoring settings peers participate in both service-delivery and evaluation efforts, creating ethical concerns. Peers' opinions about the effect or value of services could unintentionally affect data rigor. This bias is also relevant to the current study: the qualitative researcher was familiar with study concerns and challenges from their own study site, so this perspective may influence not just interpretation of results but also the development of the qualitative interview guide. This bias may have been mitigated by the involvement of the lead researchers from the national evaluation framework and project officers from AIDS United, who collaborated on the study aims, protocol development, and review of results. Additional research is needed to understand the comparative value of peer-based evaluation and data collection activities in community-based organizations, as well as to develop standards to ensure accurate reporting methods.

While RiC peers were hired for their interpersonal skills they spent much of their energies on evaluation and data collection activities. Though program managers demonstrated genuine concern for and investment in peers, the effort required for evaluation activities may be underappreciated since professionally trained staff members may take these responsibilities for granted. Though programs incorporated trainings to support peers in these functions, managers must also create cultures of acceptance where peers are encouraged to ask questions, discuss challenges, share errors without risk, and problem-solve evaluation issues. The value that each of the grantee sites and program managers held for their peer interventionists was very clear and cannot be overstated. Still, an inherent power differential may make it difficult for peers to bring attention to challenges they are experiencing or problems they see with evaluation activities.

There are clear benefits to peer-based intervention and evaluation activities. Peers may be able to conduct assessments and collect self-report data from clients in a way that feels safer and less stigmatizing to the client, so it is likely that peers take on this work in many community-based settings. Still, adding these responsibilities to peers may pose a threat to their self-care. Our findings are consistent with other studies demonstrating that the transition from client to professional can expose peers to emotional triggers, create feelings of burnout from confronting HIV personally and professionally, and generally cause feelings of stress related to workload demands (Hallum-Montes, Morgan, Rovito, Wrisby, & Anastario, 2013; Li et al., 2015).

This study has several limitations including the threat of response bias. Participants were aware that the qualitative research was sanctioned by the funder and may have been more likely to share information that presented their work positively. This bias may have been mitigated by the rapport the interviewer established with the participants and because she was part of the same grantee cohort and had a shared experience with the study participants. Because we used a convenience sample of RiC participating sites, homogeneity among sites and staff members is expected. While the primary aim of this study—to explore the role of peers in evaluation activities in this multisite study—was met, the fact that only the perspectives of peers and their supervisors were gathered limits interpretation of findings. For example, one of the questions that emerged from the current study was the degree to which peers were able to meet rigorous data collection standards; that question cannot be answered with only the perspectives of these participants. Despite our best efforts to honor the diverse contributions of peer workers, the requirements of not only protecting participant data but also distilling findings to make them accessible in a manuscript may not fully illuminate the fact that participants comprised a diverse group representing five different sites and many experiences, qualities, and positions. Although it is important to develop inferences and initiate discussion regarding the roles of peers in evaluation activities, caution must be used in transferring results to other settings. Our findings will ideally be used as a foundation for further investigation, but given our sample size and the homogeneity of peer roles our results should be interpreted with caution.

CONCLUSION

Many AIDS service organizations make investments in peer workers, and continuing to identify optimal methods of improving evaluation rigor while also supporting peers is not only a means of protecting that investment but also an ethical issue. Given many Ryan White HIV/AIDS program funds peer support as an essential enabling activity to improve clinical outcomes for PLWH (Cahill, Mayer, & Boswell, 2015), it is likely that peers are collecting data in a number of supportive service settings. Understanding these activities can inform programs and routinize data collection methods in order to improve rigor. It is also important to honor the evaluation work of peers by moving the field toward an improved recognition of these efforts so that we can better protect peer workers and the clients they serve. Requests for proposals often suggest a minimum budget to be spent on evaluation activities and many also encourage peer involvement in service delivery; however, rarely do they address appropriate roles for peers in evaluation processes. Institutions that fund programs incorporating peer-based work, including foundations, the Centers for Disease Control and Prevention, and the HIV/AIDS Bureau of the Health Resources and Services Administration, should consider a number of recommendations to improve work in this field. Specifically, the value and appropriate role of peers in not only service delivery but also program evaluation should be clearly discussed and defined. Issues related to rigor in data collection should also be further investigated. Ideally, a set of best practices and standards for peer-based evaluation will be developed. These must address concerns related to the overuse of peers in activities that they may be well-positioned to carry out, such as data collection, but may not have been hired or trained for. Developing best practices and related trainings may serve the dual purpose of not only improving data rigor but also valuing and protecting the many roles that peer workers carry out. While there are many intervention trainings targeted to peers including community health navigators, federal funding agencies might also consider developing wide-reaching training opportunities that address peer-based evaluation activities.

Additional research should inform best practices for peer-based evaluation. While peer-conducted assessments might increase the comfort of the client, it is primarily the program that benefits from this work rather than the peers or the clients. Peer-based evaluation suggests promising results given the abilities of peers to establish rapport and trust with clients, yet we must be intentional in decisions about adding responsibilities to peer workers' caseloads. This decision-making process creates a paradox in that peers are relied on to improve outcomes for clients, but these benefits sometimes come with a cost to the peer workers. Improving the lives of PLWH also includes those who are working in paid peer positions. Future studies should carefully weigh potential costs against the value of peer-based evaluation to the program, the peer, and the client.

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TABLE 1.

Participating Retention in Care Sites

Organization, Program, Location	Description of RiC-Funded Services	Interview Dates	Number of People Interviewed
The Open Door, Inc., Client-Centered Representative Payee, Pittsburgh, PA	A harm reduction housing stability program that provided client-centered representative payee services to help clients manage income and pay rent and bills on time, enabling them to reduce stress and chaos and thus prioritize medical care and adherence.	May 15, 2015	2
Christie's Place, CHANGE for Women, San Diego, CA	A program that built on trauma-informed and gender-responsive models of care to address the structural barriers to care faced by women living with HIV, by creating a network of partnership organizations and helping women to access medical care, social services, and substance use and mental health supports.	May 21, 2015	5
AIDS Alabama, Living Well, Birmingham, AL	A holistic wellness program that used peer navigators and incorporated case management, services, transportation, medication adherence support, peer accompaniment to medical appointments, and linkage to social services for marginalized PLWH.	June 10–11, 2015	6
Institute for Public Health Innovation, Total Health Partners, Prince George's County, MD	A community health workers intervention that provided personalized assistance to PLWH who had dropped out of care or were sub-optimally engaged in care, to assist them in participating and remaining in medical care.	Aug. 4–5, 2015	3
BOOM!Health, Bronx Health Connect, Bronx, NY	An intensive outreach program that used a harm reduction approach to provide a range of services including health navigation, peer support, adherence reminders, and counseling.	Sept. 9, 2015	3

TABLE 2.**Interview Protocol**

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1. As part of [project name], how are data collected?
 - Probe on processes including client assessments, working with clinics to obtain laboratory or visit data, any other data collection, data entry, up-loading data, and making sure that data were collect and complete)
 2. Describe how [organization name] collected data before [project name].
 3. Describe your role in data collection for [project name].
 - Probe: Describe how you interacted with clients to collect data.
 - Probe: Describe your role in collecting data from medical clinics.
 - Probe: Describe your role in entering data.
 - Probe: How did you and your team make sure that the data were correct and complete?
 - Probe: Did you use any technology for collecting the data? [If needed, can give example of doing a client assessment using a laptop.]
 - Probe: Describe how you worked with the evaluators for [project name]
 4. How did you get involved in collecting data for [project name]?
 - Probe: Can you describe any training you got?
 - Probe: Please describe any support that was available for data collection. [If needed, ask “did you have someone you could go to for questions?”]
 - Probe: If you know, could you describe project’s expectations for you in collecting data? How did you find out about these expectations?
 5. Describe your role in shaping the data collection processes.
 - Probe: Did you have the opportunity to share your ideas about what kinds of data should or should not be collected?
 - Probe: Did you have input on who would do data entry or how it would work?
 6. Can you describe any challenges you might have faced in collecting data?
 7. Tell me about anything that improved the evaluation process or made it easier.
 8. Has data collection and reporting affected how you and your team run [project name]? Can you describe how?
 - Probe: Has data collection affected your work with clients? [If so], can you tell me more about that?
 - Probe: To what extent has data collection affected [organization name], if you feel it has?
 9. How were evaluation results shared with program staff?
 - Probe: Did these results impact the day-to-day implementation of [program name]? If it did, can you tell me how?
 10. What concerns you about having peers collect data, if anything?
 11. What can be gained by having peers collect data?
 12. From taking part in data collection, do you feel that you’ve gained anything? Can you tell me about that?
 13. If you could do anything to improve these data collection procedures and processes, what would you do?
 14. We would really like to help other organizations learn from your work. If we were trying to have other agencies implement a data collection process like this, what would be important for them to know?
 15. Is there anything else about data collection that you’d like to share?
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