

Peer-Based Data Collection: Metric Recommendations

Background

Now that the PWI & EPOC projects are ending, we want to leave you with some lessons learned from our data collection efforts. We highly encourage you to continue data collection on your own to inform your organizational efforts and to share with potential funders and stakeholders later. We used Faces & Voices of Recovery’s expertise in data analytics in the peer-led organizational space to help us develop the recommendations (listed below) for what data to continue collecting, what data to start collecting differently, and what additional data to begin collecting post-project. Following these recommendations will better position you alongside similar organizations in the behavioral health field that are tracking these metrics, contributing to the field’s ability to develop evidence-based practice and effective interventions that mitigate crises in our state and increase your likelihood of acquiring additional funding streams.

Demographic Review

Demographics Overall

Topic	Recommendation
Profiles and Representation	<p>Utilizing demographic information to characterize individuals as composites of their demographic attributes enhances data analysis capabilities and incorporates the concept of intersectionality. For example, understanding that Hispanic women aged 45–65 tend to disengage from programming earlier than Hispanic men aged 18–45 can help determine potential service gaps and staffing issues.</p> <p>Comparing the demographic profiles of staff to the population they serve, weighted by employment status (full-time equivalent or part-time equivalent), enables more comprehensive</p>

representation analysis. This comparison can aid in identifying demographic groups that may be underrepresented in the workforce. Moreover, conducting additional analysis to determine the extent to which clinicians and peers align with the specific demographic characteristics of individuals in their caseload offers a more nuanced perspective on representation.

Multivariate analysis becomes particularly valuable when demographic data are considered collectively, portraying individuals as holistic entities rather than isolated data points. This approach allows for a deeper understanding of the intricate intersections of various demographic factors and their influence on outcomes or service provision.

Demographics as Outcomes

Expanding data collection to encompass demographic variables that evolve over time can enrich outcome measurement and enhance representation analysis. For instance, gathering information on employment status could signal the necessity for referrals to job programs and, in the future, serve as evidence of program success. Additional demographic fields, such as involvement with the Department of Children and Family Services, education level, legal-system involvement, housing situation, insurance status, and transportation accessibility, among others, can provide valuable insights.

Incorporating these measures can aid in assessing the representation of individuals being served, as peers with similar histories or experiences may relate on another level that previously collected data might not capture. This comprehensive approach to data collection not only improves our understanding of the demographics of those accessing services but also

facilitates the identification of tailored interventions and the evaluation of their effectiveness over time.

Accessibility of Services

Including accessibility as a domain in the analytics is crucial. While representation is important, understanding an individual's ability to access appropriate and timely services can significantly impact predictive analytics and outcomes for those being served.

Incorporating factors such as address or distance from service locations, in addition to transportation availability, introduces an additional dimension to the analysis. This can help identify individuals who may require additional support, such as bus passes or access to community services.

Regarding language, it's essential to consider both the language spoken by the clinician and the preferred language of the participant. While clinicians' proficiency in various languages is important, participants' accessibility hinges on receiving services in their preferred language. To fully capture accessibility, service logs should document the language in which services were provided or indicate when the participant's preferred language was used. Tracking this at the service level shifts the focus from merely having someone who speaks the participant's language to ensuring that participants receive services in their preferred language a significant percentage of the time, thereby enhancing accessibility and quality of care.

Demographic Fields

Field

Recommendation

Race and Ethnicity

The federal government is changing race to be more inclusive, and implementation of this change will assist in gathering info that may be required in the future for grants. This change is also spurred by the desire to be more inclusive of race and ethnicity. Consider this noteworthy information from the Population Reference Bureau: [PRB article titled "Race/Ethnicity Categories in Federal Surveys Are Changing: Implications for Data Users"](#)

Race and ethnicity should avoid use of "more than one race," which obscures specific racial and ethnic details. Instead, a multiselect option would enable the capture of each detail individually while still allowing for aggregation into the "more than one race" category when necessary for analysis or reporting purposes.

Ethnicity should not replace race. Both race and ethnicity classifications should be available, offering a range of options such as "Latino and white." The use of multiselect options would facilitate the capture of relevant details for population segmentation as needed.

Gender

Collecting data on cisgender and transgender identities is crucial for demographic purposes and for identifying referral and programming options that cater to specific individual needs. However, it's worth noting that in some states, providers are not permitted to ask this question. Additionally, staff members might feel uncomfortable asking or reporting on transgender identities, leading to potential underreporting of transgender individuals or overreporting of those selecting "Other/Unknown."

One way to address this is by phrasing the question as “What gender do you identify as?” followed by a multiselect response format that includes options such as “male,” “female,” “transgender,” “nonbinary,” “prefer not to self-identify,” and “decline to answer.” Including “decline to answer” as an option can serve as an indicator of discomfort, prompting follow-up or allowing for updates over time by the provider. This approach promotes inclusivity and ensures that individuals’ identities are accurately captured while respecting their privacy and comfort levels.

Sexual Identity

Incorporating additional response options such as “questioning” and “prefer not to self-identify” can contribute to mitigating instances of nonreporting, recognizing that individuals may not always feel comfortable identifying with a single group or may still be exploring their identity. This approach encourages ongoing dialogue and follow-up, particularly if the question is asked only during the initial or early phases of engagement. It acknowledges the complexity of identity and respects individuals’ journeys toward self-understanding and expression.

Age Groups

Collecting date of birth (DOB) rather than age is highly recommended for accurate age calculations at any time. DOB can be combined with initials or another convention to create a deidentified ID for each user. For example, Joe Smith, born on December 1, 1980, could have a unique ID of joSmi801201, created using the first two letters of the first name, first three letters of the last name, year of birth, month of birth, and day of birth. This approach helps maintain anonymity when participants sign in via paper or online systems, which are less secure.

Using ranges based on behavioral health (BH) prevalence of disease groups can make evaluations more meaningful. Refer to the following studies:

- [Study 1](#)
- [Study 2](#)

Grouping youth (under 18) and young adults (18–21) separately may provide clearer outcomes. Additionally, distinguishing between individuals aged 65 to 80 and 80 or older can be beneficial. Using DOB instead of age or age group allows for flexible data manipulation, enabling dynamic age grouping to better understand the impact of age on outcomes in the population and in predictive analytics models.

Language Spoken

See Accessibility of Services for additional information.

While collecting all languages spoken by an individual can be important, particularly for staff, it is crucial to focus on the participant's preferred language. Comparing participants' preferred languages with the languages spoken by staff can provide a clearer picture of whether participants' needs are being met.

It is recommended to collect the percentage of individuals who received services in their preferred language. The provision of services in the preferred language may vary significantly if multiple staff members with different specialties are involved. Just because a staff member speaks a language does not mean they are handling all interactions with the participant.

Representation

See Profiles and Representation for additional information.

When collecting information from employees, it can be difficult or seem unethical to ask about historical involvement with law enforcement and other systems. However, gathering data related to a staff's peer status, such as having had personal experience with these topics, may reduce the burden of data collection and increase willingness to provide information. Including options such as "declined to answer" or "unknown" would facilitate data collection with a required field, although it is recommended that this field is not mandatory.

Services Review

Services Overall

Topic	Recommendation
Services as an Outcome	Specificity of services allows for measures that accurately track the general outcomes of the services provided. The recommendations listed in the Service Field section and Services Provided row are relevant to both services provided and referrals. Allowing for the selection of additional categories can clearly identify the value to the community and individuals, as well as highlight the need for additional investment when services are not available when needed.
Referral Tracking	Although referred services may be more general than those that can be captured internally, tracking the reasons for referrals can be useful. Following up on whether a referral has been completed and understanding why it has been or has not been completed can add value to understanding participant preferences and the availability of services in specific areas.

Service Field

Field	Recommendation
Services Provided	<p>As noted above, the services provided, or those referred to, should allow for overlap across categories (i.e. Trauma Informed Care and Life Skills). Alternatively, clarification could be added to each of the identified services (i.e. Peer Services for BH).</p> <p>Recommendations by category include the following:</p> <p>Peer services: This service could fall under behavioral/physical health (BH/PH) or substance use disorder (SUD). Collecting this</p>

detail by either defining the type above (i.e. Peer Services for SUD) or allowing multiselect in one referral should highlight the service intent and related outcome. On the other hand, tracking of service provider with credentials or certificates may identify the type of service provided. For internal services, identifying referrals from BH/PH providers can measure how people are engaging with internal resources.

Recovery housing: This field suggests that housing is not made available for those with BH issues. However, with the Housing First Model, recovery housing may need to be expanded to include housing placement regardless of active use. The recommendation is to add short-term and long-term placement in different level facilities including transitional housing. Numbers related to placement when used with partners could indicate total number of units available and shortages that may exist in the community.

Crisis intervention: This should be categorized further. For instance, overdose Emergency Department connection to peer supports would be significantly different from BH crisis with law enforcement handoff or self-identified crisis with participant outreach. These distinctions can show the community cost/benefit when measuring the impact on other support/emergency departments.

Life skills development: This may overlap with peer supports depending on who provides the service. Using a tracking provider with credential or certificate may lead to better understanding of outcomes based on relationships that exist between the participant and care team.

Mental health services: This category is limiting as it does not specify if the activity involved assessment, diagnosis, support, or treatment. Services may be provided by peers or physicians. Using credentials or certificates or billing codes can clarify population needs and the potential for peer supports to engage individuals in BH/PH/SUD treatment, or vice versa. Integration is further complicated without clear identification of whether services were provided in tandem with internal referrals.

Trauma-informed care: Clarify if this refers to training or the application of trauma-informed care in services. Ideally, all staff are trained in trauma-informed care and therefore all interactions with participants would naturally fall under a trauma-informed service.

SUD: This category may overlap with recovery planning and other areas. Using diagnosis on services or multiselect options can address this overlap.

Justice-involved populations/reentry services/diversion programs: These programs can be very different based on services received and court mandate and should be separated. Outcomes of these programs should be measured differently; segmentation is highly recommended.

Training Review

Training Overall

Topic	Recommendation
Details and Tracking	<p data-bbox="909 383 1923 488">In addition to tracking trainings provided both organizationally and externally, it is essential to track the number of individuals trained in specific topics.</p> <p data-bbox="909 537 1944 837">Establishing job role-based training goals can significantly enhance staff capacity to deliver services effectively. For example, requiring all supervisors to undergo peer staff supervision training or ensuring that supervisors with peer reports receive this training can greatly enhance agency operations. Setting deadlines for completing these trainings based on availability prioritizes their completion and significantly impacts job readiness.</p> <p data-bbox="909 886 1944 1105">For instance, in some states, all staff members—regardless of role—who may interact with participants/clients are mandated to complete trauma-informed care training within 30 days of employment. This ensures that the onboarding process includes a training that profoundly impacts the individuals served and all points of contact, irrespective of administrative or clinical roles.</p>

Outcomes Review

Outcomes Overall

Topic	Recommendation
Details and Tracking	<p data-bbox="909 383 1950 529">Define measurable goals: Clearly define the goals and outcomes that are relevant to the recovery process, such as reducing substance use, improving mental health, enhancing social support networks, or increasing employment stability.</p> <p data-bbox="909 573 1923 756">Select appropriate measurement tools: Choose validated assessment tools and instruments that are suitable for tracking the chosen outcomes. This may include standardized questionnaires, self-report measures, or behavioral observations.</p> <p data-bbox="909 800 1944 984">Establish a tracking system: Develop a system for collecting and recording outcome data, ensuring confidentiality and privacy protections are in place. This could involve paper-based forms, electronic surveys, or specialized software platforms designed for outcomes tracking in health care settings.</p> <p data-bbox="909 1027 1944 1211">Regular monitoring and review: Implement a schedule for regular outcome assessments, considering the frequency of data collection that is feasible and appropriate for participants. Set aside time for reviewing and discussing the results with peers, providing feedback, and updating goals as needed.</p> <p data-bbox="909 1255 1944 1369">Utilize data for decision-making: Actively use the collected data to inform individualized support plans, track progress over time, and evaluate the effectiveness of peer recovery interventions.</p>

Encourage participants to actively engage with their own data and participate in the decision-making process.

Continuous improvement: Continually evaluate and refine the outcomes tracking process based on feedback from peers, staff, and stakeholders. Identify areas for improvement and implement changes to enhance the relevance, accuracy, and usefulness of the data collected.