THE DESIGN AND IMPLEMENTATION OF A PROGRAM MODEL FIDELITY ASSESSMENT

Ryan White Part A Transitional Care Coordination for Homeless and Unstably-housed PLWHA

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National Conference on Social Work and HIV/AIDS
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AGENDA

Overview of the TCC Program Model

Fidelity Assessment Years 1 & 2

> Program Self-Assessment

Fidelity Assessment Year 3

> Chart Review Assessment

Lessons Learned and Next Steps

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OVERVIEW OF THE TCC PROGRAM MODEL

Ryan White Part A TRANSITIONAL CARE COORDINATION (TCC)

Adapted from the CRITICAL TIME INTERVENTION (CTI)

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TCC Adapted from CTI

Critical Time Intervention (CTI)

- Developed by the Center for Urban Community Services (CUCS) at Columbia University and the New York Psychiatric Institute

- Target population: mentally ill individuals with a history of homelessness

- Evidence-based, cost-effective intervention provided at a "critical time" to connect and strengthen people's long-term ties with formal/informal community supports

- www.critialtime.org

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TCC Adapted from CTI

▸ **Transitional Care Coordination (TCC)**

 ▸ CUCS and NYC DOHMH Bureau of HIV/AIDS adapted CTI for the RW Part A client population in NYC

 ▸ Five (5) community-based organizations have been implementing TCC since 2011

 ▸ Performance-based contracts

 ▸ TCC programs serve over 650 clients annually

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TCC TARGET POPULATION

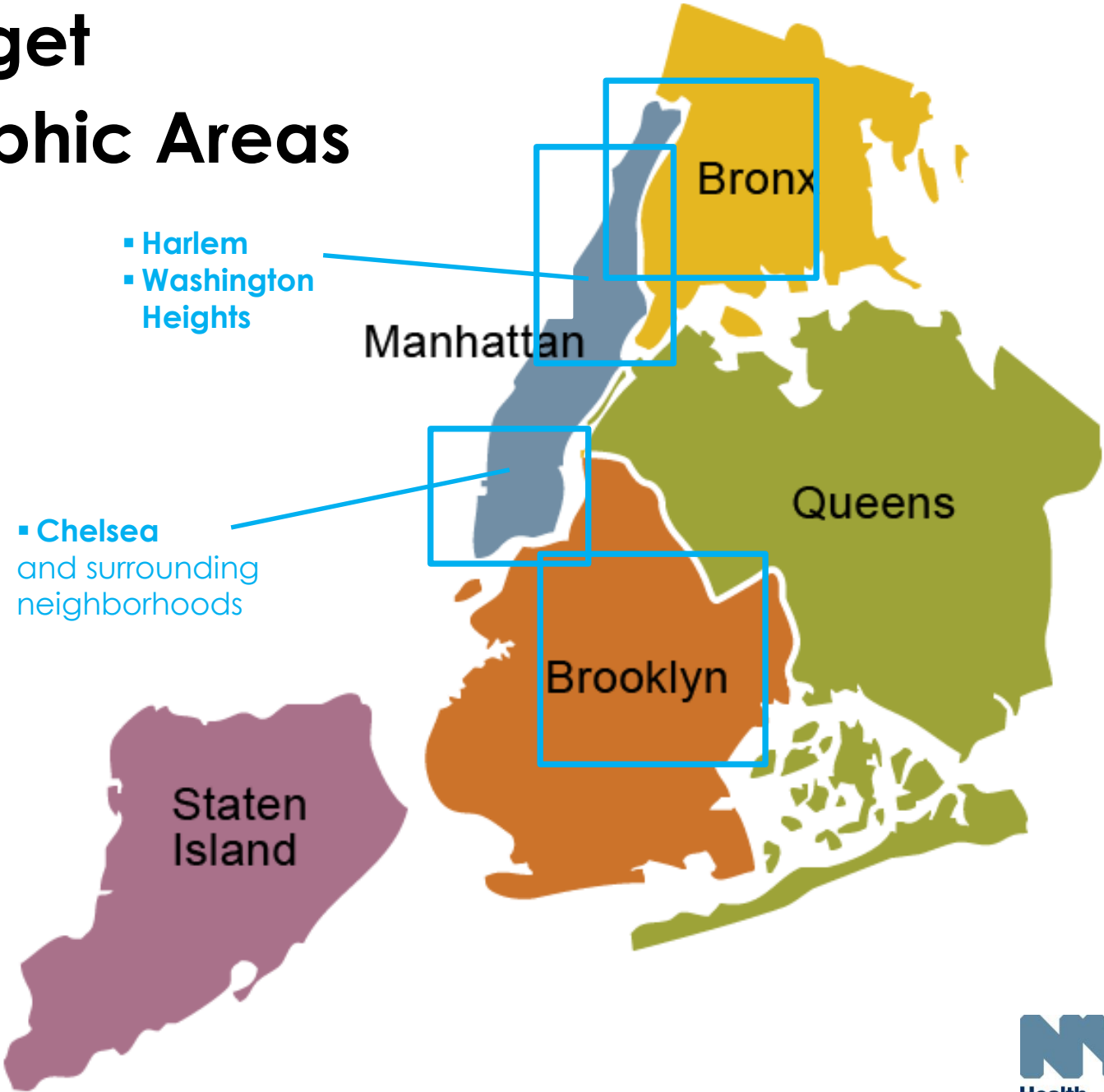|	
PLWHA (ages 18+)	One or more of the following:
Residency in NY EMA	▪ Newly diagnosed with HIV
Income < 435% FPL	▪ Lost to care
Homeless or unstably-housed	▪ Difficulty adhering to ART
	▪ Difficulty keeping appointments or receives sporadic primary care

TCC PROGRAM GOALS

Ensure entry into and continuity of HIV primary medical care	Provide linkage to housing services and other supportive social services	Decrease unnecessary Emergency Room visits and hospitalization

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TCC Target Geographic Areas

- **Harlem**
- **Washington Heights**

Manhattan

- **Chelsea** and surrounding neighborhoods

Bronx

Queens

Brooklyn

Staten Island

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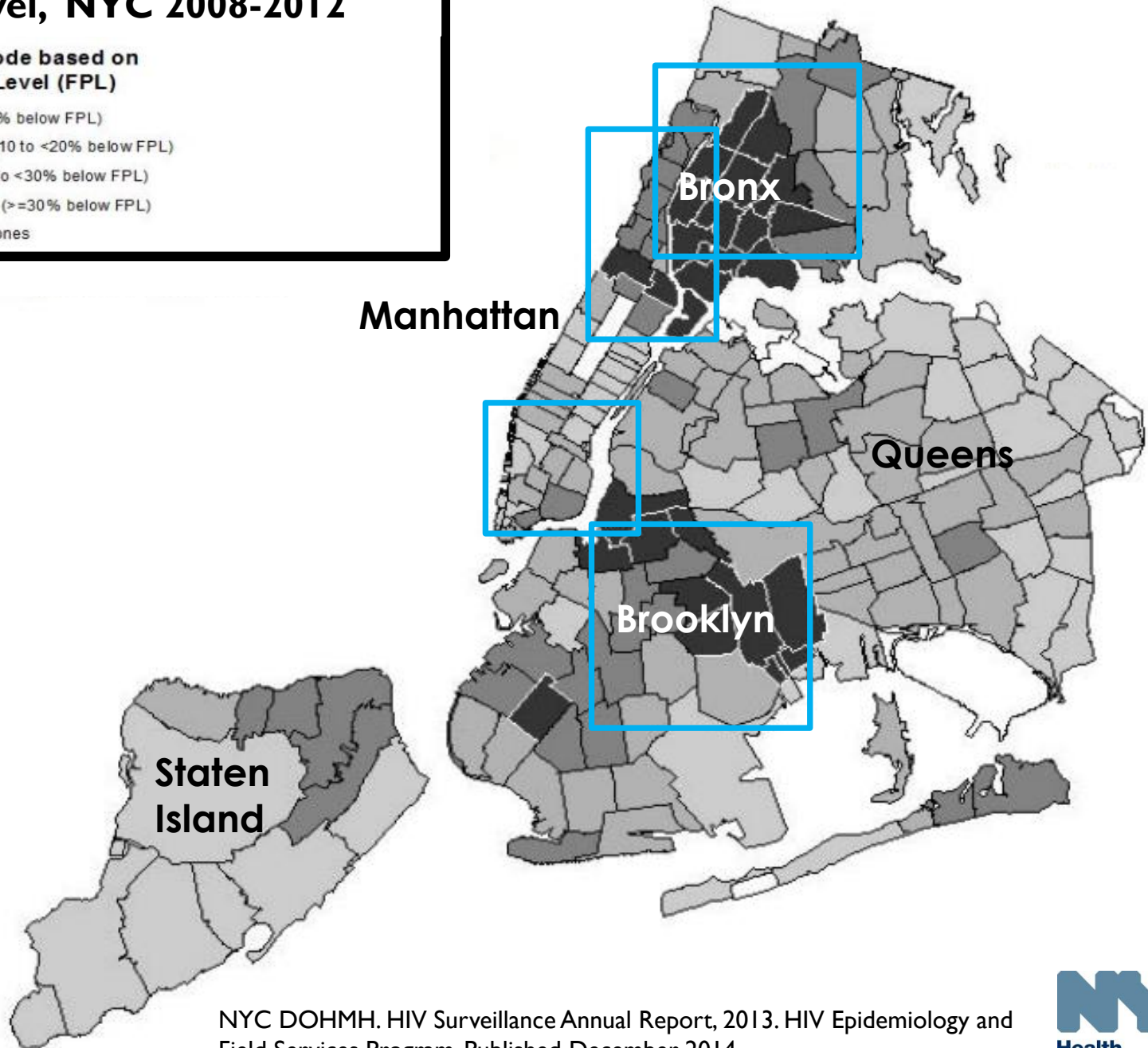Poverty level, NYC 2008-2012

Poverty by ZIP code based on Federal Poverty Level (FPL)

- Low poverty (<10% below FPL)
- Medium poverty (10 to <20% below FPL)
- High poverty (20 to <30% below FPL)
- Very high poverty (>=30% below FPL)
- Non-residential zones

Bronx

Manhattan

Queens

Brooklyn

Staten Island

NYC DOHMH. HIV Surveillance Annual Report, 2013. HIV Epidemiology and Field Services Program. Published December 2014

HIV prevalence, NYC 2013

PLWHA as percent of population[1] by ZIP code
- 0.1 – 0.5
- 0.6 – 1.0
- 1.1 – 1.8
- 1.9 – 6.4
- Non-residential zones

Bronx

Manhattan

Queens

Brooklyn

Staten Island

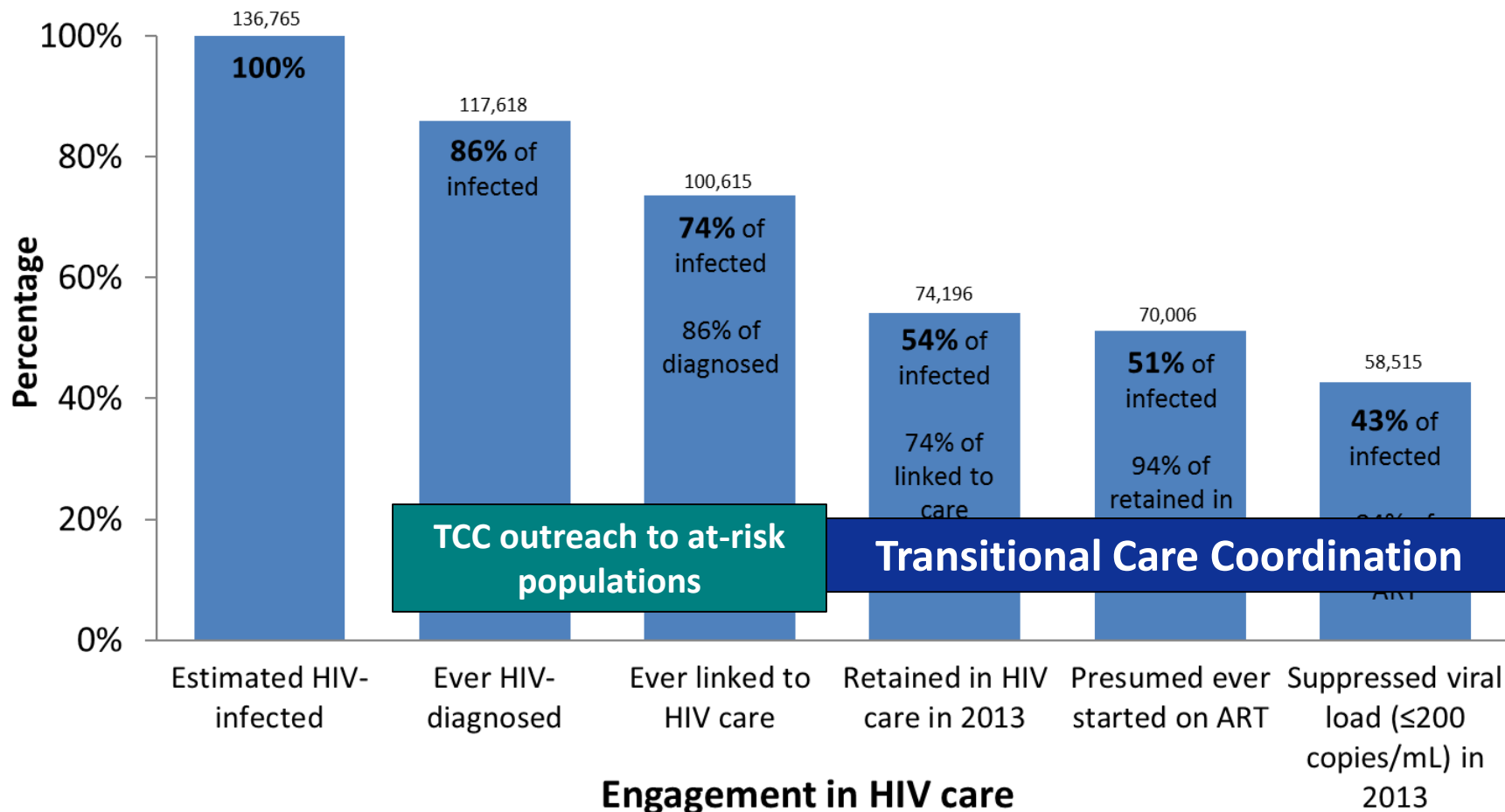NYC DOHMH. HIV Surveillance Annual Report, 2013. HIV Epidemiology and Field Services Program. Published December 2014

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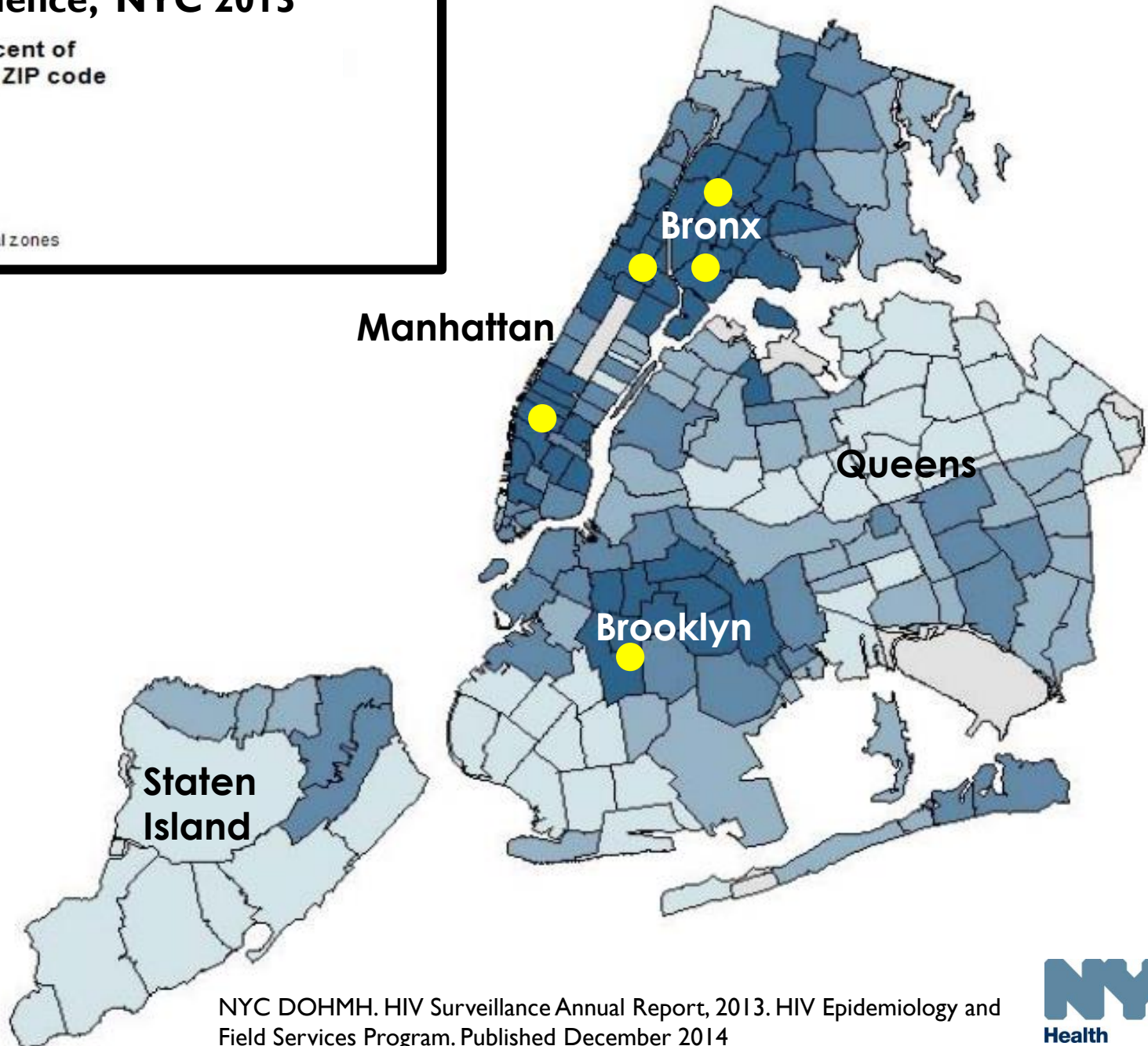
Number and proportion of persons with HIV in New York City and engaged in selected stages of the continuum of care at the end of 2013

Percentage (y-axis)

Engagement in HIV care (x-axis)

- Estimated HIV-infected: 136,765 — **100%**
- Ever HIV-diagnosed: 117,618 — **86%** of infected
- Ever linked to HIV care: 100,615 — **74%** of infected; 86% of diagnosed
- Retained in HIV care in 2013: 74,196 — **54%** of infected; 74% of linked to care
- Presumed ever started on ART: 70,006 — **51%** of infected; 94% of retained in
- Suppressed viral load (≤200 copies/mL) in 2013: 58,515 — **43%** of infected

TCC outreach to at-risk populations

Transitional Care Coordination

Of all persons estimated to be infected with HIV in NYC, 43% have a suppressed viral load.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2014.
For definitions of the stages of the continuum of care, see Appendix.

Core Components of TCC Program Model

▸ Time-limited case management

▸ Five (5) phases

▸ Emphasis on early engagement

▸ Community-based work

▸ Team-based intervention

  ▸ Recommended Program Staffing
    - Program Director (MSW)
    - Clinical Supervisor (LCSW, LMSW)
    - Program Coordinator
    - Outreach Specialist(s)

Core Components of TCC Program Model

▸ Comprehensive Care Plan (CCP) with 1-3 Areas of Focus
- - Medical   - Case Management
- - Health   - Benefits/Entitlement Assistance
- - Housing   - Building Support Network

▸ Promote gradual behavior change
- ▸ Harm Reduction
- ▸ Motivational Interviewing
- ▸ TCC Health Promotion Curriculum

▸ Three (3) Primary Linkages
- ▸ Primary Care
- ▸ Housing Services
- ▸ Long-term Case Management

▸ Intensity of services with client decreases as client self-sufficiency increases

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FIVE PHASES OF TCC

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Targeted Outreach and Referrals Using TCC Criteria	Intense Period of Engagement Assessment Develop Comp. Care Plan (CCP) Health Promotion Begin Linkages to Providers	Adjust and Monitor Linkages Health Promotion Less Frequent Meetings between TCC Staff and Client	Adjust and Monitor Linkages Finalize Linkages Client Graduation	Follow Up with Client and/or Providers
PHASE 0 Outreach & Engagement	**PHASE 1** Transition to TCC	**PHASE 2** Try Out	**PHASE 3** Transfer of Care	**PHASE 4** Follow-Up
MONTH 1	**MONTHS 1-3**	**MONTHS 4-6**	**MONTHS 7-9**	**MONTH 12**

CCP → CCP → CCP → CCP

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TCC Client Demographics*

Gender
N = 622
- Male
- Female
- Transgender

2.3%

23.6%

74.1%
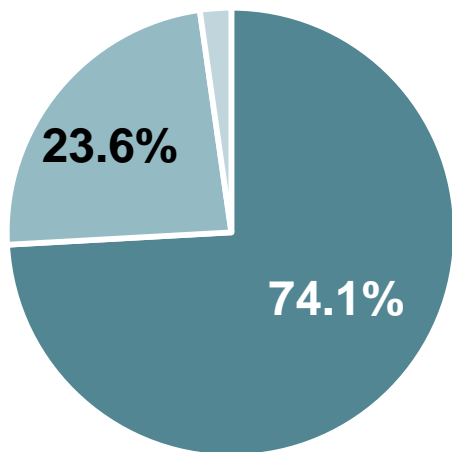
Race/Ethnicity
N = 622
- Black
- Hispanic
- White
- Other

6%

9%

54%

31%
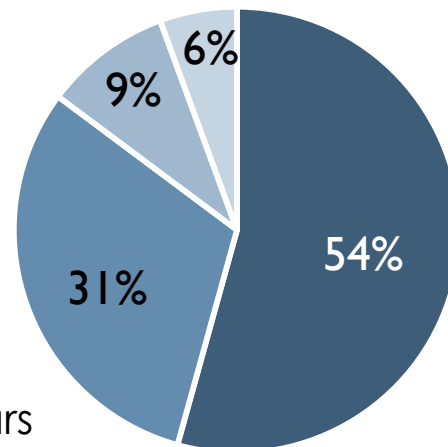
Age
N = 622
- <=29 years
- 30-49 years
- >=50 years

11.4%

42.4%

46.1%
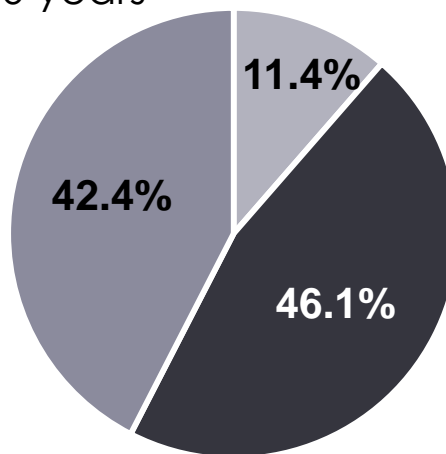
*Clients with an open enrollment at any point from 3/1/2013 – 2/28/2014 (GY 2013) and a Comprehensive Care Plan completed before 12/1/13.

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Living Situation at Intake (N= 622)

Single Room Occupancy (SRO) hotel	**59.7%**
Staying in someone else's (family's or friend's) room, apartment, or house	**21.7%**
Room, apartment, or house that you rent (not affiliated with a supportive housing program)	**9.0%**
Emergency shelter (non-SRO hotel)	**3.7%**
Hospital, institution, long-term care facility or substance abuse treatment/detox center	**2.4%**
Supportive Housing Program; Homeless/Place not meant for human habitation (such as a vehicle, abandoned building or outside); Apartment or house that you own; Other hotel or motel (paid for without emergency shelter voucher or rental subsidy); Other; Blank	**<2% each**

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ASSESSING FIDELITY
TO THE TCC PROGRAM MODEL

Why does implementation fidelity matter?

- Measuring fidelity helps us understand:
  - How and why an intervention works (or doesn't work)
  - To what extent outcomes can be attributed to an intervention
  - How outcomes can be improved

> **How closely does the actual implementation of Transitional Care Coordination (TCC) align with the TCC Program Model?**

Carroll, et al (2007) A conceptual framework for implementation fidelity. *Implementation Science, 2(40), 1-9.*

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FIDELITY ASSESSMENT Years 1 & 2 (2011- 2013)

Self-Assessment + Fidelity Alignment Plan

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Assessment Methods and Tools

TCC-CTI Fidelity Scale

TCC-CTI Self-Assessment Tool

On-site Fidelity Conversation Meetings

Fidelity Alignment Plans

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Example Fidelity Standards

≥ 3 community-based meetings with client during Phase 1

≥ 95% of weeks had team supervision meeting

Compliance Fidelity [Components] (15)

Context Fidelity [Structure] (8)

Competence Fidelity (15)

Program Quality (15)

Closing note documents final joint transfer-of-care meeting

Positive mediation and negotiation between client and support network
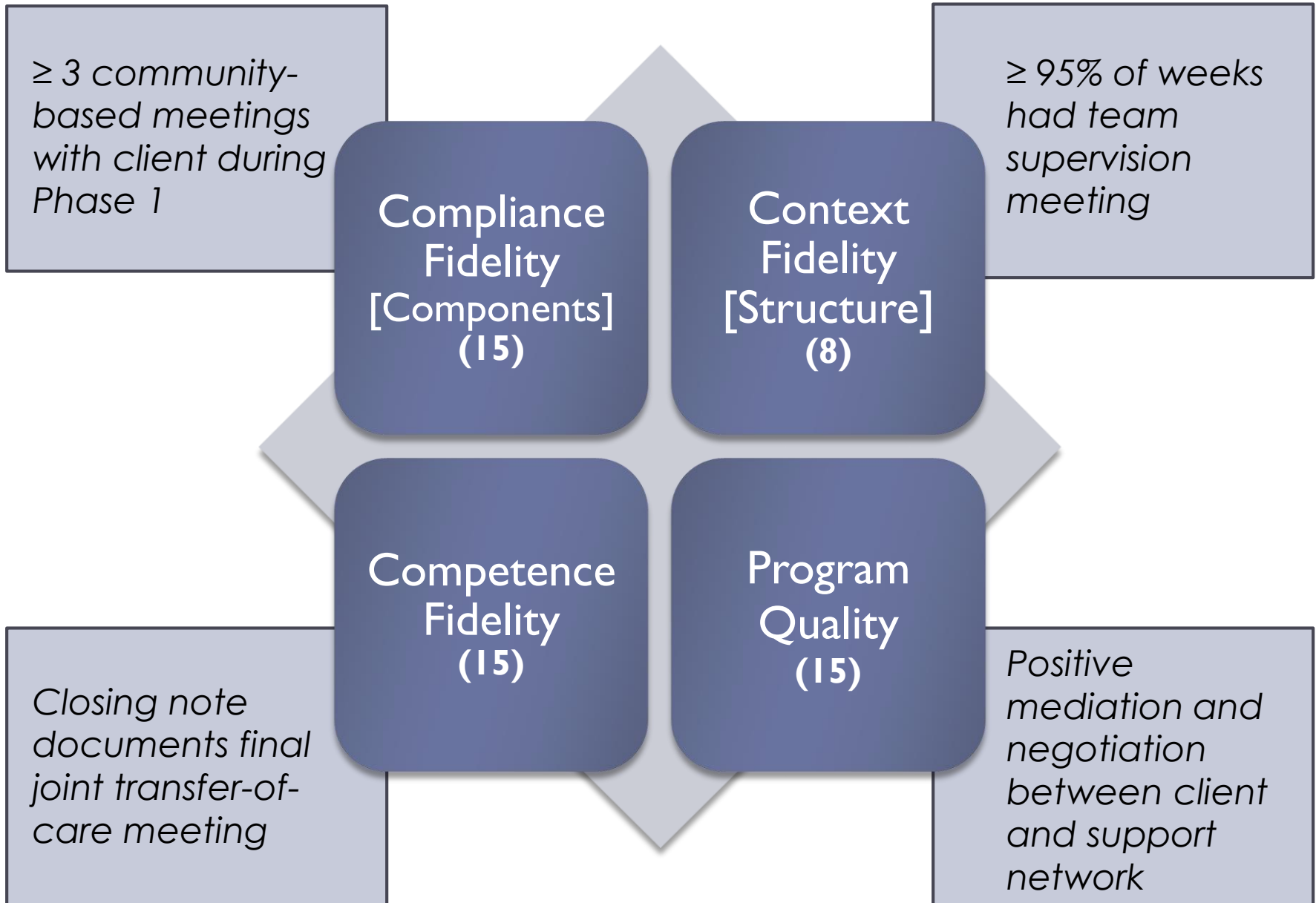
Self-Assessment Results

Average Score

Fidelity Scale (1 = Never, 5 = Always)

A	B	C	D	E
4.58	4.42	4.39	4.22	4.18

TCC Agencies

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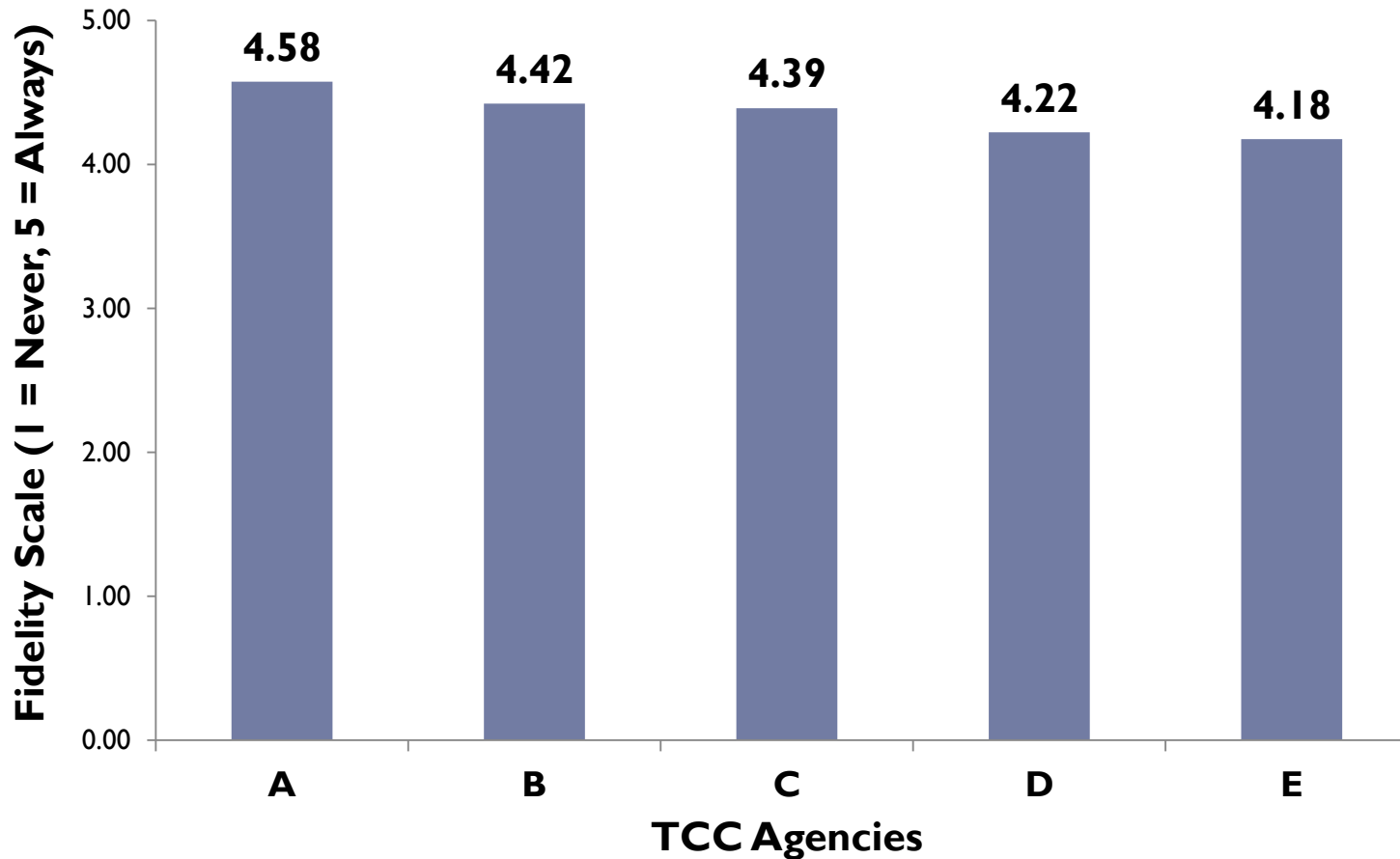
HIGH SCORING STANDARDS

‣ Early engagement

‣ *Formal* supports

‣ Community-based meetings

‣ Focused Care Plans

‣ Team supervision meetings

‣ Worker's role with clients

‣ Worker's role with linkages

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LOW SCORING STANDARDS

- *Informal* supports

- Timely Care Plan Updates

- Decreased communication with client by Phase 3

- Worker's role with linkages
  - Educate clients' families and providers about TCC

- Closing notes:
  - final transfer-of-care meeting
  - client feedback
  - prognosis for client's long-term continuity of care and housing stability

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Fidelity to TCC Model

TCC-CTI Scoring Key

>85%	• Ideally Implemented
71%-85%	• Well Implemented
56%-70%	• Fairly Implemented
41%-55%	• Poorly Implemented
<40%	• Not Implemented

Fidelity Percentage (y-axis: 50% to 100%)

- A: **87%**
- B: **85%**
- C: **86%**
- D: **81%**
- E: **80%**

TCC Agencies (x-axis)
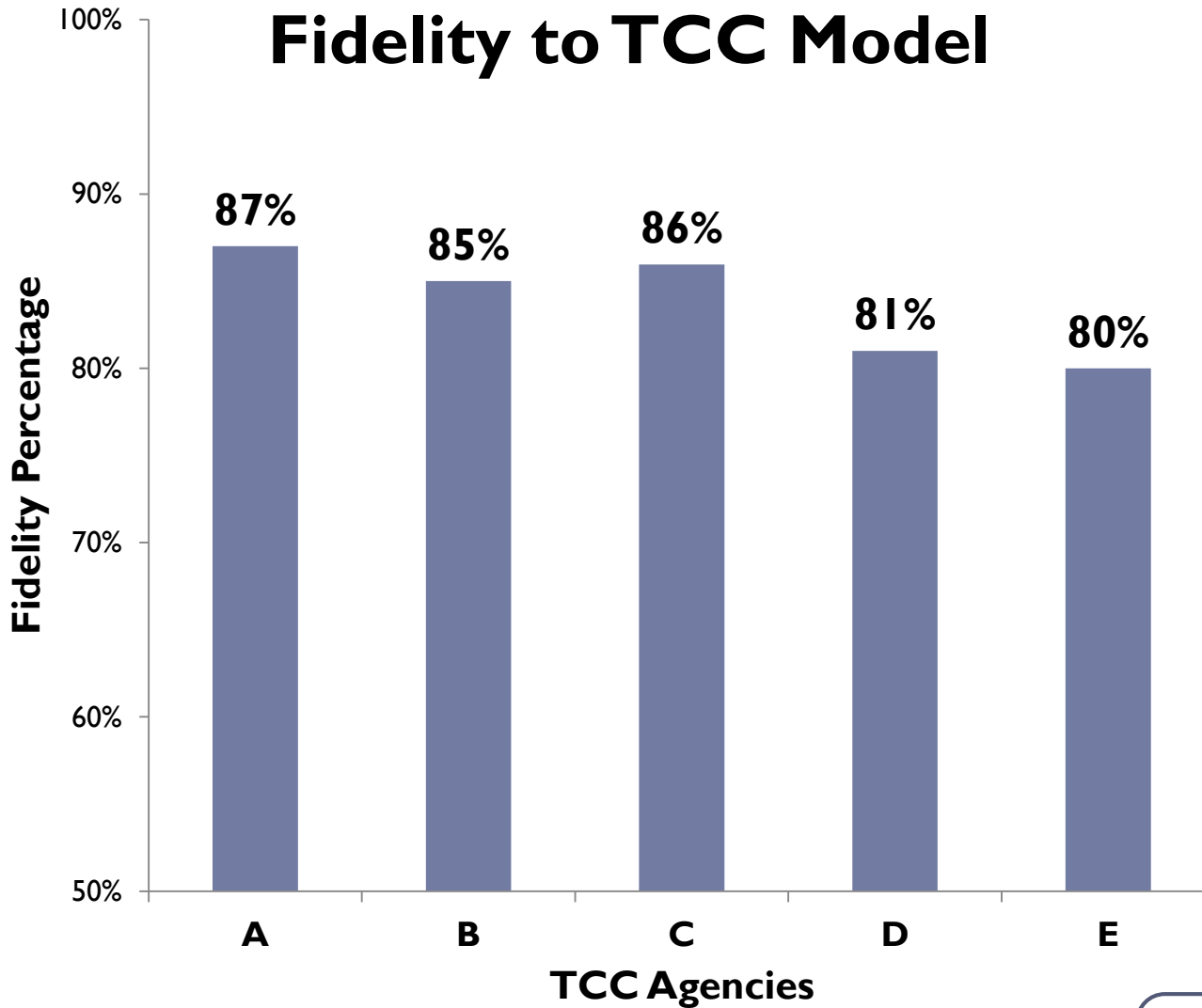
$$\text{Fidelity \%} = \frac{\text{Total Score}}{\text{Total Possible Score}}$$

On-Site Fidelity Conversation Meetings

Conducted by the Center for Urban Community Services (CUCS) with each TCC program

- Review completed TCC Self-Assessment

- Focus group discussion with program staff

- Discuss concrete plan to improve fidelity

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Fidelity Alignment Plan (agency-level)

▸ Developed by CUCS based on Self-Assessment results and Fidelity Conversation Meetings

  ▸ Concrete action steps

  ▸ Person(s) responsible

  ▸ Due date

▸ Documents initial and adjusted scores

▸ Finalized by CUCS and agency

Feedback from Providers

▸ Designed to help programs; not punitive

▸ Allowed opportunity for real and honest conversations

▸ Clarified elements of TCC program model

▸ Realistic recommendations

▸ Transparent, collaborative process

▸ External perspective on their work

▸ Reassurance that they were "on the right track"

CUCS Findings

▸ High degree of fidelity

▸ Providers scored themselves lower on some standards than evidence would indicate

▸ Common challenges

▸ Phase transitions do not fit all clients; flexibility is needed to best serve the client

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CUCS Recommendations

▸ Additional training for TCC Program Staff

- Transfer-of-care
- Termination issues
- Motivational Interviewing

▸ Consider flexible requirements

▸ Annual Fidelity Conversation Meetings

▸ Annual Fidelity Alignment Plans

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Evaluation Method Strengths

▸ Adapted from evidence-based evaluation tools

▸ Multiple methods

▸ Collaborative process ➔ concrete fidelity
alignment plan

▸ Self-Assessment Tool
  ▸ Opportunity for reflection
  ▸ Starts conversations!

▸ Fidelity Conversation Meetings

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Evaluation Method Limitations

‣ Self-report

 ‣ Validity and accuracy

 ‣ ~Social desirability bias

‣ Team self-assessment vs. Program Director-only self-assessment

‣ Supervisor presence during focus groups

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Lessons Learned

▸ Set realistic evaluation goals

▸ Introduce the evaluation project early

▸ Frame evaluation as Quality Improvement
  ▸ Not meant to be punitive

▸ Completed assessment tools can be used as staff training tools

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FIDELITY ASSESSMENT Year 3 (2013-2014)

Chart Review

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Assessment Methods and Tools

TCC Fidelity Chart Review Tool

On-site Chart Review

Agency-level Analysis

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TCC Fidelity Chart Review Tool

Compliance Fidelity [Components] (15)

Context Fidelity [Structure] (8)

Competence Fidelity (15)

Program Quality (15)
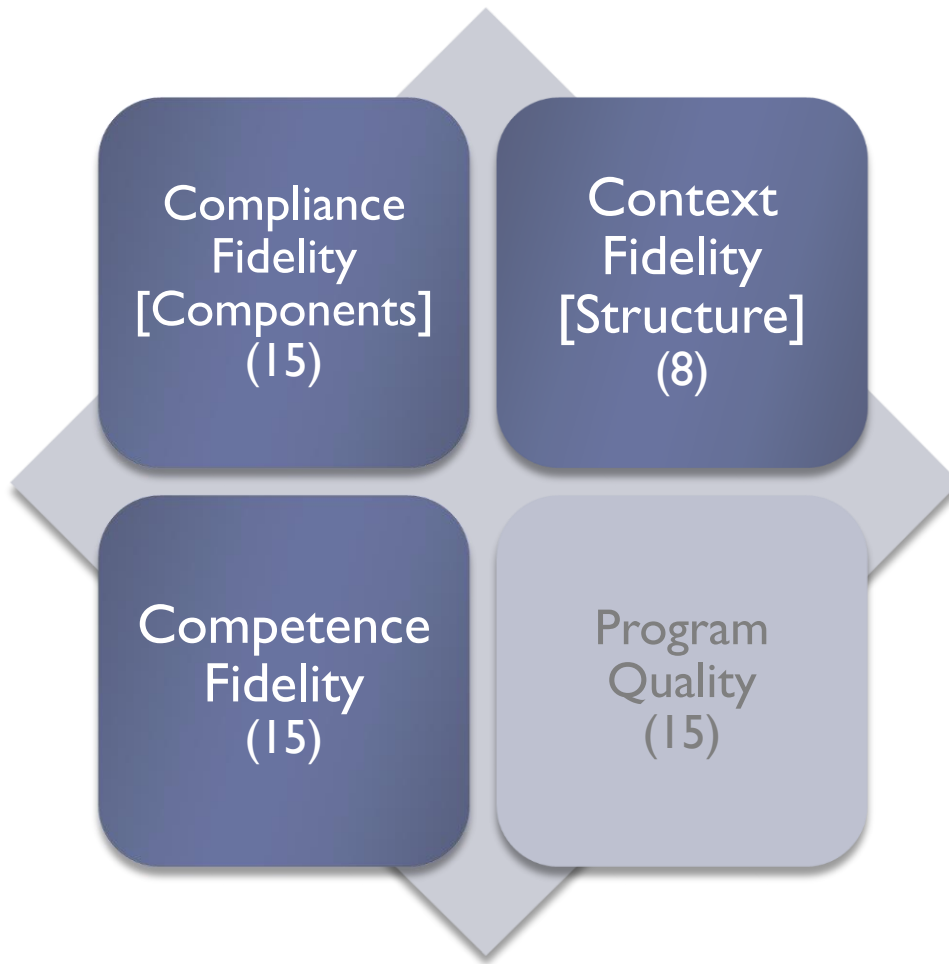
22 standards selected from Self-Assessment Tool

+
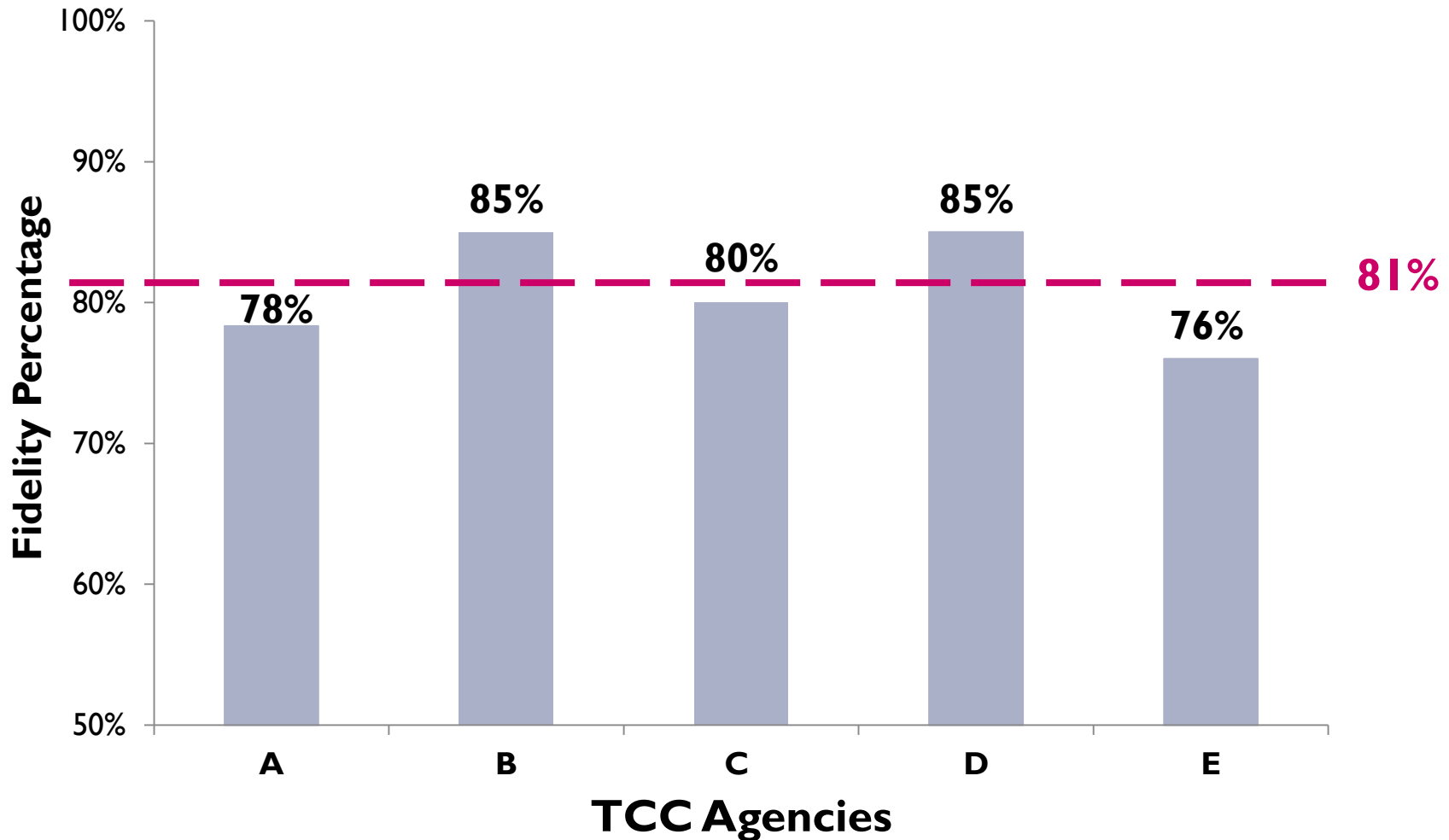
6 new standards

28-question Chart Review Tool

FIDELITY DOMAINS

DOMAIN 1: Documentation Timeliness	DOMAIN 2: Fidelity to Phase Timeline	DOMAIN 3: Fidelity to Phase Content
Care Plan Development within 30 days of Intake?	Did staff meet with client ≥ 1 time during the first month?	Does Care Plan include 1-3 Areas of Focus?
Care Plan Update 1 within 90-120 days?	Action steps on Care Plan have target dates?	Are goals and objectives S.M.A.R.T.?
Care Plan Update 2 within 90-120 days?	Documentation of follow-up in Phase 4?	Documentation of client feedback regarding their experience in TCC?

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TCC Chart Review Tool
(6 of 28 questions)

FIDELITY TO PHASE TIMELINE				
Early Engagement Early Linkage Outreach (Phase 1)	Did staff meet with client ≥ 1 time <u>during the first month</u>? (Q.1)	☒ Yes ☐ No # times: 2	Did staff meet with formal support (service provider) ≥ 1 time? (Q.3)	☒ Yes ☐ No # times: 3
	Did staff conduct ≥ 3 community-based meetings with client? (Q.4)	☒ Yes ☐ No # times: 3	Did staff conduct ≥ 2 community-based meetings with supports (informal or formal) and client? (Q.5)	☐ Yes ☒ No # times: 1
Monitoring (Phases 2 & 3)	Did staff communicate with client no more than once every 3 weeks by Phase 3? (Q.14)	☒ Yes ☐ No Freq: 1 x every 3 wks	Did staff record specific ways linkages to supports are or are not working? (Q.15)	☐ Yes ☒ No

Agency	A	B	C	D	E	All Providers
# charts reviewed	6	6	6	4	5	27 charts

AREAS OF STRENGTH
(Lowest # of Discrepancies)

# of Discrepancies

Timely Care Plan development	0
Strong supervision and team communication	0
Strong client engagement in Phase 1	0

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CHALLENGES
(Highest # of Discrepancies)

# of Discrepancies

S.M.A.R.T. goals and objectives	22
Decreased communication with client by Phase 3	10
Community-based meetings with client and supports	10
Community-based meetings with client	9

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Fidelity to TCC Model
(All Providers)
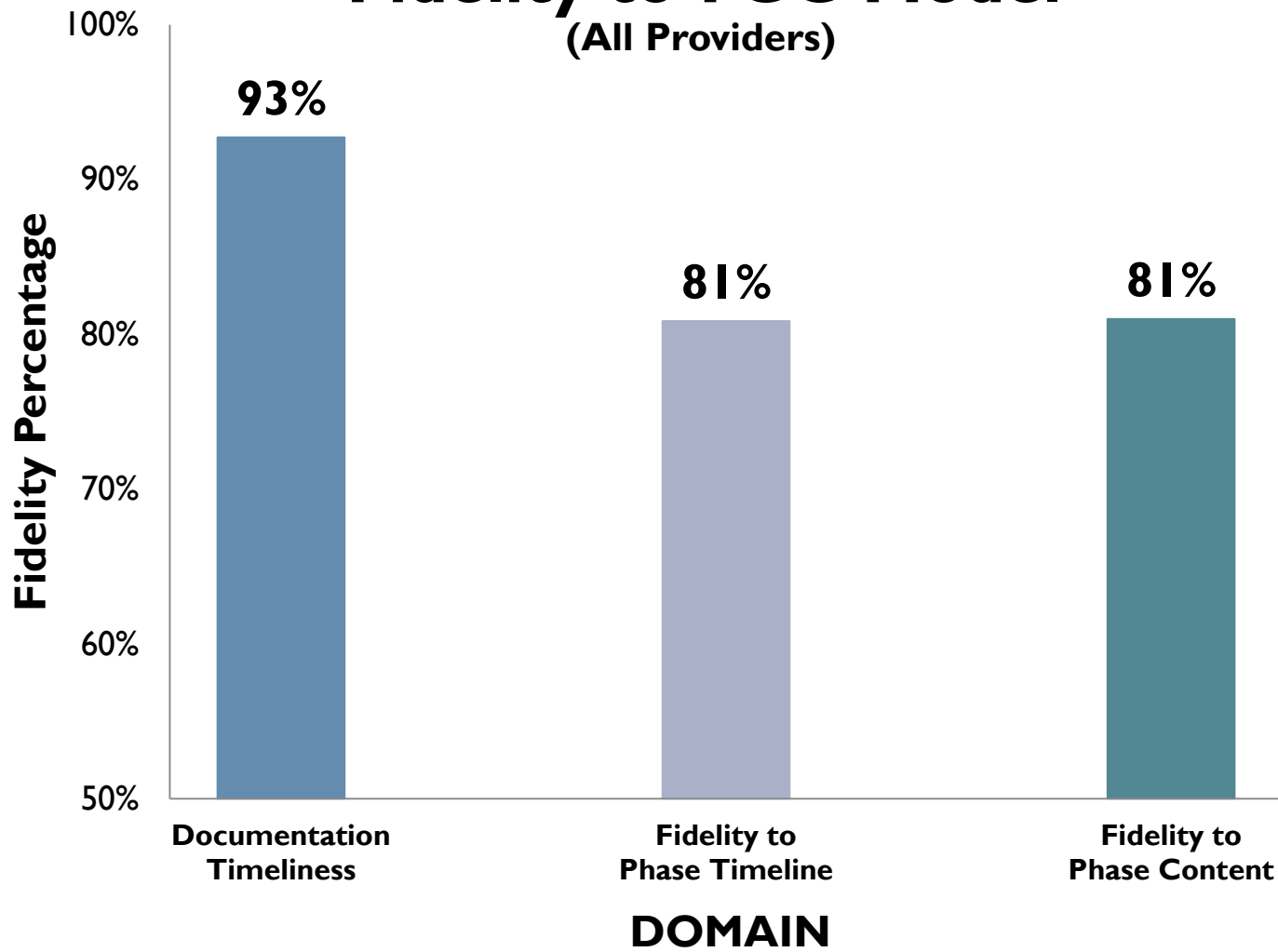
$$\text{Fidelity \%} = 100\% - \left(\frac{\text{\# Discrepancies}}{\text{Total Possible \# Discrepancies}} \right)$$

Fidelity Percentage

DOMAIN

- 93% — Documentation Timeliness
- 81% — Fidelity to Phase Timeline
- 81% — Fidelity to Phase Content

100%
90%
80%
70%
60%
50%

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DOMAIN 1: Documentation Timeliness

Health (NYC)

DOMAIN 2: Fidelity to Phase Timeline

Health
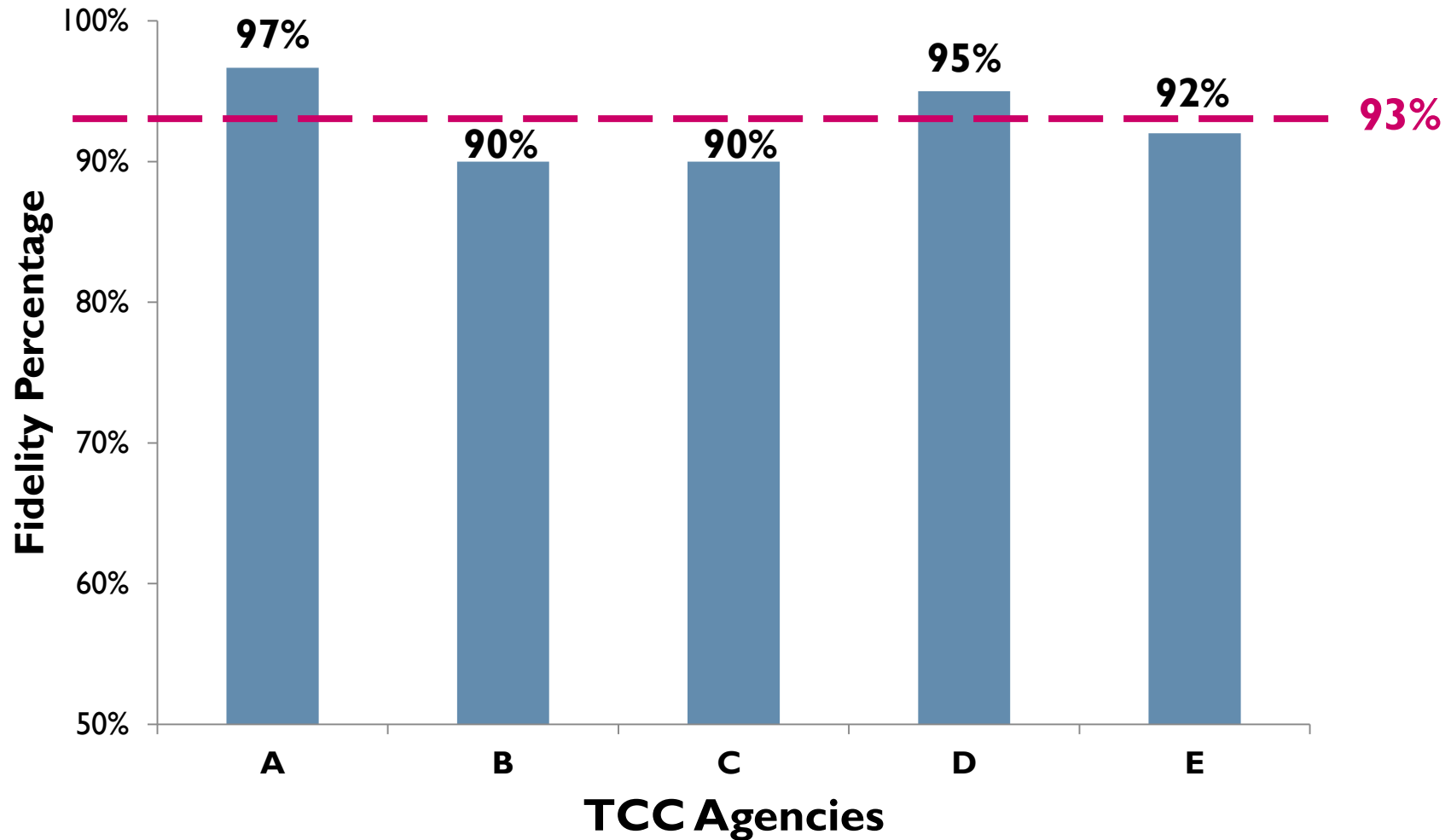
DOMAIN 3: Fidelity to Phase Content
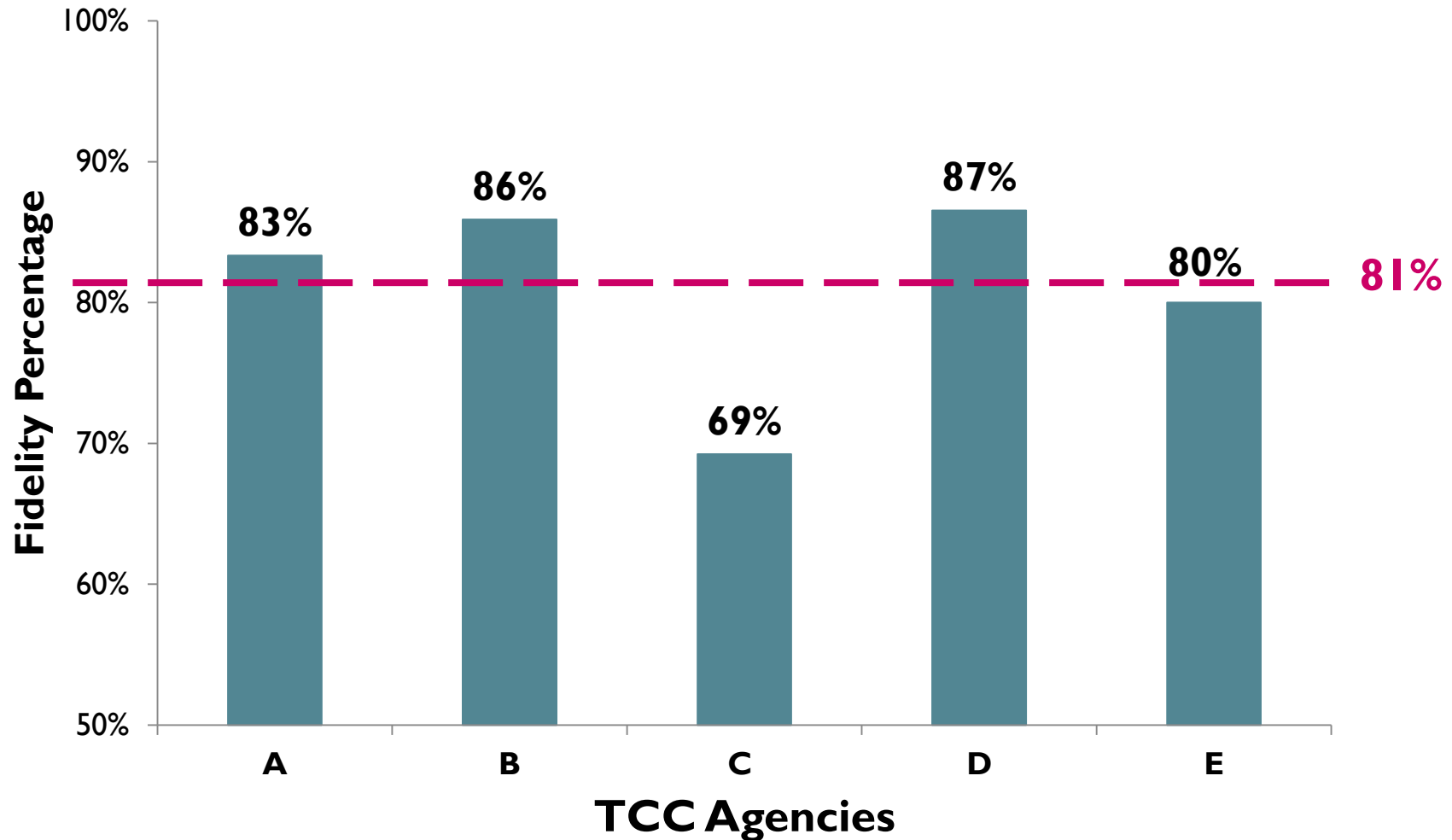
Agency-level Analysis

HARVEY BALLS

▸ Graphic symbols communicate qualitative information

▸ Used in comparison charts to evaluate items and their subcategories using weighted criteria

▸ Convey data quickly
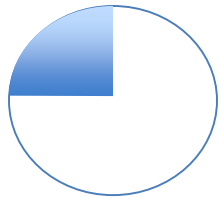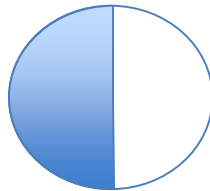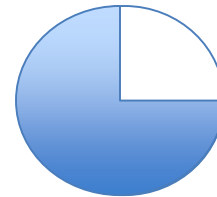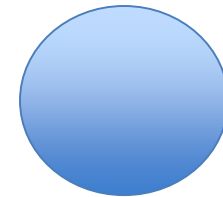
Below Average   Average   Above Average   Excellent

Harvey Balls Analysis

DOMAIN 1: Documentation Timeliness (20%)	DOMAIN 2: Fidelity to Phase Timeline (40%)	DOMAIN 3: Fidelity to Phase Content (40%)

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AGENCY A – Harvey Balls Analysis

Service Provision Category	DOMAIN 1: Documentation Timeliness (20%)	DOMAIN 2: Fidelity to Phase Timeline (40%)	DOMAIN 3: Fidelity to Phase Content (40%)	Total Score 100%
Supervision	N/A	● (Excellent)	● (Excellent)	● (Excellent)
Care Plans & Progress Notes	◑ (Average)	◕ (Above Average)	◑ (Average)	◑ (Average)
Early Engagement (Phase 1)	● (Excellent)	◑ (Average)	N/A	◕ (Above Average)
Monitoring (Phases 2-3)	◑ (Average)	◑ (Average)	◕ (Above Average)	◑ (Average)
Graduation (Phases 3-4)	● (Excellent)	◑ (Average)	◔ (Below Average)	◑ (Average)

Legend: ◔ Below Average ◑ Average ◕ Above Average ● Excellent

Evaluation Method Strengths

▸ Developed from evidence-based evaluation tools

▸ Chart review reduces risk of provider bias

▸ Minimal resources or time required of providers

▸ Visually-engaging presentation of findings

Evaluation Method Limitations

▸ Single method

▸ Program Quality standards excluded

▸ Less collaborative process

▸ Evaluation staff resources and time constraints

▸ Small sample size

▸ Evaluator bias

Lessons Learned

Self-Assessment, Fidelity Conversation Meetings, & Fidelity Alignment Plans

- Critical reflection
- In-depth discussion
- Collaboration
- Team-based approach
- Transparency
- Concrete plan for improving fidelity

Chart Review

- Increased objectivity
- Secondary method

Next Steps

- 2015
  - No formal fidelity assessment
  - Use Self-Assessment tool as a TA tool for Quality Improvement
    - Reflection exercise for program staff
    - Discuss scores at Annual Routine Site Visit
    - DOHMH will use scores to identify:
      - Agency-level TA needs
      - TCC service category-wide TA needs

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