Translation of a Ryan White-Funded, Evidence-Informed Intervention for Broad Scale-Up and Sustainability

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Disclosures

Presenters have no relevant financial or nonfinancial interest to disclose.

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Commercial Support was not received for this activity.

Learning Objectives

- **At the conclusion of this activity, the participant will be able to:**
  1. Identify at least two criteria that can be applied to select components of an integrated intervention for translation and broader scale-up
  2. Assess the potential advantages of an online toolkit, over paper-based program materials and in-person trainings and technical assistance
  3. Describe three key steps in the process of translating an intervention for dissemination through an online toolkit

Presentation Outline

- **Background**
  - NYC Ryan White Part A Care Coordination Program
  - STEPS to Care Project
- **Methods & Findings**
- **Lessons Learned**
- **Website Demonstration**
- **Future of STEPS to Care**

Background Part I

The Ryan White HIV Care Coordination Program

NYC Ryan White Part A Care Coordination Program (CCP)

- Comprehensive Medical Case Management for persons recently HIV-diagnosed, new to ART, or with a history of non-adherence to visits and/or ART
- Key components: 1) case finding and outreach; 2) patient navigation; 3) case conferencing; 4) case management; 5) adherence support; 6) structured health promotion
- Required staff: Care Coordinator (CC), Patient Navigator (PN)
- Setting: Onsite or affiliated primary care

Case Finding and Outreach


Photo of navigator in New York City

- **Initial case finding**
  - EMR queries (out of care, unsuppressed)
  - HIV testing and other referrals
- **Outreach for re-engagement**
  - Daily phone calls starting immediately after missed appointment
  - Field/home visit after 3 days of failed phone outreach*
  - Field/home visits every week until client is located
  - Letter sent after two weeks of failed outreach
  - Second (certified) letter sent after two months of failed outreach

** Online resources also used to locate client via other contact details*


Photo of navigator entering apartment building

Patient Navigation

- **Patient Navigators are key players on care team**
  - Have the most interaction with the clients
  - Bridge the gap between the clinic and the community
  - Reflect the community they serve
- **Services (often in client's home) include:**
  - Health promotion (following structured curriculum)
  - Accompaniment
  - Treatment adherence support, including modified DOT
- **Tool examples: field safety guide, logistics planning supports**

Photo of navigator in New York City

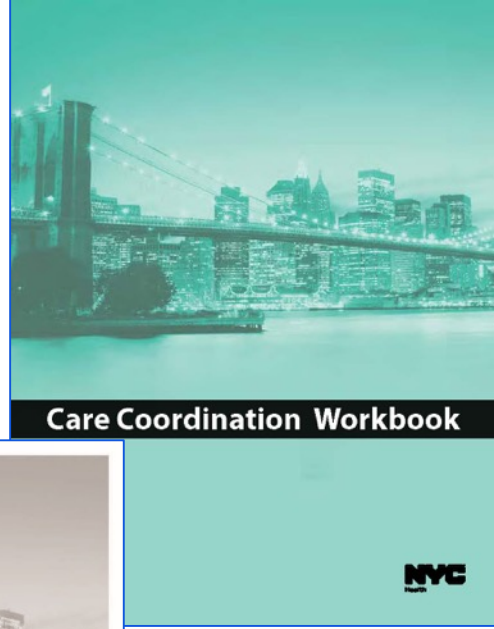
Multidisciplinary Case Conferencing

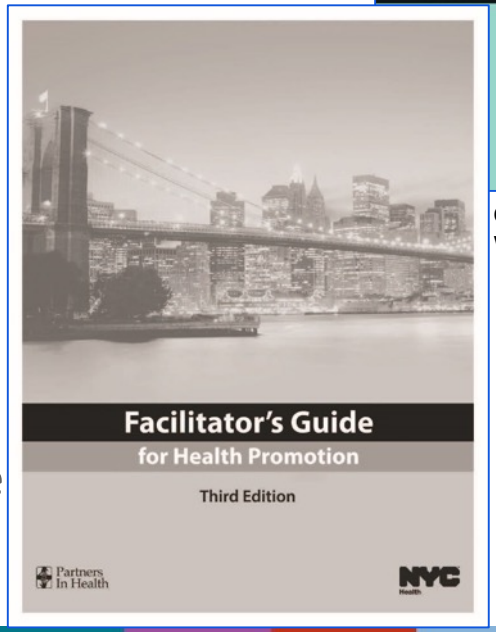
- **Interdisciplinary care team meeting**
  - Program Staff (CC and/or PN)
  - Clinician (MD/DO/NP/PA)
  - Patient (optional)
- **Review labs, adherence, home conditions**
  - Tool: case conference form (customizable)
- **Develop and update client care plan**
  - Tool: comprehensive care plan (customizable)

Photo of care team meeting

Health Promotion

- **HIV education, coaching and counseling**
- **Adapted Partners in Health PACT curriculum**
- **Conducted by Patient Navigators**
  - One-on-one sessions
- **Staff receive ongoing training**
- **Helpful tools:**
  - Care Coordination Workbook
  - Care Coordination Facilitator's Guide
  - Curriculum Coverage Log



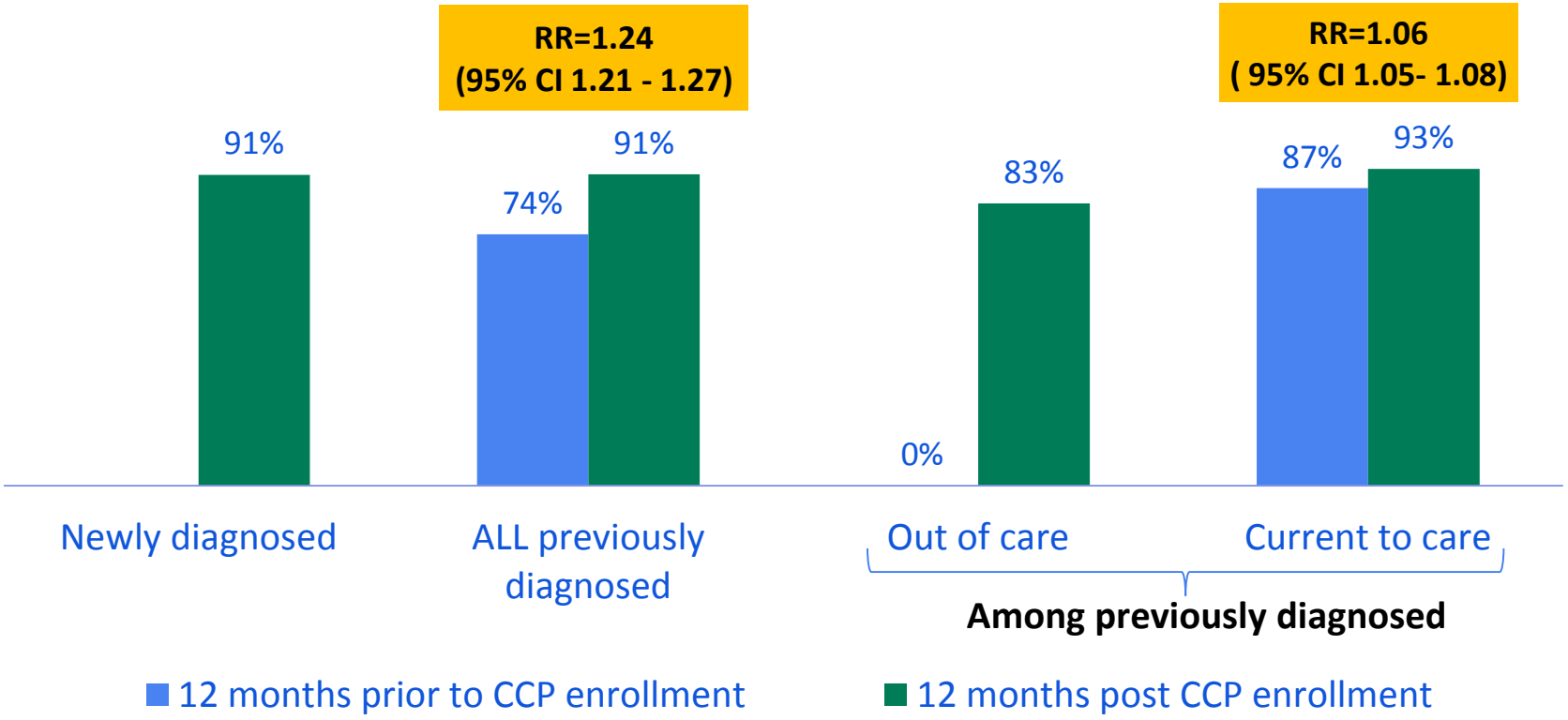


Covers of Care Coordination Workbook and Facilitator's Guide

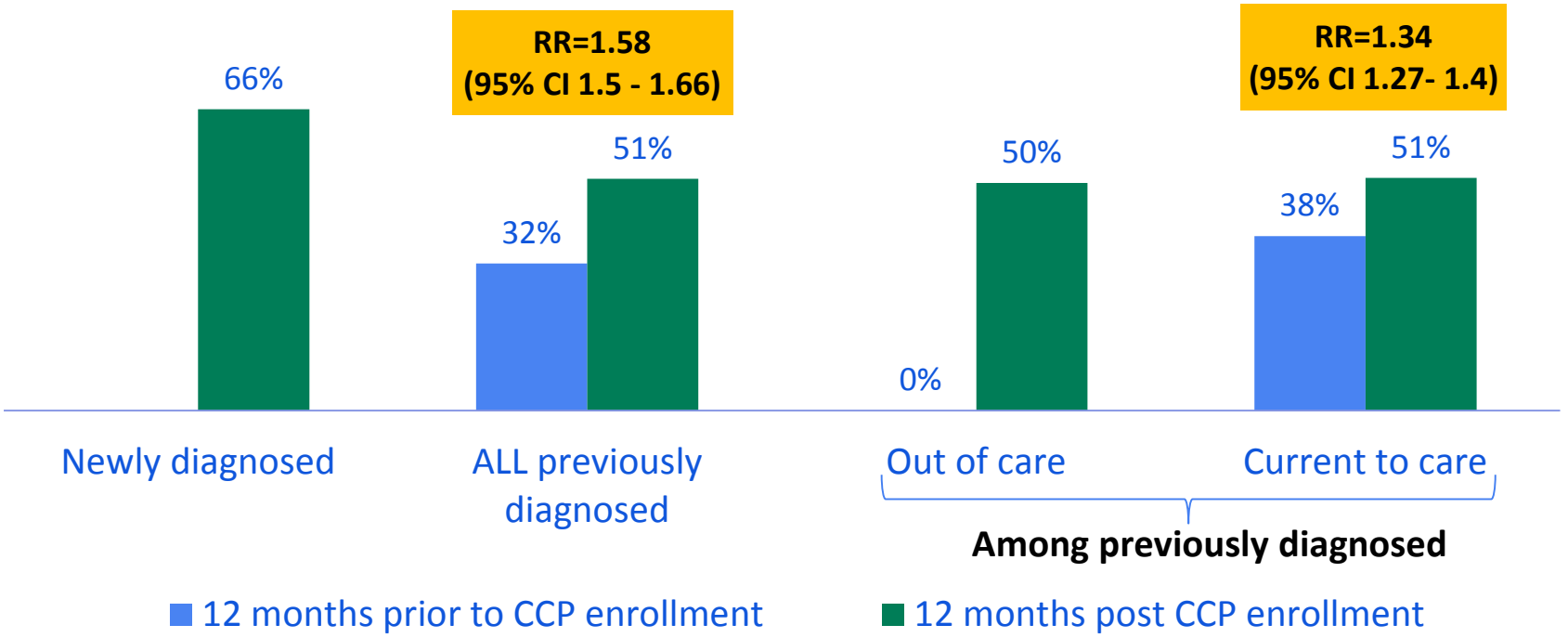
Evidence Basis: CHORDS Study (PIs: D. Nash, M. Irvine)

- **CHORDS: Costs, Health Outcomes & Real-world Determinants of Success in HIV Care Coordination (NIH R01)**
- **Purpose: To assess the CCP effectiveness among enrollees and relative to "usual care" for NYC PLWH, and identify client- and program-level factors for optimal HIV outcomes**
- **Comparisons: First compared clients *post-enrollment to pre-enrollment*; then compared clients to *other PLWH meeting CCP eligibility criteria, based on NYC HIV surveillance registry***

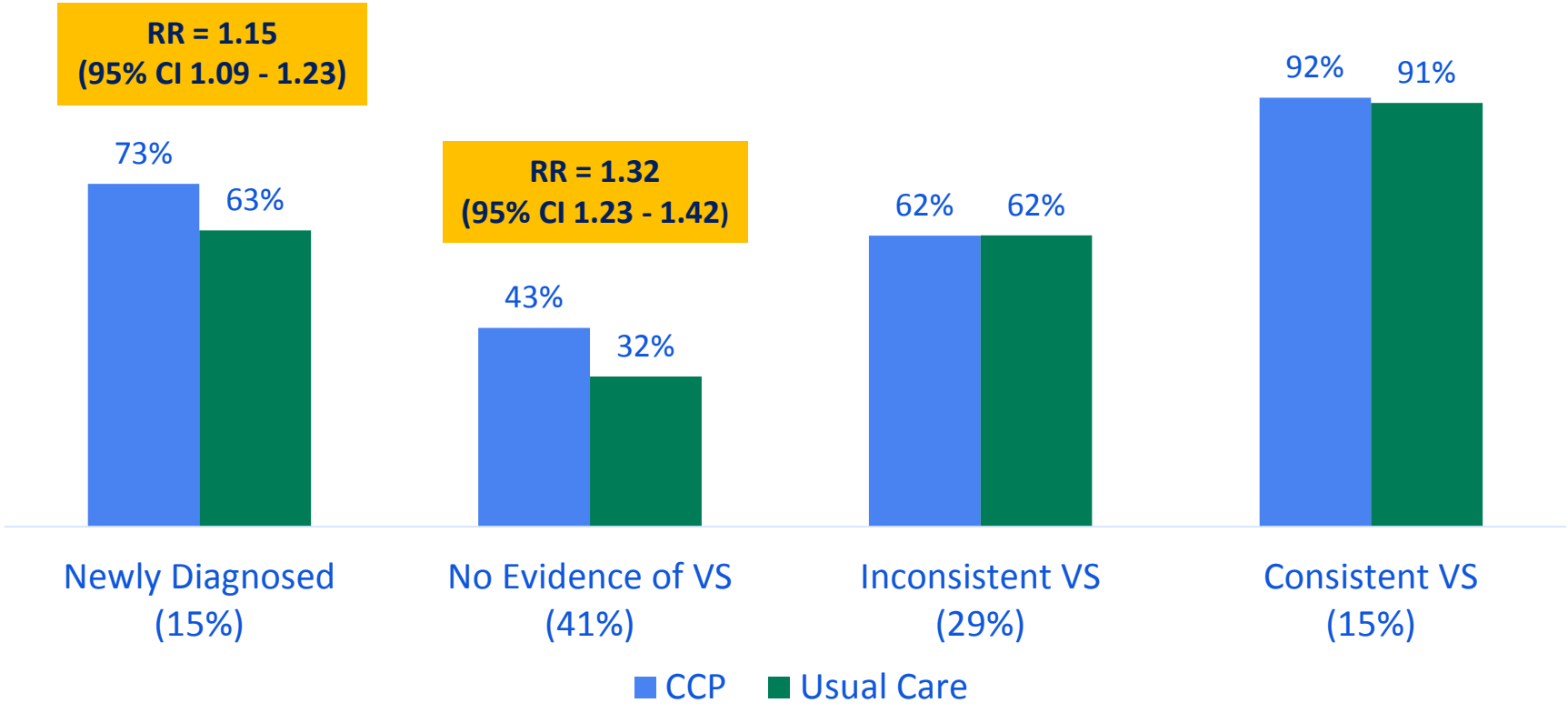
Engagement in Care (EiC) Pre- vs. Post-enrollment (%)



Viral Suppression (VS), Pre- vs. Post-enrollment (%)



12-mo. Viral Suppression (%): CCP vs. 'Usual Care' (non-CCP), by Baseline Status



Trainings & Technical Assistance (TA) for Original CCP

Resource-intensive Program Startup and Maintenance:

- **Trainings required by health department**
  - 10-day core CCP training for all staff
  - 4-day Health Promotion Training of Trainers
  - One-day topic-focused trainings
- **Ongoing TA from health department**
  - Project Officers (program model experts) for day-to-day guidance on implementation
  - Semi-annual Provider Meetings
  - Site visits and webinars

Photo of health department programmatic technical assistance leads

Background Part II

STEPS to Care Project

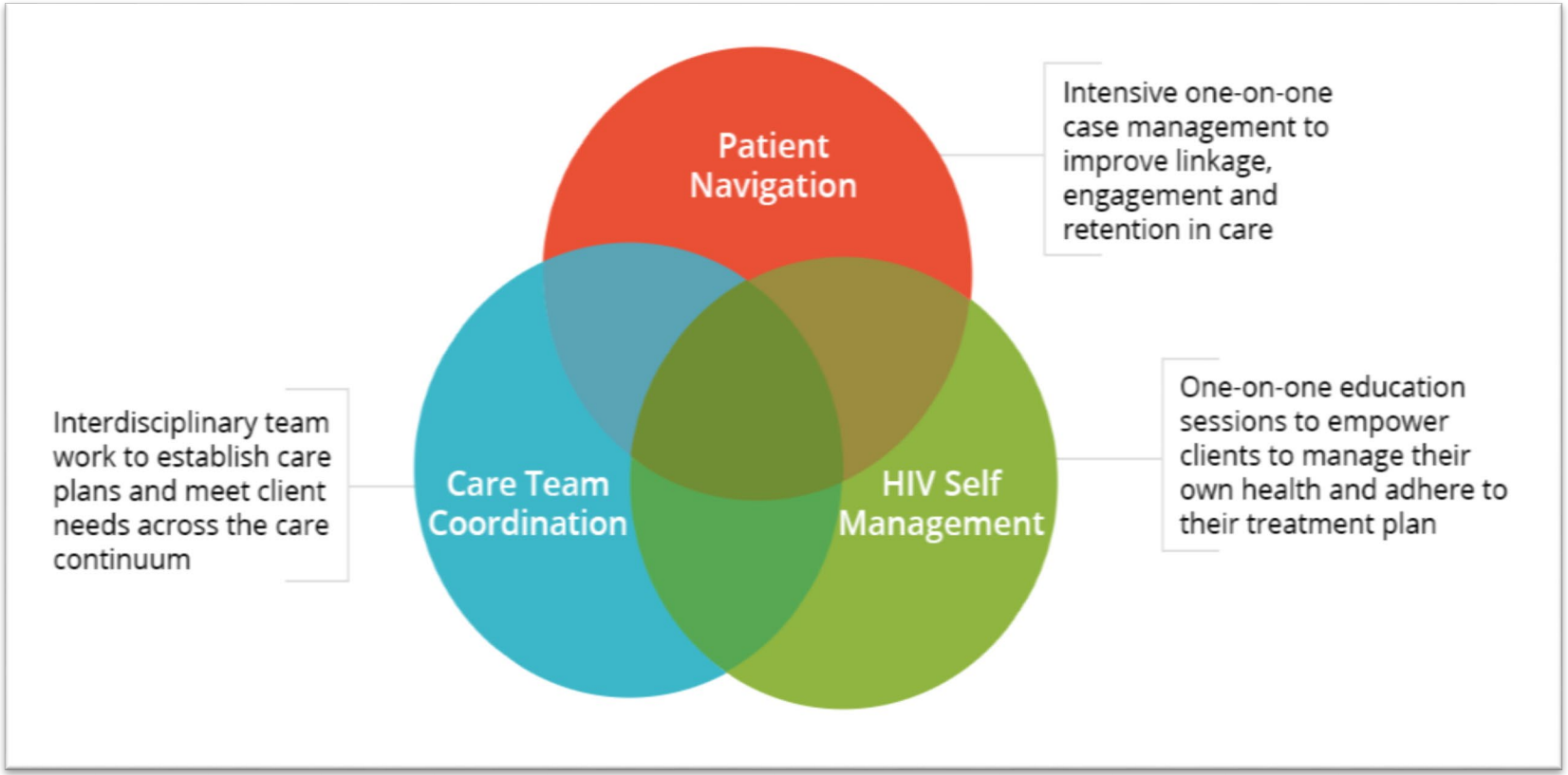
What is STEPS to Care?

- **Funder:** CDC, under a 3-year Cooperative Agreement; Aisha L. Wilkes, MPH, PO
- **Grantee:** Education Development Center, Inc. (EDC); Lydia O'Donnell, EdD, PI
- **Partner:** NYC Dept. of Health & Mental Hygiene (DOHMH); Mary Irvine, DrPH, PI
- **Purpose:** Translation of evidence-informed CCP strategies into web-based tools and training to improve linkage, retention, and reengagement of PLWH in care
- **Final Product:** Provider- and Client-directed Web-based tools

Why Translate to Web-based Tools?

- While evidence-based programs (e.g., CCP) for advancing the care continuum have been identified, it remains a challenge to transfer effective strategies to new and diverse settings.
- For best practices to be spread and sustained, alternatives to costly face-to-face training and one-on-one TA are needed.
- An online learning platform with an array of interactive tools makes strategies available to all those interested in practice change, and can accelerate large-scale technology transfer.

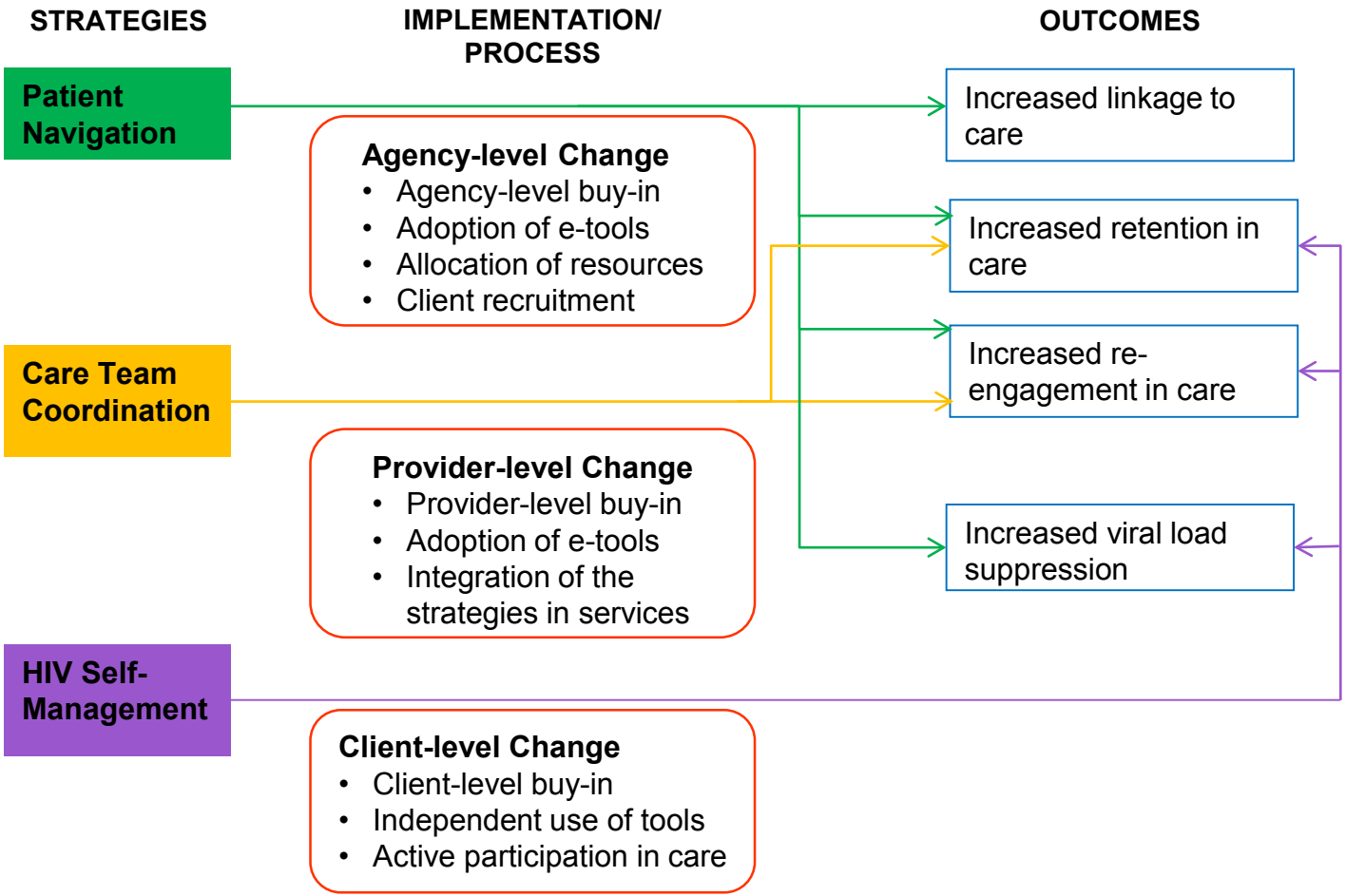
STEPS to Care Strategies



Selection of Strategies from CCP

- **Chose strategies to have the greatest impact nationally:**
  - Able (and expected) to be used with every CCP client (full population)
  - Fairly flexible, transferable to other jurisdictions/service landscapes
  - Broad enough to incorporate all core components of the CCP
  - Mutually supportive/synergistic (whole greater than sum of its parts)
- **Examples of CCP strategies *not* selected for translation:**
  - DOT (used only with a small subset of CCP clients)
  - Enrollment “tracks” prescribing frequency of health promotion sessions (quarterly, monthly, or weekly)

STEPS to Care Logic Model



Project Implementation

- Step 1: Program review including literature summary and engagement of 4 “model program” agencies as key informants
- Step 2: Translation and development of strategies into web-based tools and trainings
- Step 3: Piloting these web-based tools and trainings with HIV service provider agencies
- Step 4: Using agency feedback to refine web-based tools and trainings for CDC dissemination

Methods & Findings

Step 1: Program Review

- **Literature review and summary on the 3 strategies, to confirm evidence (beyond NYC) for their promotion of HIV care continuum outcomes**

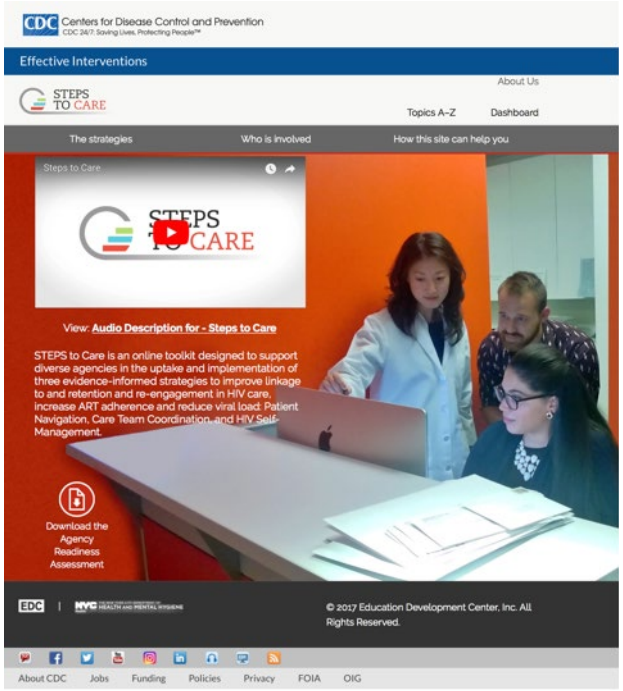
- **Site visits and consultation with 4 model CCP-implementing agencies**

- **Findings used to determine the universe of tools needed and the design of the web-based tools**
  - Interaction of all three strategies
  - Appropriate identification and hiring of staff
  - Obtaining agency buy-in
  - Formalization of procedures

Photo of an agency's CCP staff who participated in a site visit

Step 2: Translation into Web-based Tools

- **Tools designed for:**
  - Program planning
  - Staff training
  - Ongoing technical assistance and guidance
- **Tailored for use by:**
  - Program administrators/directors
  - Care coordinators
  - Patient navigators
  - PLWH (clients/consumers)



Screenshot of STEPS to Care web page on Effective Interventions

Types of Tools

- Web-pages/text
- Videos
- Checklists & protocols
- Downloadable & fillable forms
- Excel spreadsheets
- Client website

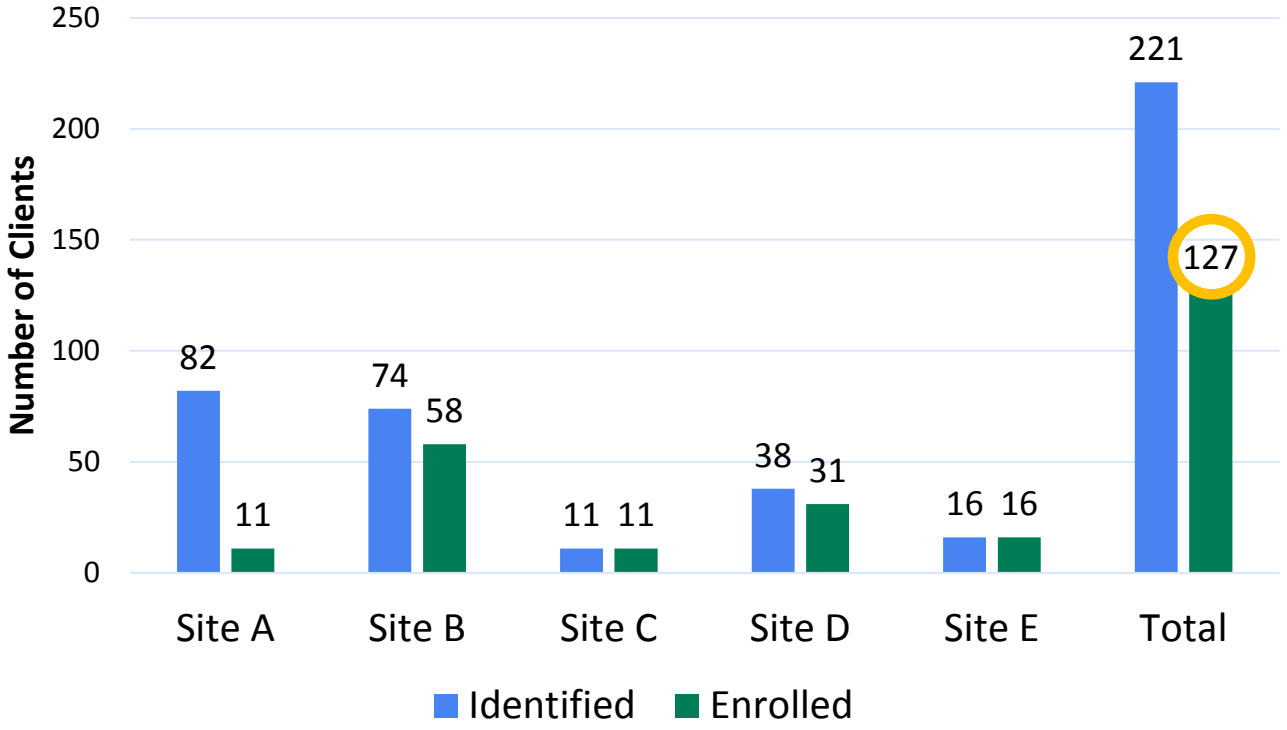
Screenshots of STEPS to Care web pages on Effective Interventions site

Step 3: Pilot Test — NYC

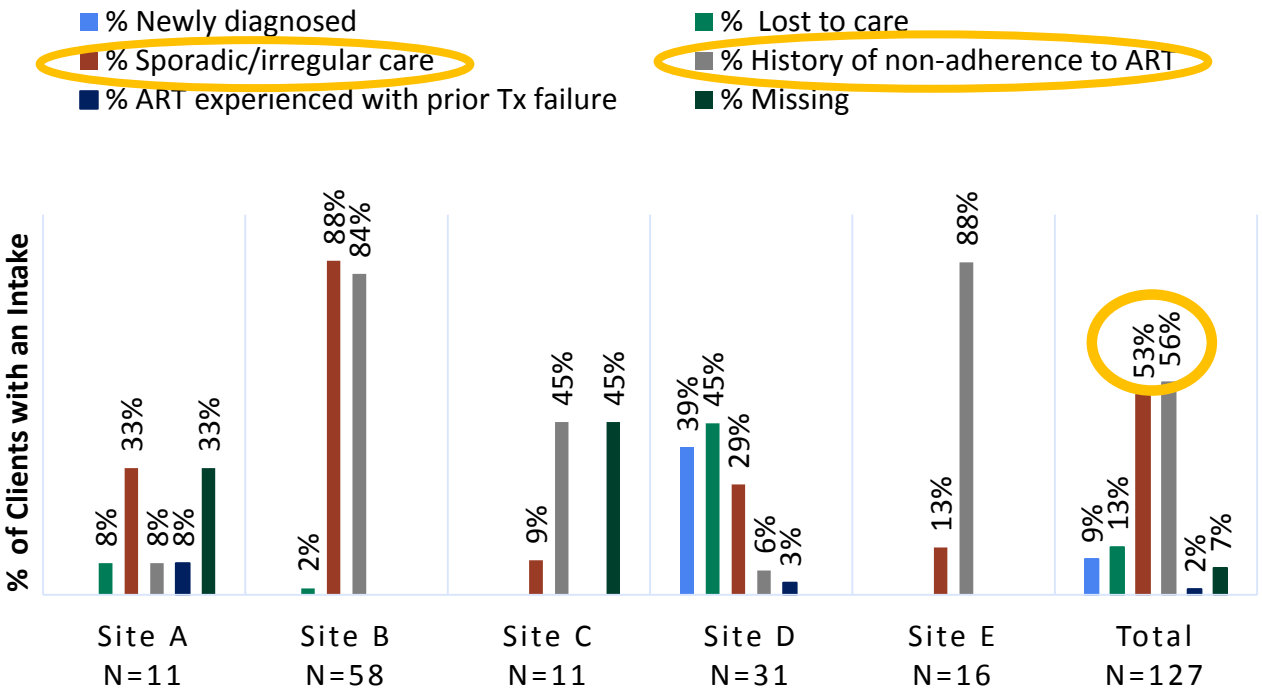
- **Piloting conducted in 5 NYC agencies — July 2015-February 2016**
  - 3 community health centers and 2 hospitals
  - 2 Bronx-based, 2 Manhattan-based, and 1 Brooklyn-based agency, representing a mix of:
    - Medicaid Health Homes, Designated AIDS Centers, & Federally Qualified Health Centers
  - 2 agencies had CCP contracts, 1 had given up CCP contract, 2 had other case management only
  - All annually served >300 HIV patients, >75% of whom were Black or Latinx
  - All had some existing practice for care team coordination/case conferences

Photo of New York City skyline

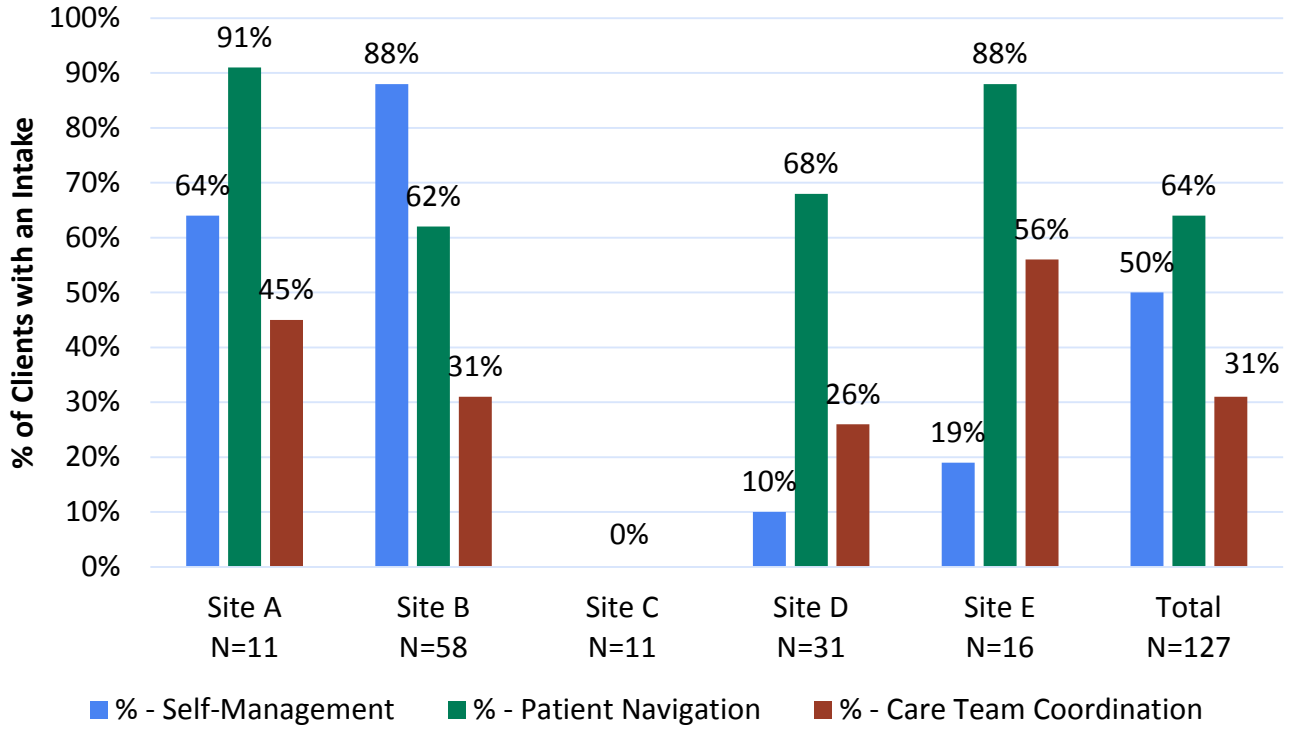
Clients Identified vs. Clients who Completed Enrollment



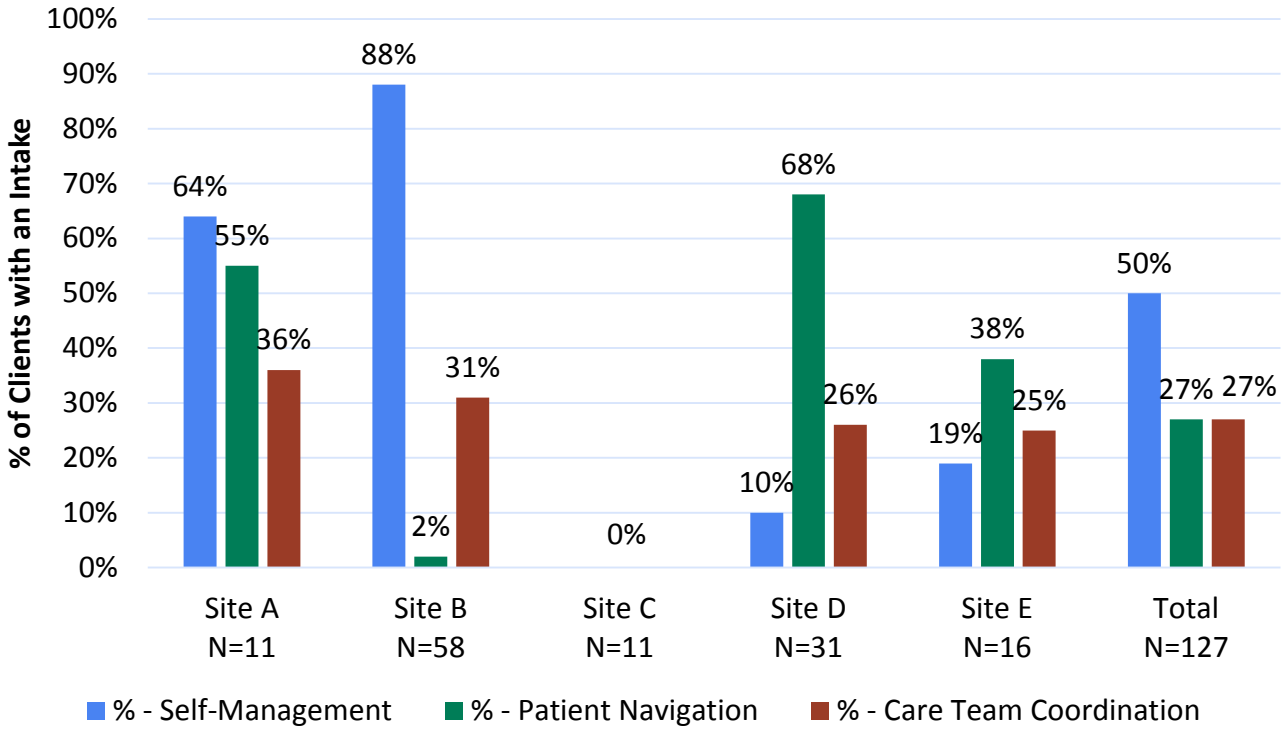
Reasons for Enrollment



Clients Receiving Specific Service Types



Clients with a STEPS to Care Tool Used in ≥1 Encounter



NYC Pilot Test Key Findings

Need Identified	Refinement to Toolkit
Guidance on how to deliver HIV Self-Management sessions	Added Facilitators' Guide
Tips on which tools to access first	Redesigned Dashboard
More tools for agency administrators	Added Preview Guide for Program Directors and FAQs
Support for selective adoption	Added Key Components Checklist

Implementation

+ **STEPS to Care used as a resource for professional development**
+ **STEPS to Care facilitated team communication**
- **Limited use of Care Team Coordination tools**
- **Data entry under-represented services**

2nd pilot

Step 3 (cont'd): Pilot Test — Expanded Pilot

- **Piloting conducted in 3 additional agencies — July 2016-February 2017**
  - Federally qualified health center (FQHC) in Atlanta, GA
  - Hospital in Charleston, SC
  - Community Health Center, Boston, MA

- **STEPS to Care clients at these agencies were primarily Black and male**

- **Process data collected via Key Informant Interviews and monthly reporting grids**

Expanded Pilot Key Findings

- **STEPS to Care intake completed with 58 clients and service delivery with 166 clients**
- **More delivery of Care Team Coordination Strategy**

"STEPS gives us an opportunity to provide intensive case management services in a structured way. It expands the reach of our Patient Navigators and potential of our case management team."
- Program Director

"This is what I was looking for…something that I could integrate the entire team so that they would become like one unit. We used StC to make improvements on how the system functions and how different roles in care coordination system relate to each other."
- Patient Navigator

Step 4: Refinement & Dissemination

- **Used the following to determine how tools for each strategy should be refined**
  - Local and national pilot feedback
  - Community Advisory Board input
  - CDC clearance process

- **Disseminated the refined web-based tools on a dedicated CDC website:** https://effectiveinterventions.cdc.gov/en/2018-design/care-medication-adherence/group-4/steps-to-care

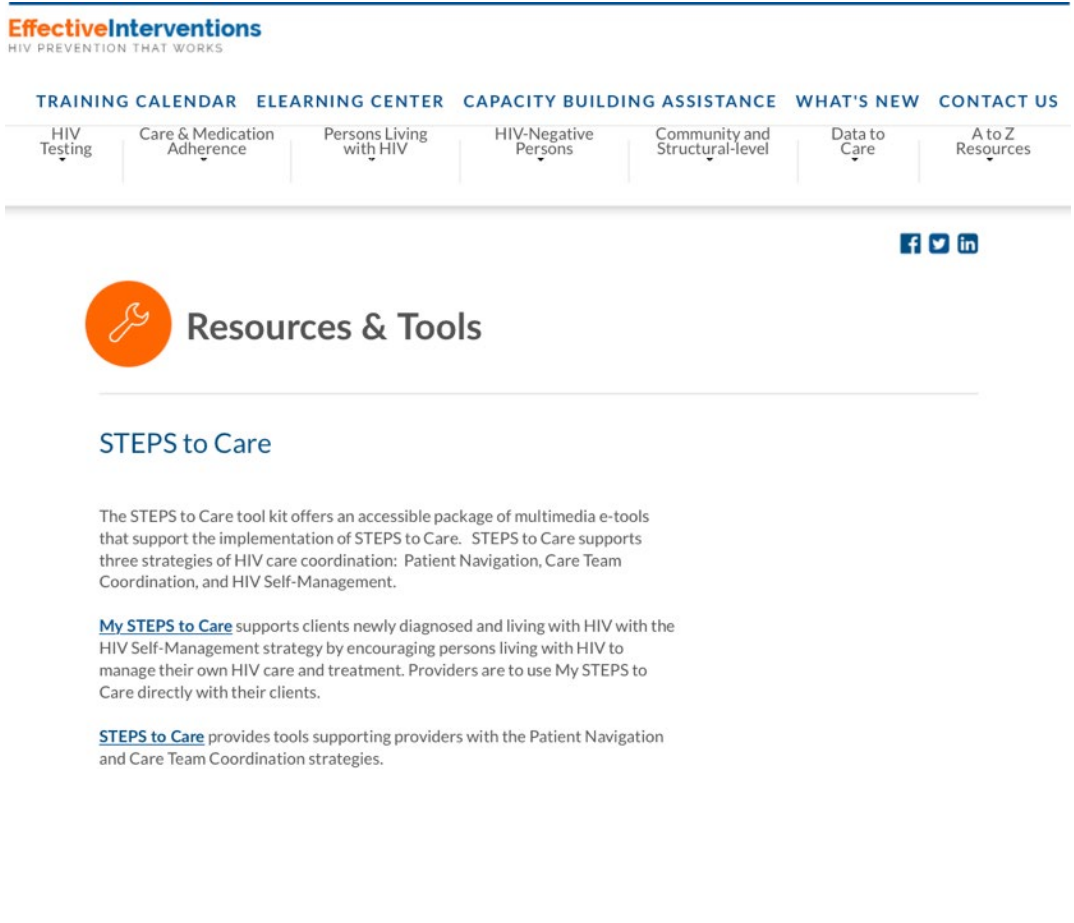
LESSONS LEARNED

Lessons Learned

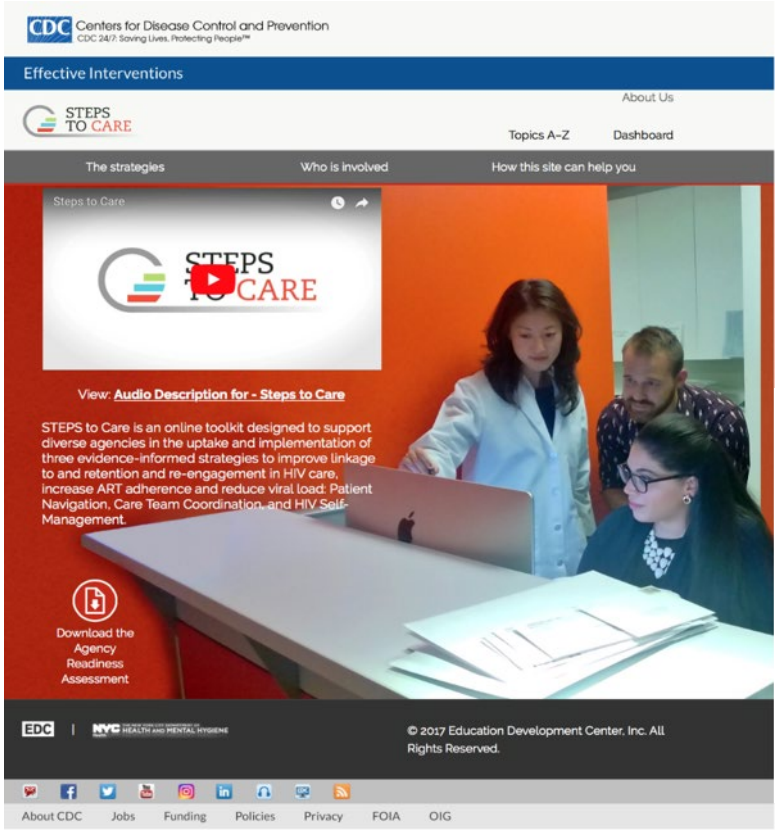
- Need to clearly define key components, to help agencies tailor/selectively adopt
- Current funding and agency policy may limit field work
- Assumption of minimal training and TA is unrealistic
- More marketing resources are needed
- Agency STEPS to Care champion and provider participation are keys to success
- Brief pilot with agencies selected to meet project-driven criteria (vs. self-selecting based on interest) does not simulate real-world conditions of dissemination/use

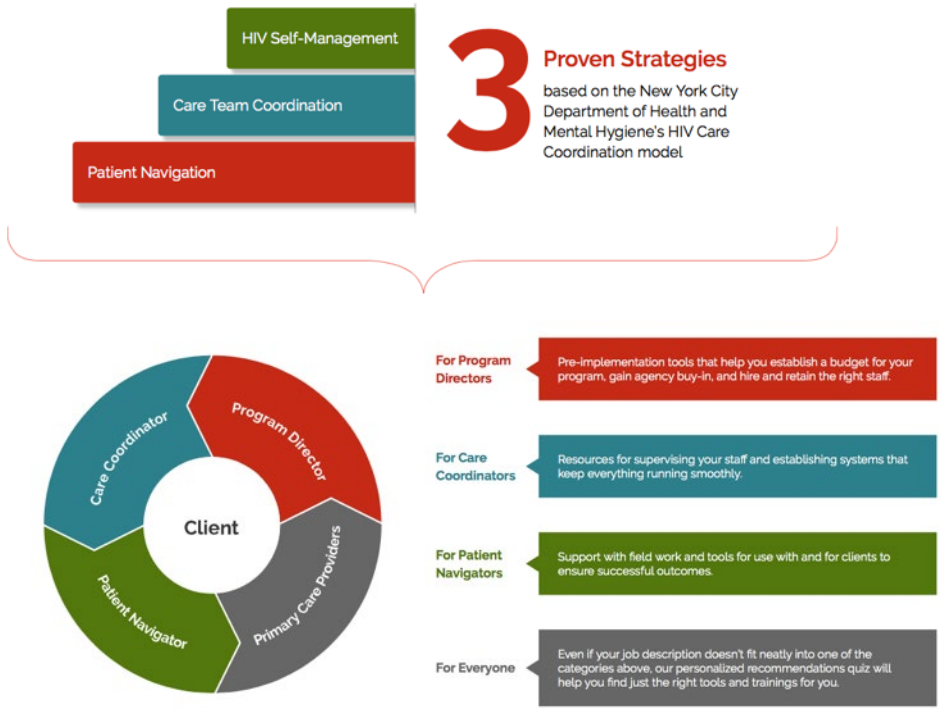
WEBSITE DEMONSTRATION

The Tool Kit


EffectiveInterventions
HIV PREVENTION THAT WORKS
TRAINING CALENDAR
ELEARNING CENTER
CAPACITY BUILDING ASSISTANCE
WHAT'S NEW
CONTACT US
HIV Testing
Care & Medication Adherence
Persons Living with HIV
HIV-Negative Persons
Community and Structural-level
Data to Care
A to Z Resources
Resources & Tools
STEPS to Care
The STEPS to Care tool kit offers an accessible package of multimedia e-tools that support the implementation of STEPS to Care. STEPS to Care supports three strategies of HIV care coordination: Patient Navigation, Care Team Coordination, and HIV Self-Management.
My STEPS to Care supports clients newly diagnosed and living with HIV with the HIV Self-Management strategy by encouraging persons living with HIV to manage their own HIV care and treatment. Providers are to use My STEPS to Care directly with their clients.
STEPS to Care provides tools supporting providers with the Patient Navigation and Care Team Coordination strategies.

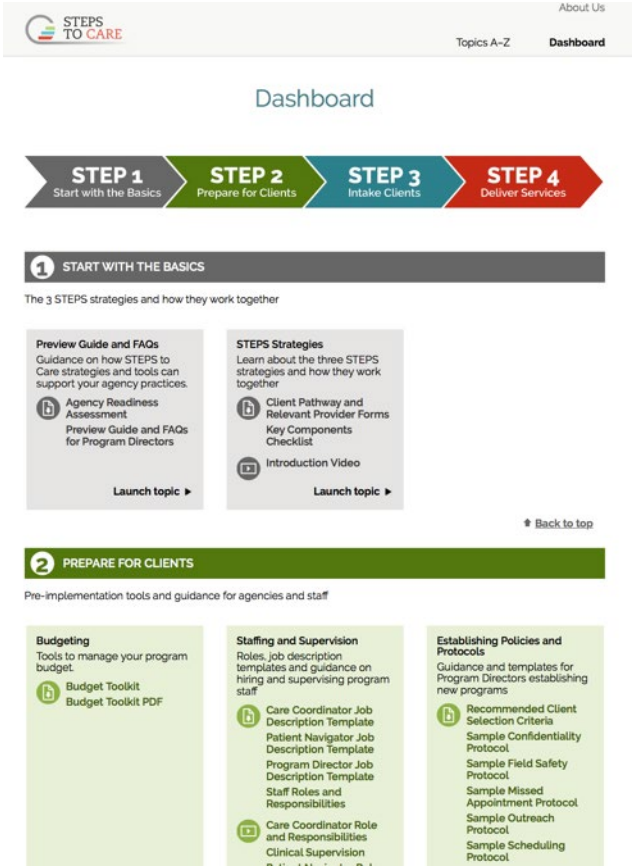
Provider Site





Navigating through the STEPS to Care Toolkit

- View tools by implementation steps on the **Dashboard**



Navigating through the STEPS to Care Toolkit (cont'd)

- View tools by topic on the **Topics A-Z page**

Care Team Coordination Topic Page

Care Team Coordination

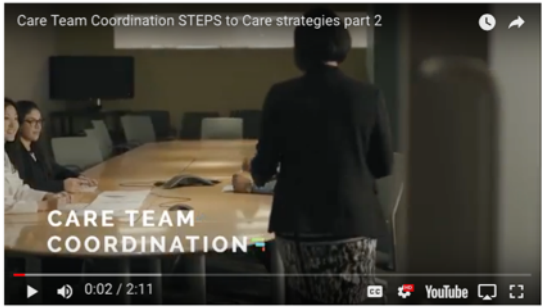
1. **Care Team Coordination Introduction**
2. **Care Team Meetings**
3. **Care Team Meeting Types**
4. **Care Team Communication**
5. **Care Team Roles and Responsibilities**
6. **Best Practices for Success**
7. **Working with Primary Care Providers**
8. **Downloads**

Care Team Coordination Introduction

Care Team Coordination is a strategy that allows STEPS staff to establish and assess Care Plans to meet client needs across the care continuum and improve adherence and retention outcomes. **Regular Care Team meetings ensure the team remains updated about and responsive to the client's changing needs and circumstances**.

After reviewing the Care Team Coordination information and resources below, you will know:

- Purpose and goals of Care Team Coordination
- Key participants and their roles in Care Team meetings
- Types of Care Team meetings (initial hand-off, formal, and informal)
- Purpose and goals of Care Team meetings
- Best practices for integrating Care Team meetings into your program structure
- Strategies for supporting good communication among Care Team members



View: Audio Description for - Care Team Coordination

Staying Safe in the Field Training

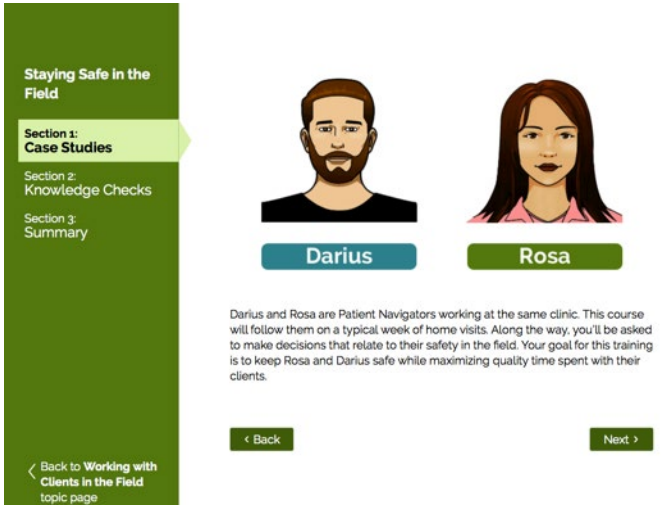
FIELD SAFETY TRAINING

The Field Safety training below provides an overview of some key points for safety in the field. By the end of this training, you will be able to:

- Identify appropriate precautions for meeting clients offsite
- Make good choices regarding personal safety in the field

Jump to the Trainings section below to launch the training.

Estimated time to completion: 20 minutes



Intake Assessment Form

The Intake Forms

Intake is conducted by completing the two forms below.

LOGISTICS FOR PATIENT NAVIGATION AND CONTACT INFORMATION FORM

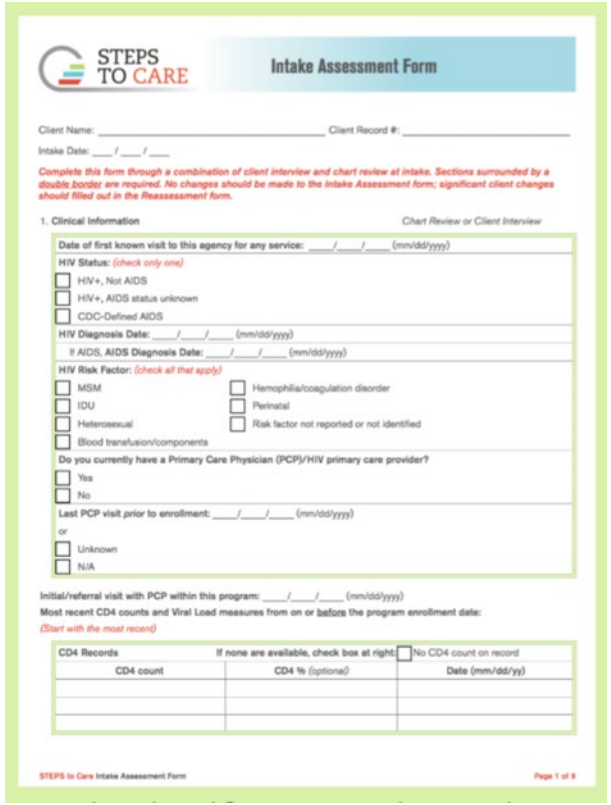
This form should be completed during the first client intake session. Staff should use this form to collect basic contact information and scheduling preferences and to set communication norms for Patient Navigation sessions.

This form should be updated regularly, particularly when there is a major change for the client that could affect service delivery. While the Care Coordinator is likely to be responsible for initially completing the form during intake, the Patient Navigator should update this document whenever he or she becomes aware of a change.

These change events could include:

- New housing arrangements
- New daily/weekly schedule (that could be the result of finding employment or child care)
- New cell phone number
- Change in alternative contacts

Download the Logistics for Patient Navigation and Contact Information Form



STEPS TO CARE

Intake Assessment Form

Client Name: _____ Client Record #: _____

Intake Date: ___ / ___ / ___

Complete this form through a combination of client interview and chart review at intake. Sections surrounded by a double border are required. No changes should be made to the Intake Assessment form; significant client changes should filled out in the Reassessment form.

1. **Clinical Information** — *Chart Review or Client Interview*

Date of first known visit to this agency for any service: ____/____/____ (mm/dd/yyyy)

HIV Status: *(check only one)*

- ☐ HIV+, Not AIDS
- ☐ HIV+, AIDS status unknown
- ☐ CDC-Defined AIDS

HIV Diagnosis Date: ____/____/____ (mm/dd/yyyy)

If AIDS, **AIDS Diagnosis Date:** ____/____/____ (mm/dd/yyyy)

HIV Risk Factor: *(check all that apply)*

- ☐ MSM
- ☐ IDU
- ☐ Heterosexual
- ☐ Blood transfusion/components
- ☐ Hemophilia/coagulation disorder
- ☐ Perinatal
- ☐ Risk factor not reported or not identified

Do you currently have a Primary Care Physician (PCP)/HIV primary care provider?

- ☐ Yes
- ☐ No

Last PCP visit *prior* to enrollment: ____/____/____ (mm/dd/yyyy)

or

- ☐ Unknown
- ☐ N/A

Initial/referral visit with PCP within this program: ____/____/____ (mm/dd/yyyy)

Most recent CD4 counts and Viral Load measures from on or before the program enrollment date:

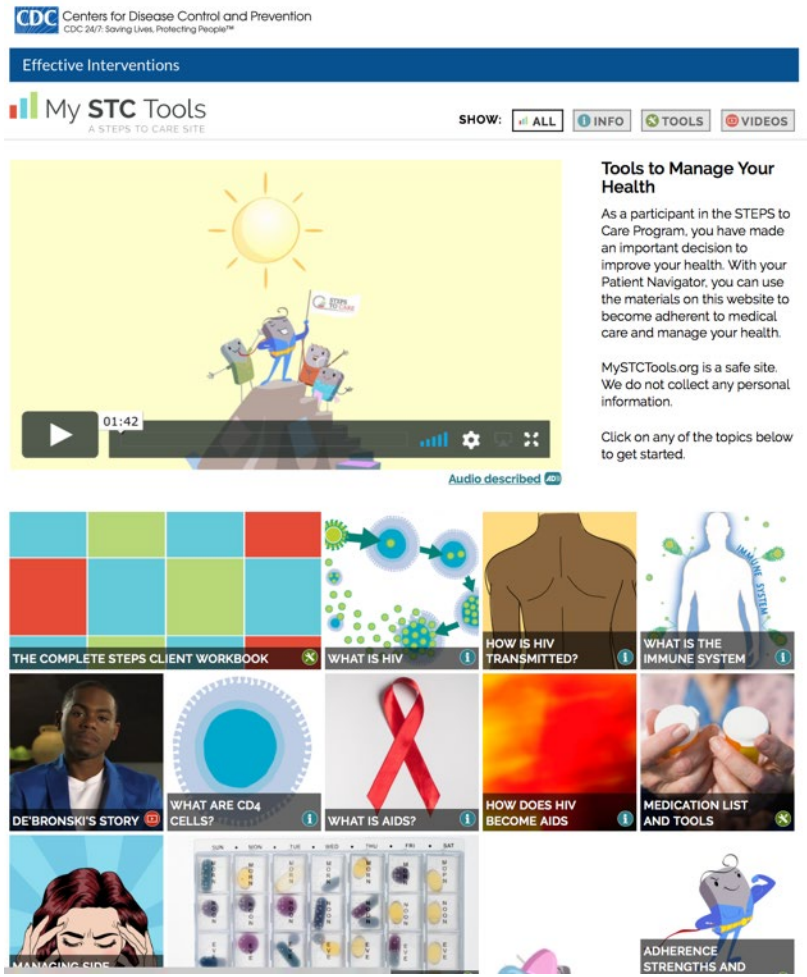
(Start with the most recent)

CD4 Records — If none are available, check box at right: ☐ No CD4 count on record

CD4 count	CD4 % *(optional)*	Date (mm/dd/yy)

STEPS to Care Intake Assessment Form — Page 1 of 9

My STC Tools


CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
Effective Interventions
My STC Tools
A STEPS TO CARE SITE
SHOW: ALL INFO TOOLS VIDEOS
01:42
Audio described
Tools to Manage Your Health
As a participant in the STEPS to Care Program, you have made an important decision to improve your health. With your Patient Navigator, you can use the materials on this website to become adherent to medical care and manage your health.
MySTCTools.org is a safe site. We do not collect any personal information.
Click on any of the topics below to get started.
THE COMPLETE STEPS CLIENT WORKBOOK
WHAT IS HIV
HOW IS HIV TRANSMITTED?
WHAT IS THE IMMUNE SYSTEM
DE'BRONSKI'S STORY
WHAT ARE CD4 CELLS?
WHAT IS AIDS?
HOW DOES HIV BECOME AIDS
MEDICATION LIST AND TOOLS
ADHERENCE STRENGTHS AND

Client Workbook

TOOL

The Complete STEPS Client Workbook

View and download the complete STEPS to Care Client Workbook below. This workbook contains all of the PDF materials found on this website.

Download The Complete STEPS Client Workbook

You are viewing a PDF in your web browser. Use the icons in the right side of the frame below to print or download the material.

Adherence Tools

TOOL

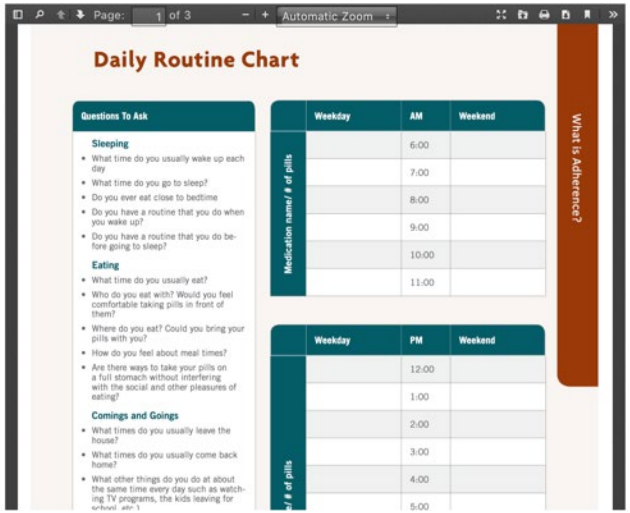
Adherence Tools

In order for HIV medications to work, it is important that you take them on time, every day. And while it's easy to know this, it can be challenging to do.

Your Patient Navigator can help you use the tools below to make it easier to be consistent with your medications.

Download Adherence Tools

You are viewing a PDF in your web browser. Use the icons in the right side of the frame below to print or download the material.



TOOL

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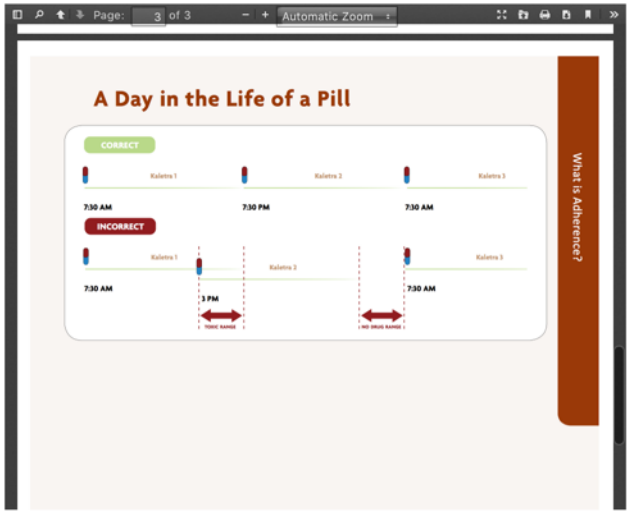
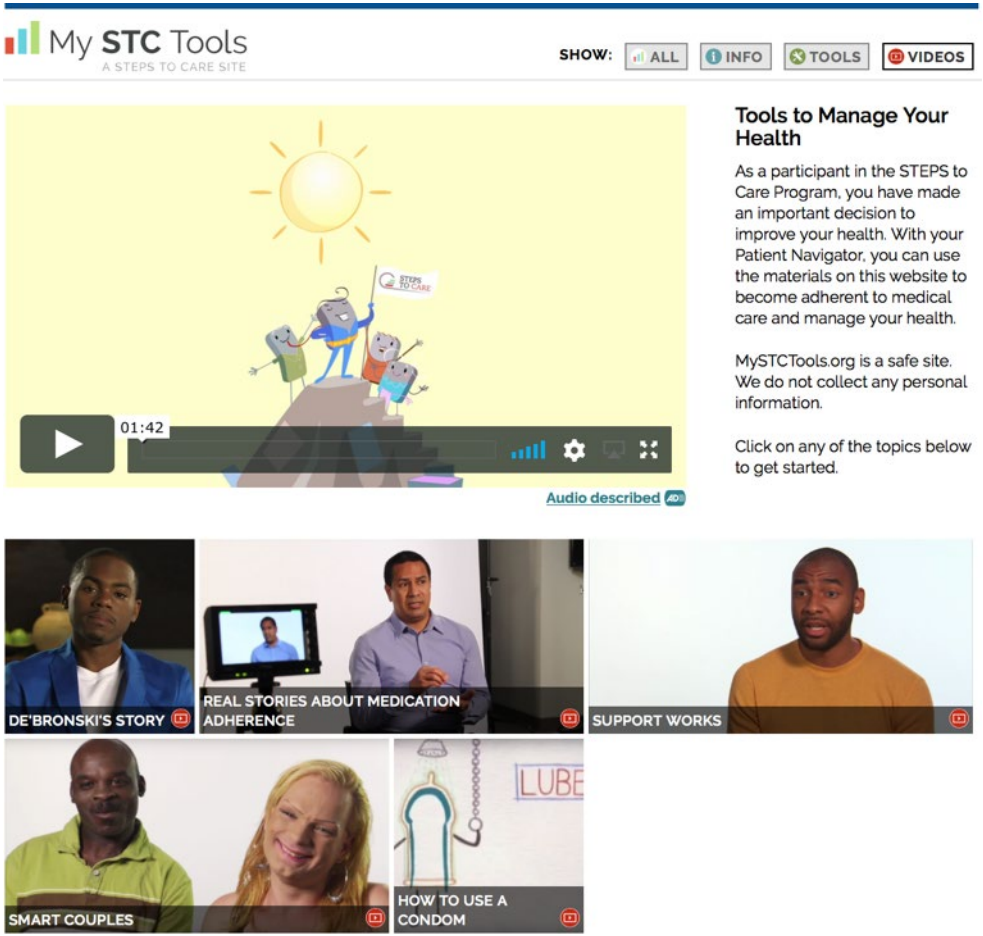


Client Site Videos



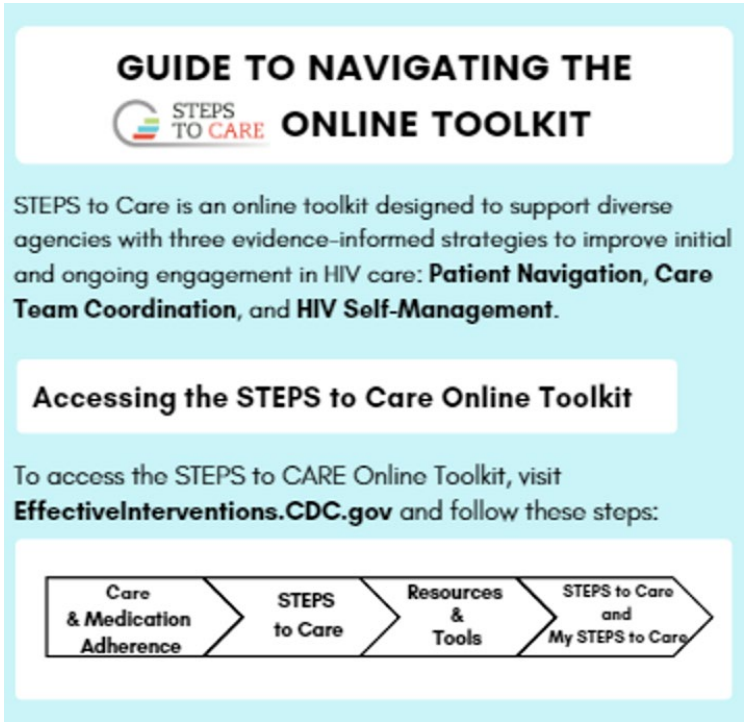
FUTURE OF STEPS TO CARE

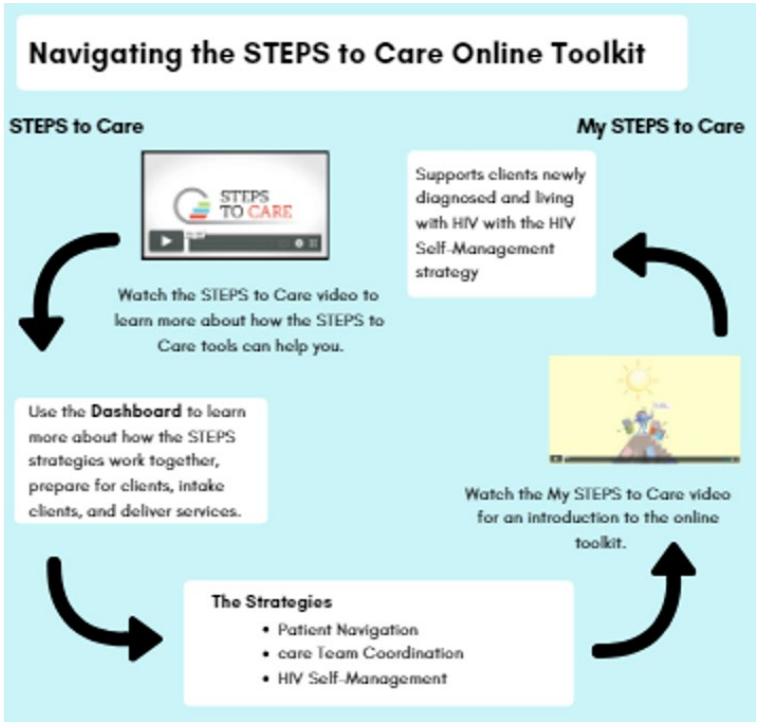
Dissemination

- Users: public health agencies and direct services organizations
  - CDC and HRSA, recipients, and sub-recipients
- Orientation in *HIV Navigation Services* trainings
- Infographic:
  - EffectiveInterventions.cdc.gov
  - Info dissemination at conferences, etc.
- Webinar
- Announcements via various listservs

Accessing STEPS to Care - Infographic

- ***The below is a draft in progress.***





Ready for STEPS to Care?

Tools on STEPS to Care website

https://effectiveinterventions.cdc.gov/en/2018-design/care-medication-adherence/group-4/steps-to-care

- **Agency Readiness Assessment –** downloadable tool to assess infrastructure, staffing, client selection criteria, budgeting, etc.
- **Preview Guide and FAQ –** resource for planning and pre-implementation

CDC Capacity Building Assistance

- **For individualized TA and training on STEPS to Care implementation,** visit: **https://wwwn.cdc.gov/Cris2009/pages/main/e1.aspx** or: **www.getcbanow.org**

Acknowledgments

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Thank you!

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.