THE DESIGN AND IMPLEMENTATION OF A PROGRAM MODEL FIDELITY ASSESSMENT

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

Gina Gambone, MPH
New York City Department of Health and Mental Hygiene
Bureau of HIV/AIDS Prevention and Control
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
OVERVIEW OF THE TCC PROGRAM MODEL

Ryan White Part A TRANSITIONAL CARE COORDINATION (TCC)

Adapted from the CRITICAL TIME INTERVENTION (CTI)
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.criticaltime.org
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
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

TCC TARGET POPULATION

<table>
<thead>
<tr>
<th>PLWHA (ages 18+)</th>
<th>One or more of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residency in NY EMA</td>
<td>• Newly diagnosed with HIV</td>
</tr>
<tr>
<td>Income &lt; 435% FPL</td>
<td>• Lost to care</td>
</tr>
<tr>
<td>Homeless or unstably housed</td>
<td>• Difficulty adhering to ART</td>
</tr>
<tr>
<td></td>
<td>• Difficulty keeping appointments or receives sporadic primary care</td>
</tr>
</tbody>
</table>
TCC Target Geographic Areas

- Harlem
- Washington Heights
- Chelsea and surrounding neighborhoods
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

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 by ZIP code

- 0.1 - 0.5
- 0.6 - 1.0
- 1.1 - 1.8
- 1.9 - 6.4
- Non-residential zones

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

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
  - Health
  - Housing
  - Case Management
  - Benefits/Entitlement Assistance
  - 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
FIVE PHASES OF TCC

PHASE 0
Outreach & Engagement

Targeted Outreach and Referrals Using TCC Criteria

MONTH 1

PHASE 1
Transition to TCC

Intense Period of Engagement

Assessment

Develop Comp. Care Plan (CCP)

Health Promotion

Begin Linkages to Providers

MONTHS 1-3

PHASE 2
Try Out

Adjust and Monitor Linkages

Health Promotion

Less Frequent Meetings between TCC Staff and Client

MONTHS 4-6

PHASE 3
Transfer of Care

Adjust and Monitor Linkages

Finalize Linkages

Client Graduation

MONTHS 7-9

PHASE 4
Follow-Up

Follow Up with Client and/or Providers

MONTH 12

CCP

CCP

CCP

CCP

CCP
TCC Client Demographics*

**Gender**
- N = 622
- Male
- Female
- Transgender 2.3%

23.6% Male
74.1% Female
2.3% Transgender

**Race/Ethnicity**
- N = 622
- Black
- Hispanic
- White
- Other

54% Black
31% Hispanic
9% White
6% Other

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

42.4% <=29 years
46.1% 30-49 years
11.4% >=50 years

*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.
# Living Situation at Intake (N= 622)

<table>
<thead>
<tr>
<th>Living Situation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Room Occupancy (SRO) hotel</td>
<td>59.7%</td>
</tr>
<tr>
<td>Staying in someone else's (family's or friend's) room, apartment, or house</td>
<td>21.7%</td>
</tr>
<tr>
<td>Room, apartment, or house that you rent (not affiliated with a supportive housing program)</td>
<td>9.0%</td>
</tr>
<tr>
<td>Emergency shelter (non-SRO hotel)</td>
<td>3.7%</td>
</tr>
<tr>
<td>Hospital, institution, long-term care facility or substance abuse treatment/detox center</td>
<td>2.4%</td>
</tr>
<tr>
<td>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</td>
<td>&lt;2% each</td>
</tr>
</tbody>
</table>
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?

FIDELITY ASSESSMENT Years 1 & 2 (2011-2013)

Self-Assessment + Fidelity Alignment Plan
Assessment Methods and Tools

- TCC-CTI Fidelity Scale
- TCC-CTI Self-Assessment Tool
- On-site Fidelity Conversation Meetings
- Fidelity Alignment Plans
≥ 3 community-based meetings with client during Phase 1

Closing note documents final joint transfer-of-care meeting

≥ 95% of weeks had team supervision meeting

Positive mediation and negotiation between client and support network

Example Fidelity Standards

Compliance Fidelity [Components] (15)
Context Fidelity [Structure] (8)
Competence Fidelity (15)
Program Quality (15)

Compliance Fidelity [Components] (15)
Context Fidelity [Structure] (8)
Competence Fidelity (15)
Program Quality (15)

[Components] [Structure] [Context] [Competence] [Program Quality]

Example Fidelity Standards

≥ 3 community-based meetings with client during Phase 1

Closing note documents final joint transfer-of-care meeting

≥ 95% of weeks had team supervision meeting

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

Average Score

<table>
<thead>
<tr>
<th>TCC Agencies</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>4.58</td>
</tr>
<tr>
<td>B</td>
<td>4.42</td>
</tr>
<tr>
<td>C</td>
<td>4.39</td>
</tr>
<tr>
<td>D</td>
<td>4.22</td>
</tr>
<tr>
<td>E</td>
<td>4.18</td>
</tr>
</tbody>
</table>

Fidelity Scale (1 = Never, 5 = Always)
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
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
Fidelity to TCC Model

Fidelity % = \( \frac{\text{Total Score}}{\text{Total Possible Score}} \)

TCC-CTI Scoring Key

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

<table>
<thead>
<tr>
<th>TCC Agencies</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>B</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>C</td>
<td>86%</td>
<td>92%</td>
</tr>
<tr>
<td>D</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>E</td>
<td>80%</td>
<td>86%</td>
</tr>
</tbody>
</table>

TCC-CTI Scoring Key

- **>85%**: Ideally Implemented
- **71%-85%**: Well Implemented
- **56%-70%**: Fairly Implemented
- **41%-55%**: Poorly Implemented
- **<40%**: Not Implemented
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
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
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
FIDELITY ASSESSMENT Year 3
(2013-2014)

Chart Review
Assessment Methods and Tools

- TCC Fidelity Chart Review Tool
- On-site Chart Review
- Agency-level Analysis
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

<table>
<thead>
<tr>
<th>Domain 1: Documentation Timeliness</th>
<th>Domain 2: Fidelity to Phase Timeline</th>
<th>Domain 3: Fidelity to Phase Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plan Development within 30 days of Intake?</td>
<td>Did staff meet with client ≥ 1 time during the first month?</td>
<td>Does Care Plan include 1-3 Areas of Focus?</td>
</tr>
<tr>
<td>Care Plan Update 1 within 90-120 days?</td>
<td>Action steps on Care Plan have target dates?</td>
<td>Are goals and objectives S.M.A.R.T.?</td>
</tr>
<tr>
<td>Care Plan Update 2 within 90-120 days?</td>
<td>Documentation of follow-up in Phase 4?</td>
<td>Documentation of client feedback regarding their experience in TCC?</td>
</tr>
</tbody>
</table>
# 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 during the first month? (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 | | Did staff record specific ways linkages to supports are or are not working? (Q.15) | ☑ Yes ☐ No |

<table>
<thead>
<tr>
<th>Agency</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>All Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td># charts reviewed</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>27 charts</td>
</tr>
</tbody>
</table>
AREAS OF STRENGTH
(Lowest # of Discrepancies)

- Timely Care Plan development: 0
- Strong supervision and team communication: 0
- Strong client engagement in Phase 1: 0
# CHALLENGES
(Highest # of Discrepancies)

<table>
<thead>
<tr>
<th>Challenge</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.M.A.R.T. goals and objectives</td>
<td>22</td>
</tr>
<tr>
<td>Decreased communication with client by Phase 3</td>
<td>10</td>
</tr>
<tr>
<td>Community-based meetings with client and supports</td>
<td>10</td>
</tr>
<tr>
<td>Community-based meetings with client</td>
<td>9</td>
</tr>
</tbody>
</table>
Fidelity to TCC Model
(All Providers)

- **Documentation Timeliness**: 93%
- **Fidelity to Phase Timeline**: 81%
- **Fidelity to Phase Content**: 81%

Fidelity % = 100% – \(\frac{\text{# Discrepancies}}{\text{Total Possible # Discrepancies}}\)
DOMAIN 1: Documentation Timeliness

Fidelity Percentage

<table>
<thead>
<tr>
<th>TCC Agencies</th>
<th>Year 3 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>97%</td>
</tr>
<tr>
<td>B</td>
<td>90%</td>
</tr>
<tr>
<td>C</td>
<td>90%</td>
</tr>
<tr>
<td>D</td>
<td>95%</td>
</tr>
<tr>
<td>E</td>
<td>92%</td>
</tr>
</tbody>
</table>

Overall Fidelity Percentage: 93%
DOMAIN 2: Fidelity to Phase Timeline

<table>
<thead>
<tr>
<th>TCC Agencies</th>
<th>Fidelity Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>78%</td>
</tr>
<tr>
<td>B</td>
<td>85%</td>
</tr>
<tr>
<td>C</td>
<td>80%</td>
</tr>
<tr>
<td>D</td>
<td>85%</td>
</tr>
<tr>
<td>E</td>
<td>76%</td>
</tr>
</tbody>
</table>

YEAR 3

TCC Agencies’ Fidelity Percentage: 81%
DOMAIN 3: Fidelity to Phase Content

<table>
<thead>
<tr>
<th>TCC Agencies</th>
<th>Fidelity Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>83%</td>
</tr>
<tr>
<td>B</td>
<td>86%</td>
</tr>
<tr>
<td>C</td>
<td>69%</td>
</tr>
<tr>
<td>D</td>
<td>87%</td>
</tr>
<tr>
<td>E</td>
<td>80%</td>
</tr>
</tbody>
</table>

YEAR 3

81%
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Domain 1: Documentation Timeliness (20%)</th>
<th>Domain 2: Fidelity to Phase Timeline (40%)</th>
<th>Domain 3: Fidelity to Phase Content (40%)</th>
</tr>
</thead>
</table>

**YEAR 3**
# AGENCY A – Harvey Balls Analysis

<table>
<thead>
<tr>
<th>Service Provision Category</th>
<th>DOMAIN 1: Documentation Timeliness (20%)</th>
<th>DOMAIN 2: Fidelity to Phase Timeline (40%)</th>
<th>DOMAIN 3: Fidelity to Phase Content (40%)</th>
<th>Total Score 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Plans &amp; Progress Notes</td>
<td>Below Average</td>
<td>Average</td>
<td>Above Average</td>
<td></td>
</tr>
<tr>
<td>Early Engagement (Phase 1)</td>
<td>Below Average</td>
<td>Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring (Phases 2-3)</td>
<td>Below Average</td>
<td>Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduation (Phases 3-4)</td>
<td>Above Average</td>
<td></td>
<td>Below Average</td>
<td></td>
</tr>
</tbody>
</table>

Below Average | Average | Above Average | Excellent

YEAR 3
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
ACKNOWLEDGEMENTS

NYC DOHMH Bureau of HIV/AIDS

- Wilbur Yen, MPH, LMSW
- Annika Shore, MPH
- Michael Wong, MPH
- Graham Harriman, MA
- Mary Kay Diakite, MSW
- Lola Arakaki, MPH

SPECIAL THANKS to
TCC Program Staff
Center for Urban Community Services (CUCS)
THANK YOU!

Contact Information

Gina Gambone
Project Officer, NYC DOHMH

ggambone1@health.nyc.gov