



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



Education
Development
Center



Presenters:

Aisha L Wilkes, MPH

Behavioral Scientist

Centers for Disease Control and Prevention
(CDC)

Kate Penrose, MS

Senior Research Analyst, Care & Treatment
NYC DOHMH

Graham Harriman, MA

Director, Care & Treatment
NYC Department of Health &
Mental Hygiene (NYC DOHMH)

Athi Myint-U, EdM

Senior Instructional Designer
Education Development Center

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Disclosures

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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

■ 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 in New York City



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

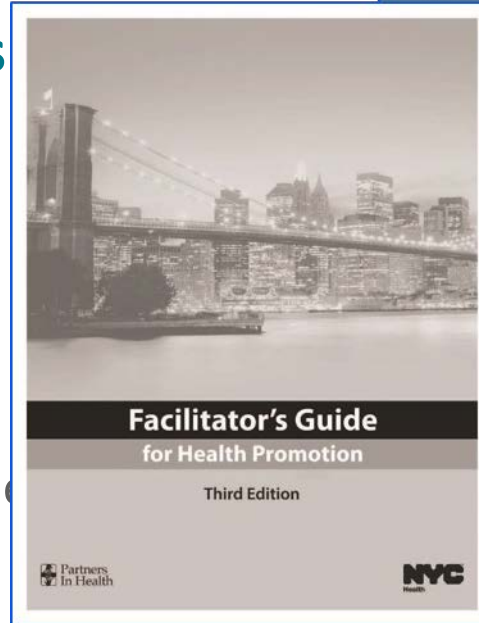
- **Interdisciplinary care team meeting**
 - Program Staff (CC and/or PN)
 - Clinician (MD/DO/NP/PA)
 - Patient (optional)
- **Review labs, adherence, home conditions**
 - Tool: case conference form (customizable)
- **Develop and update client care plan**
 - Tool: comprehensive care plan (customizable)

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

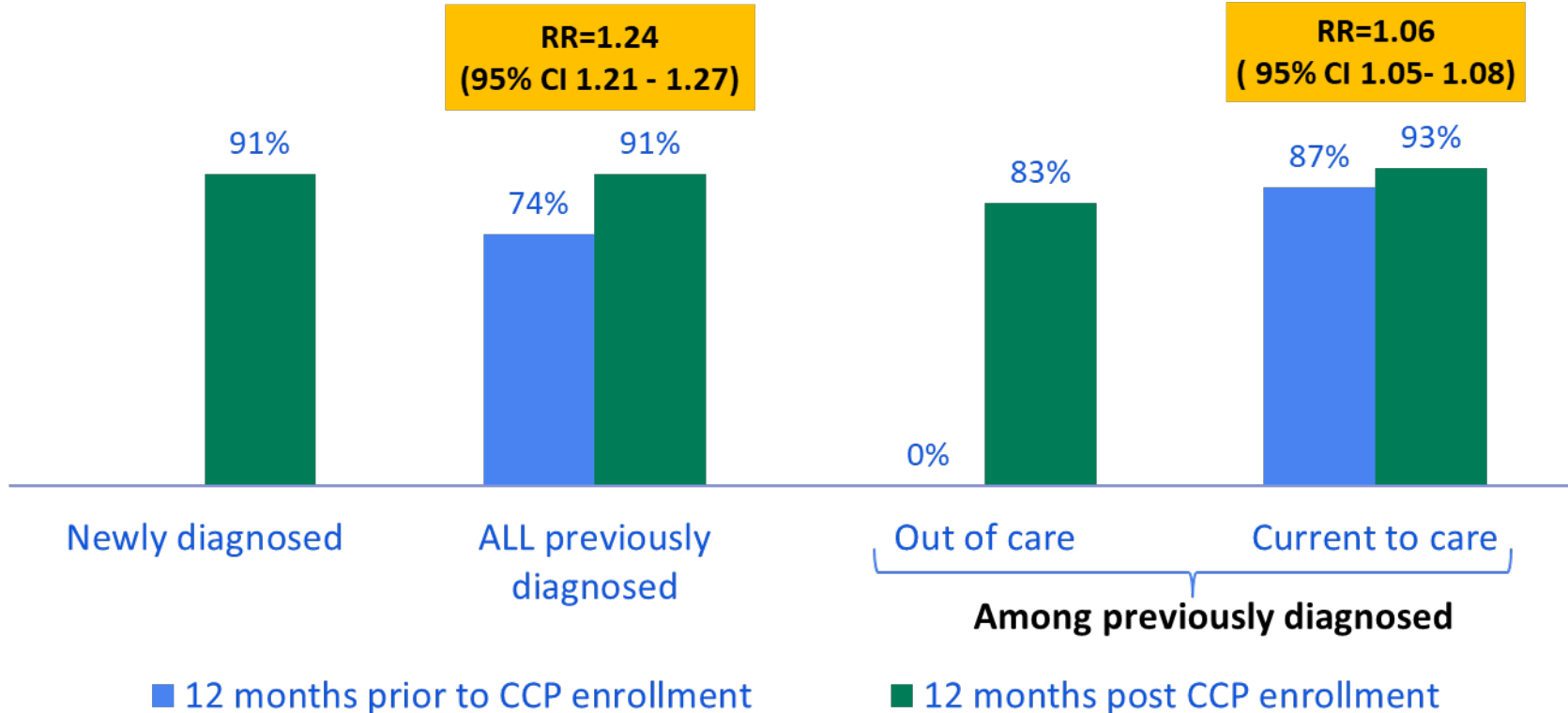


Covers of Care Coordination Workbook and Facilitator's Guide

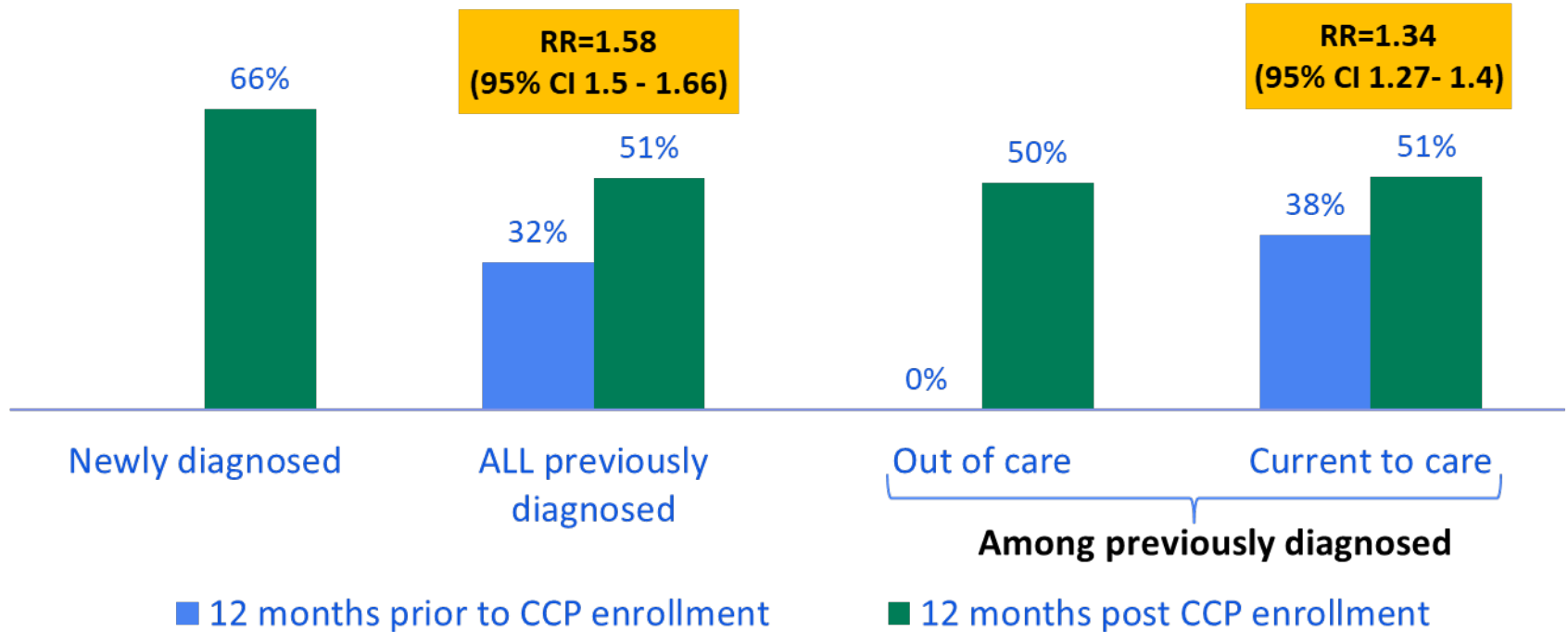
Evidence Basis: CHORDS Study (PIs: D. Nash, M. Irvine)

- 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*

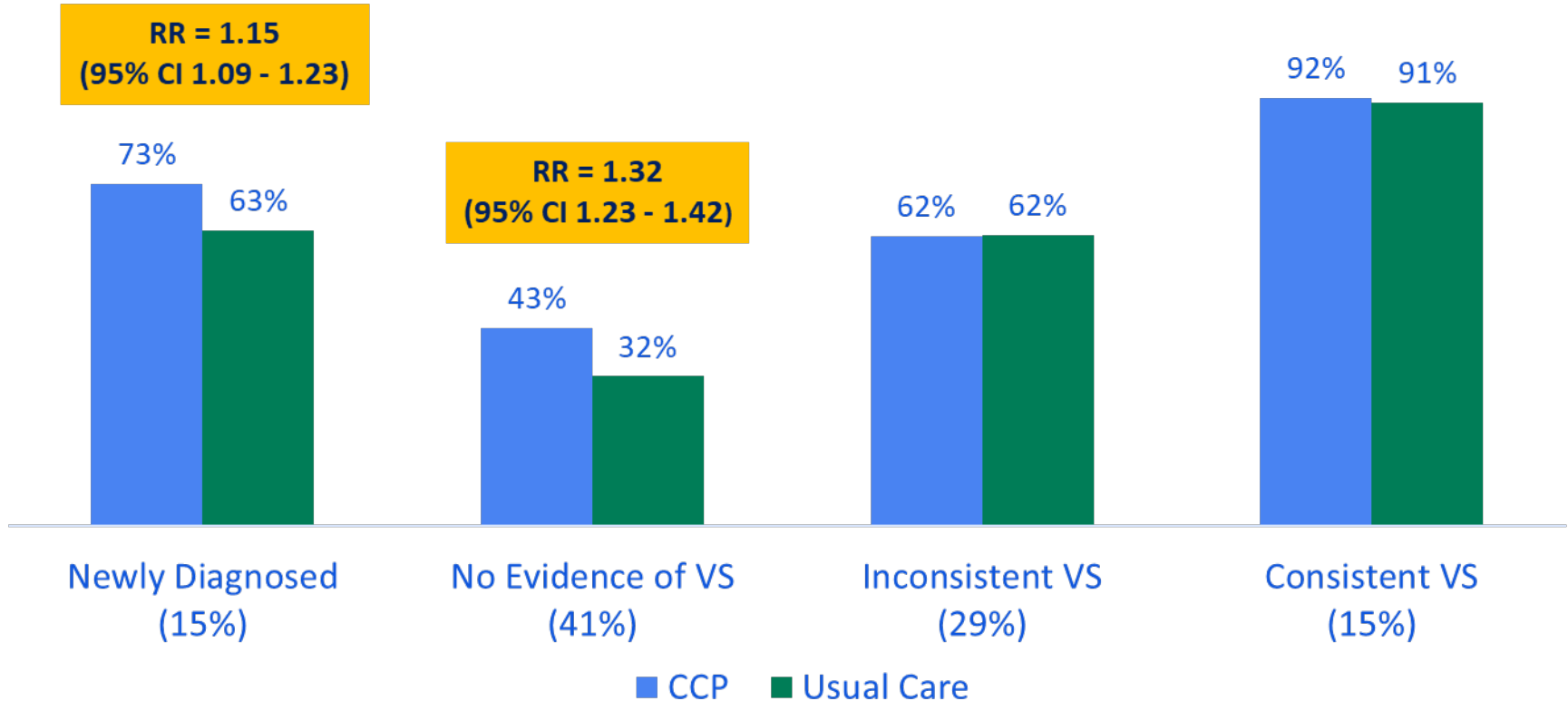
Engagement in Care (EiC) Pre- vs. Post-enrollment (%)



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?

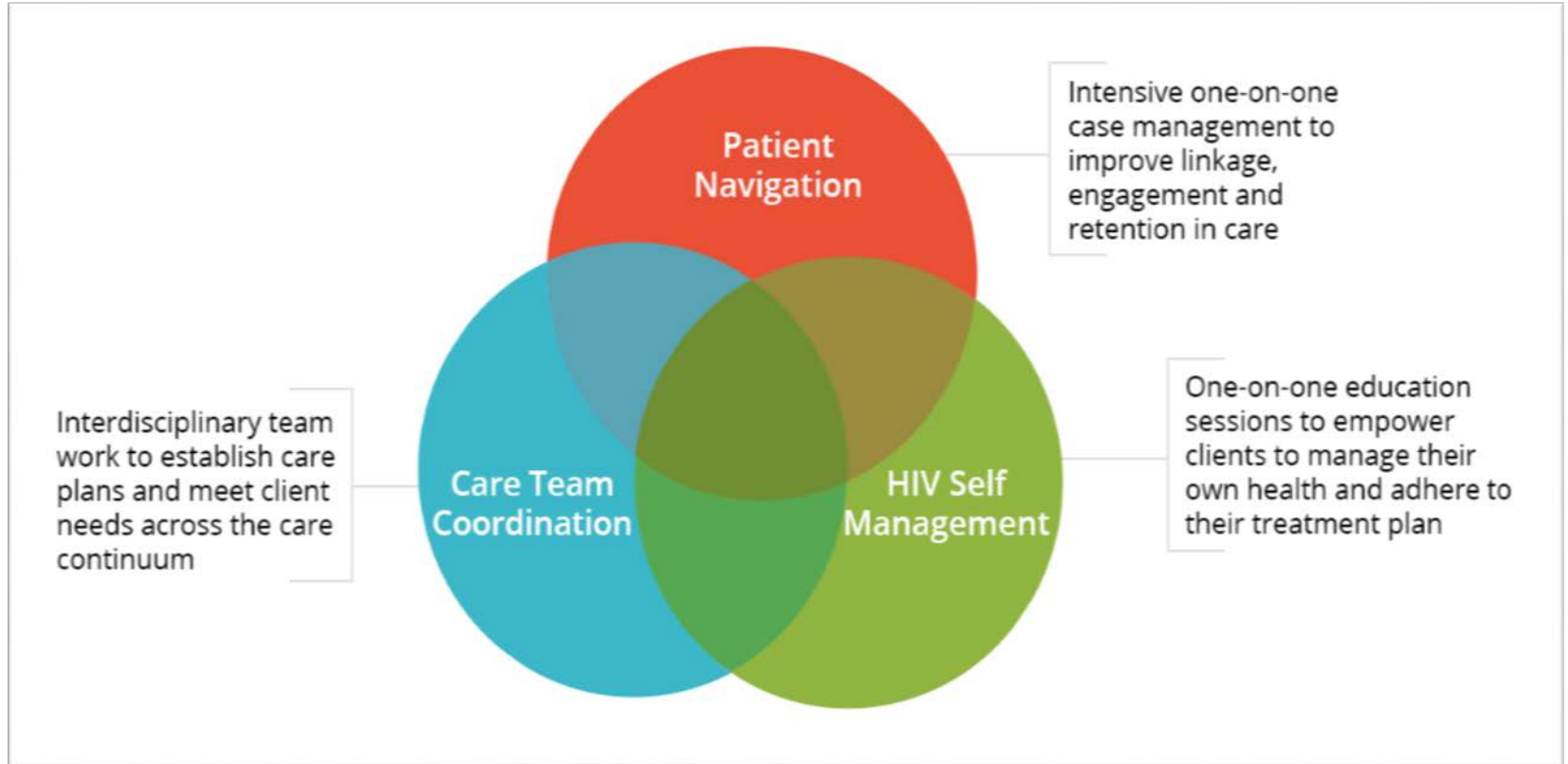


- Funder: CDC, under a 3-year Cooperative Agreement; Aisha L. Wilkes, MPH, PO
- Grantee: Education Development Center, Inc. (EDC); Lydia O'Donnell, EdD, PI
- Partner: NYC Dept. of Health & Mental Hygiene (DOHMH); Mary Irvine, DrPH, PI
- Purpose: Translation of evidence-informed CCP strategies into web-based 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.

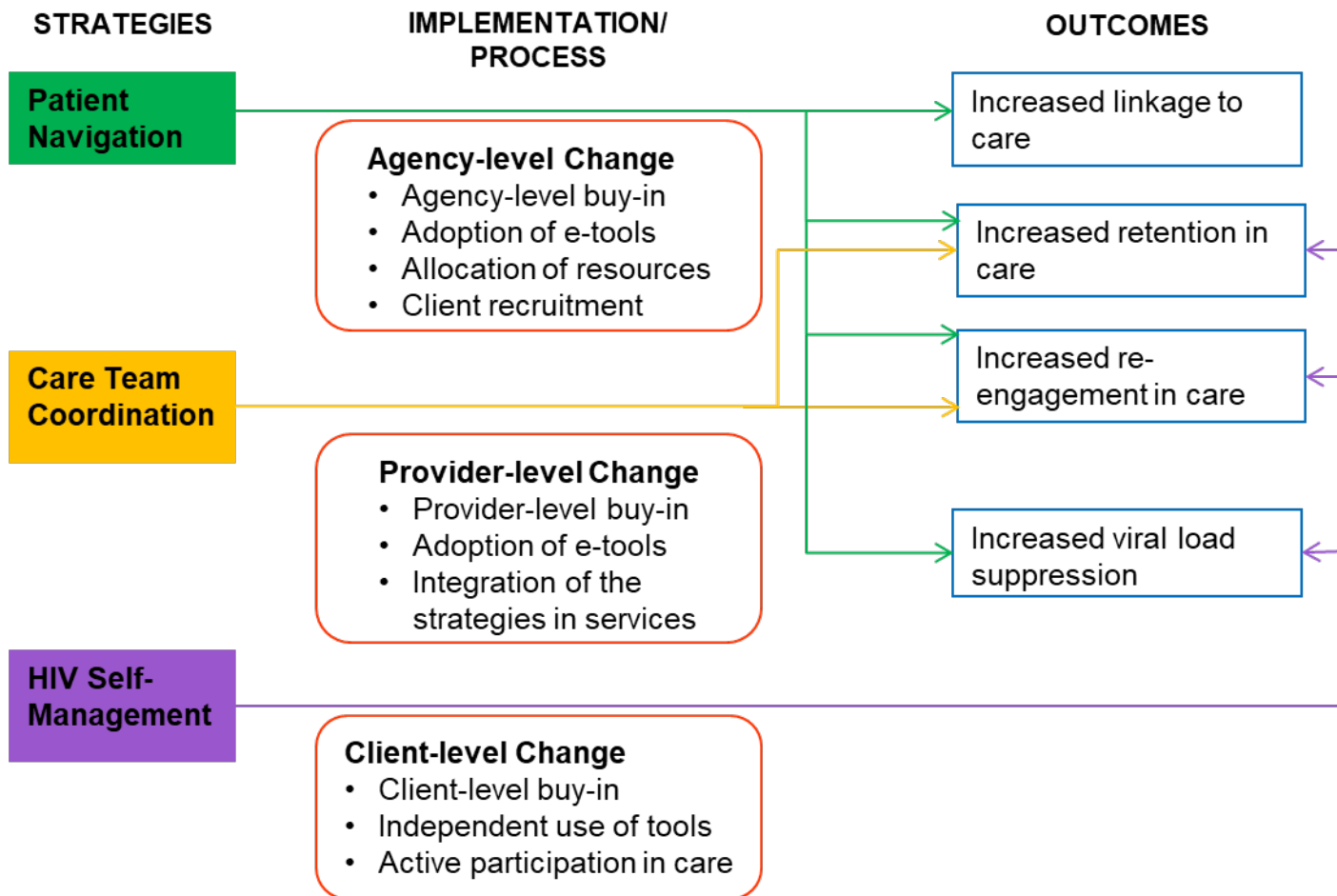
STEPS to Care Strategies



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

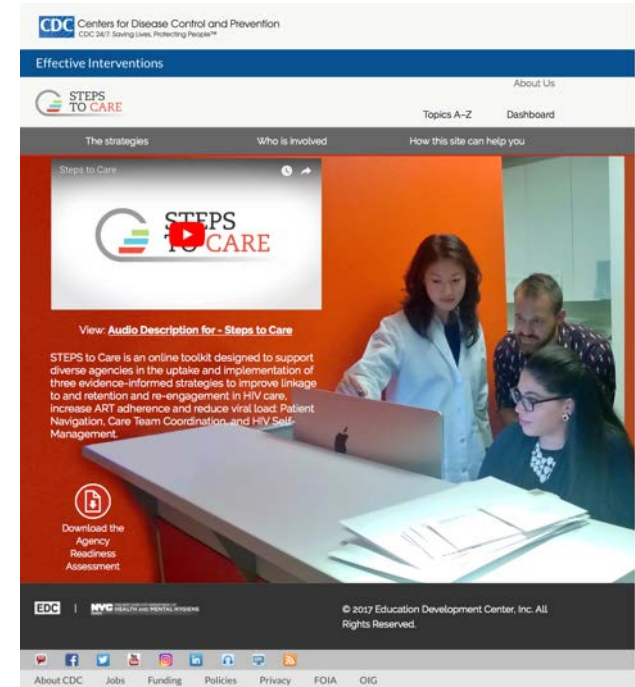
- Literature review and summary on the 3 strategies, to confirm evidence (beyond NYC) for their promotion of HIV care continuum outcomes
- Site visits and consultation with 4 model CCP-implementing agencies
- Findings used to determine the universe of tools needed and the design of the web-based tools
 - 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

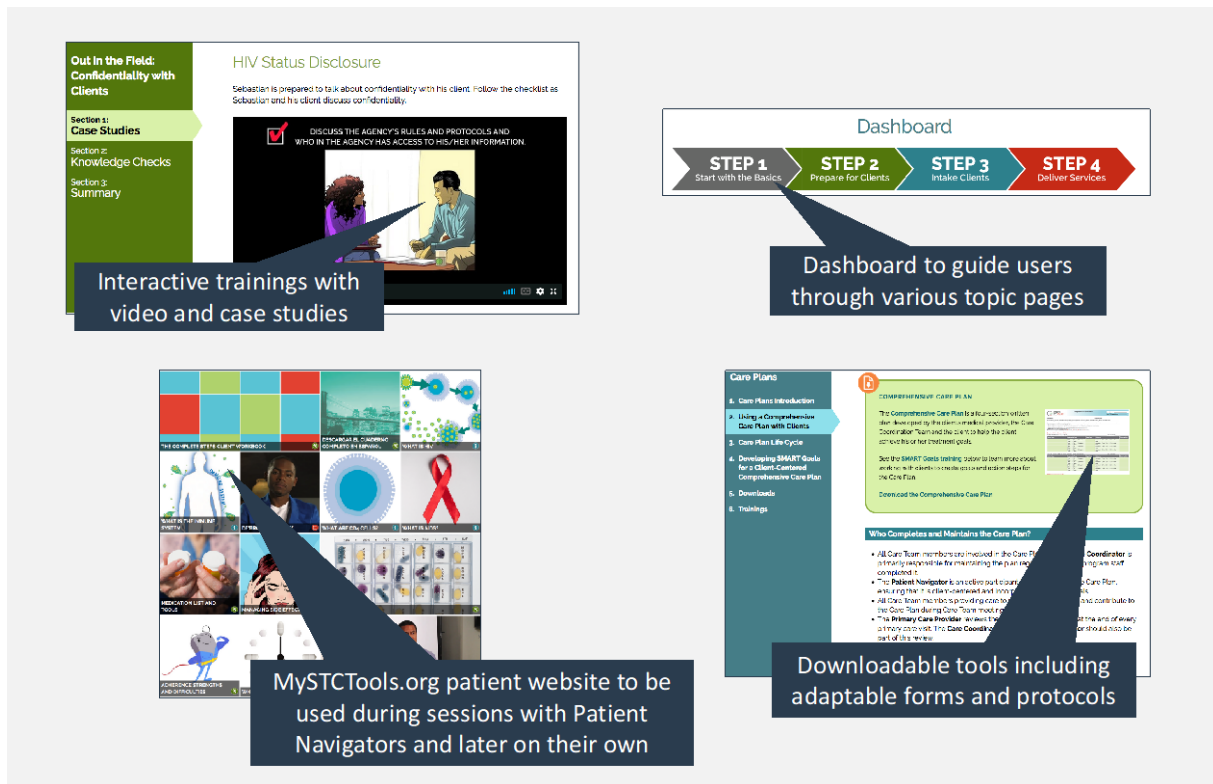
- **Tools designed for:**
 - Program planning
 - Staff training
 - Ongoing technical assistance and guidance
- **Tailored for use by:**
 - Program administrators/directors
 - Care coordinators
 - Patient navigators
 - PLWH (clients/consumers)



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



The image displays four screenshots of the STEPS to Care web pages, each with a descriptive callout box:

- Out in the Field: Confidentiality with Clients**: A screenshot of a video titled "HIV Status Disclosure" showing a man and a woman in a discussion. The callout box states: "Interactive trainings with video and case studies".
- Dashboard**: A screenshot of a dashboard with four steps: STEP 1 Start with the Basics, STEP 2 Prepare for Clients, STEP 3 Intake Clients, and STEP 4 Deliver Services. The callout box states: "Dashboard to guide users through various topic pages".
- MySTCTools.org patient website**: A screenshot of a grid of various tools and resources, including a human body diagram, a red ribbon, and a calendar. The callout box states: "MySTCTools.org patient website to be used during sessions with Patient Navigators and later on their own".
- Care Plans**: A screenshot of a "Comprehensive Care Plan" form. The callout box states: "Downloadable tools including adaptable forms and protocols".

Screenshots of STEPS to Care web pages on Effective Interventions site

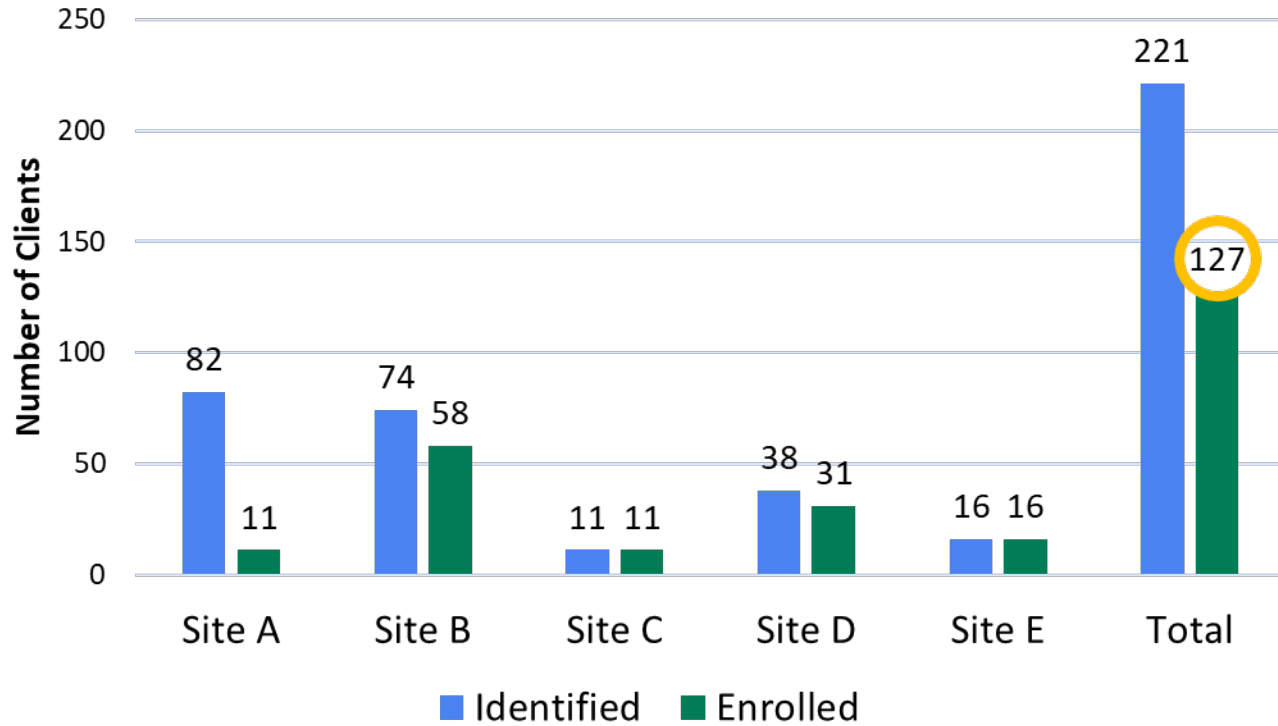
Step 3: Pilot Test — NYC

- **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

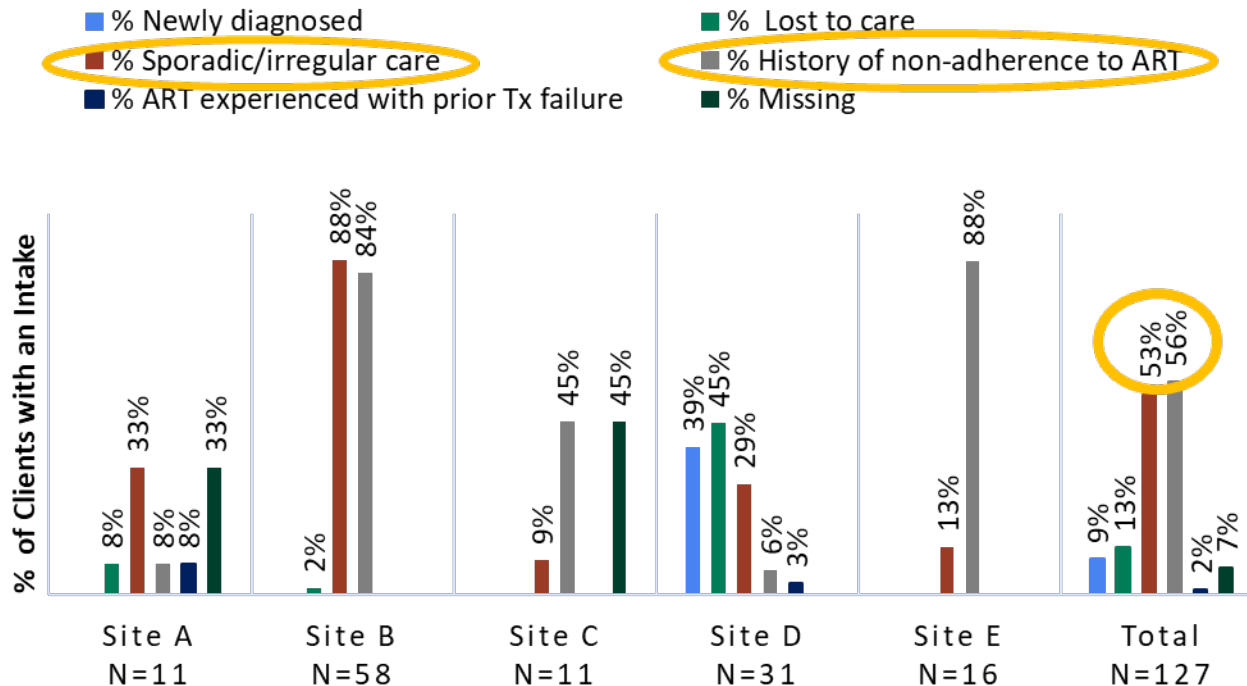
Photo of New York City skyline



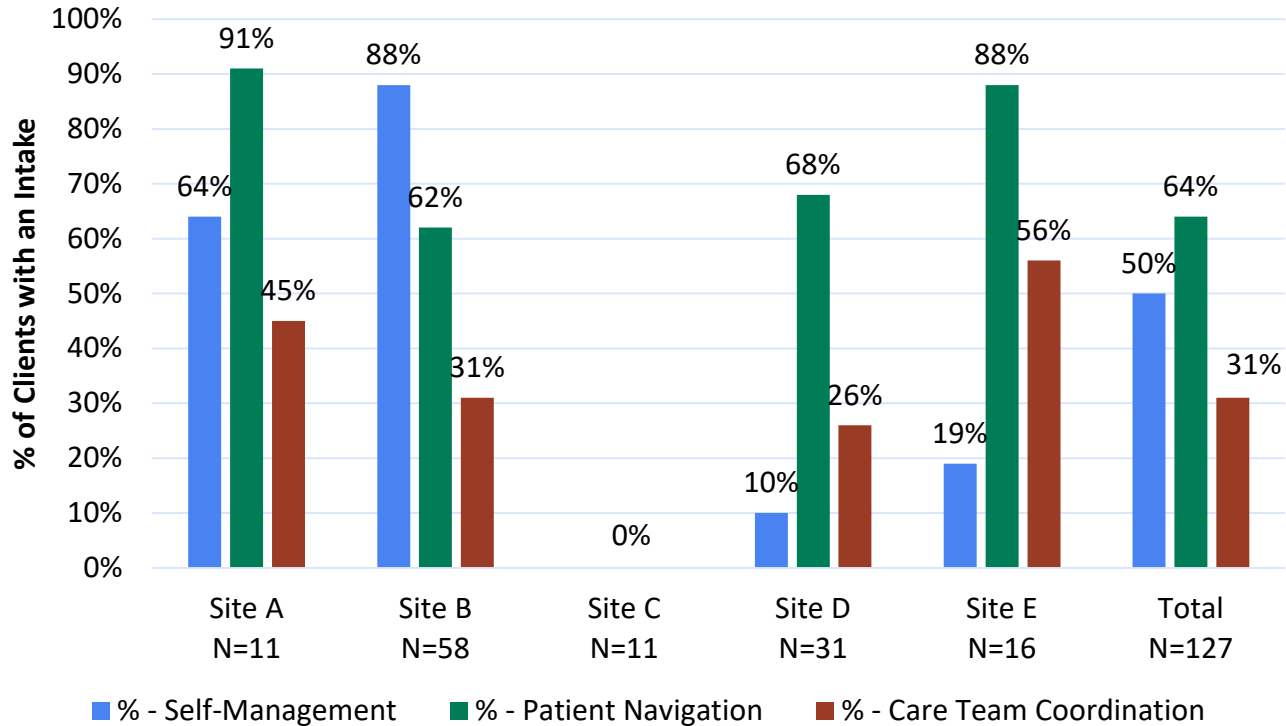
Clients Identified vs. Clients who Completed Enrollment



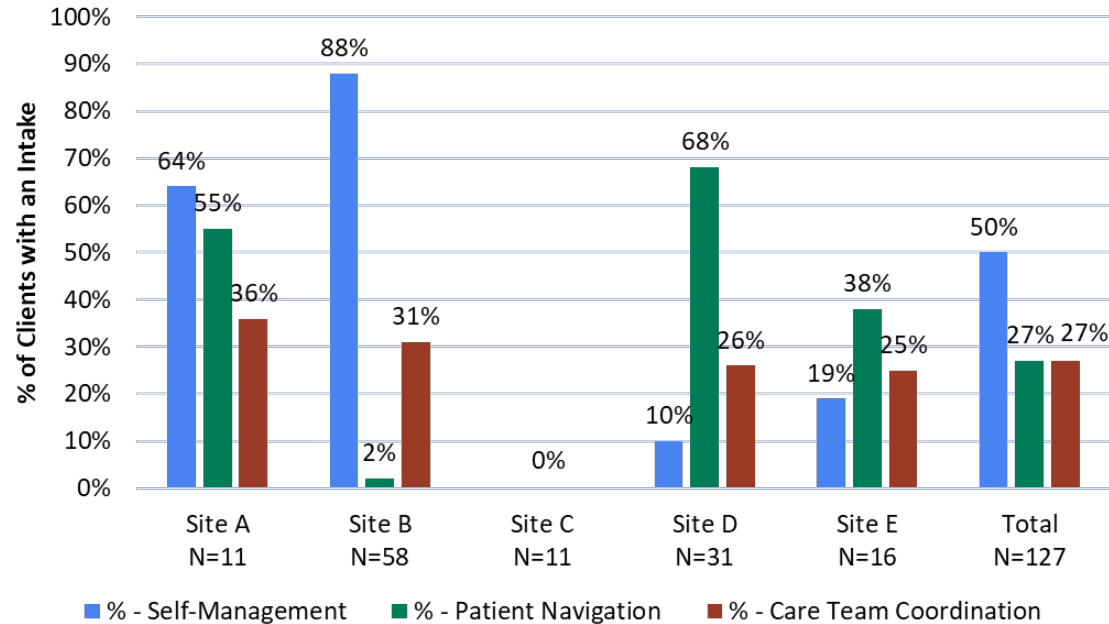
Reasons for Enrollment



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](#)

[E LEARNING 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

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People™

Effective Interventions

STEPS TO CARE

About Us
Topics A-Z Dashboard

The strategies Who is involved How this site can help you

Steps to Care

View: [Audio Description for - Steps to Care](#)

STEPS to Care is an online toolkit designed to support diverse agencies in the uptake and implementation of three evidence-informed strategies to improve linkage to and retention and re-engagement in HIV care, increase ART adherence and reduce viral load: Patient Navigation, Care Team Coordination, and HIV Self-Management.

Download the Agency Readiness Assessment

EDC | NYC HEALTH AND MENTAL HYGIENE

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- For Program Directors**
Pre-Implementation tools that help you establish a budget for your program, gain agency buy-in, and hire and retain the right staff.
- For Care Coordinators**
Resources for supervising your staff and establishing systems that keep everything running smoothly.
- For Patient Navigators**
Support with field work and tools for use with and for clients to ensure successful outcomes.
- For Everyone**
Even if your job description doesn't fit neatly into one of the categories above, our personalized recommendations quiz will help you find just the right tools and trainings for you.

Navigating through the STEPS to Care Toolkit

- View tools by implementation steps on the Dashboard

The screenshot displays the STEPS to Care Toolkit Dashboard. At the top, there is a navigation bar with the STEPS TO CARE logo, links for 'About Us', 'Topics A-Z', and 'Dashboard'. Below the navigation bar, the word 'Dashboard' is centered. A horizontal progress bar shows four steps: STEP 1 (Start with the Basics), STEP 2 (Prepare for Clients), STEP 3 (Intake Clients), and STEP 4 (Deliver Services). STEP 1 is highlighted with a large number '1' and the text 'START WITH THE BASICS'. Below this, a sub-header reads 'The 3 STEPS strategies and how they work together'. The main content area for Step 1 is divided into two columns. The left column is titled 'Preview Guide and FAQs' and includes a link to 'Agency Readiness Assessment' with a 'Launch topic' button. The right column is titled 'STEPS Strategies' and includes links to 'Client Pathway and Relevant Provider Forms Key Components Checklist' and 'Introduction Video', both with 'Launch topic' buttons. At the bottom right of the Step 1 section is a 'Back to top' link. Below the Step 1 section, a green header bar indicates '2 PREPARE FOR CLIENTS'. Under this header, a sub-header reads 'Pre-implementation tools and guidance for agencies and staff'. The content for Step 2 is organized into three columns: 'Budgeting' (with a link to 'Budget Toolkit PDF'), 'Staffing and Supervision' (with links to 'Care Coordinator Job Description Template', 'Patient Navigator Job Description Template', 'Program Director Job Description Template', 'Staff Roles and Responsibilities', and 'Care Coordinator Role and Responsibilities Clinical Supervision'), and 'Establishing Policies and Protocols' (with links to 'Recommended Client Selection Criteria', 'Sample Confidentiality Protocol', 'Sample Field Safety Protocol', 'Sample Missed Appointment Protocol', 'Sample Outreach Protocol', and 'Sample Scheduling Protocol').

STEPS TO CARE

About Us
Topics A-Z
Dashboard

Dashboard

STEP 1 Start with the Basics
STEP 2 Prepare for Clients
STEP 3 Intake Clients
STEP 4 Deliver Services

1 START WITH THE BASICS

The 3 STEPS strategies and how they work together

Preview Guide and FAQs
Guidance on how STEPS to Care strategies and tools can support your agency practices.
Agency Readiness Assessment
Preview Guide and FAQs for Program Directors
Launch topic ►

STEPS Strategies
Learn about the three STEPS strategies and how they work together.
Client Pathway and Relevant Provider Forms Key Components Checklist
Introduction Video
Launch topic ►

Back to top

2 PREPARE FOR CLIENTS

Pre-implementation tools and guidance for agencies and staff

Budgeting
Tools to manage your program budget.
Budget Toolkit
Budget Toolkit PDF

Staffing and Supervision
Roles, job description templates and guidance on hiring and supervising program staff.
Care Coordinator Job Description Template
Patient Navigator Job Description Template
Program Director Job Description Template
Staff Roles and Responsibilities
Care Coordinator Role and Responsibilities
Clinical Supervision

Establishing Policies and Protocols
Guidance and templates for Program Directors establishing new programs.
Recommended Client Selection Criteria
Sample Confidentiality Protocol
Sample Field Safety Protocol
Sample Missed Appointment Protocol
Sample Outreach Protocol
Sample Scheduling Protocol

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

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



The screenshot shows the 'Topics A-Z' page of the STEPS to Care Toolkit. At the top, there is a navigation bar with the 'STEPS TO CARE' logo on the left, 'ABOUT US' on the right, and 'Topics A-Z' and 'Dashboard' in the center. Below the navigation bar is a large blue circular icon with a white square and an arrow pointing right. Underneath this icon is the text 'All STEPS to Care Topics (A to Z)'. The main content area displays six topic cards arranged in a 2x3 grid. Each card has a title, a brief description, and a 'Launch topic' button with a right-pointing arrow. The topics are: Budgeting, Care Plans, Care Team Coordination, Client Intake, Establishing Policies and Protocols, and HIV Self-Management. Each card also features a small red circular icon with a white 'b' and a green circular icon with a white 's'.

STEPS TO CARE

ABOUT US

Topics A-Z Dashboard

Launch topic

Budgeting
Establish and monitor a program budget using the Budget Toolkit.

Care Plans
Understand the purpose of a Care Plan and how to use the Care Plan Form. Develop the skills for creating SMART goals with clients.

Care Team Coordination
Create a strong and cohesive Care Team. Includes a video on care team communication strategies, guidance on scheduling meetings, and all necessary forms.

Client Intake
Learn about the client intake process and take a training on best practices in client interviewing. Contains all forms required for intake and guidance on completing the forms using client interviews and chart reviews.

Establishing Policies and Protocols
Find guidance and resources for establishing program policies and protocols that work for staff and clients.

HIV Self-Management
Deliver HIV Self-Management education sessions to clients using the MySTCtools.org website and client workbook materials.

Launch topic ▶

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

Staying Safe in the Field

Section 1: Case Studies

Section 2: Knowledge Checks

Section 3: Summary



Darius



Rosa

Darius and Rosa are Patient Navigators working at the same clinic. This course will follow them on a typical week of home visits. Along the way, you'll be asked to make decisions that relate to their safety in the field. Your goal for this training is to keep Rosa and Darius safe while maximizing quality time spent with their clients.

[← Back](#)

[Next >](#)

[← Back to Working with
Clients in the Field
topic page](#)

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

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: <input type="checkbox"/> 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

Effective Interventions

My STC Tools
A STEPS TO CARE SITE

SHOW: ALL INFO TOOLS VIDEOS



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.



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.

PDF viewer interface showing page 1 of 3. The main content is a "Daily Routine Chart" with a sidebar titled "What is Adherence?".

Daily Routine Chart

Questions To Ask

- Sleeping**
 - What time do you usually wake up each day?
 - What time do you go to sleep?
 - Do you ever eat close to bedtime?
 - Do you have a routine that you do when you wake up?
 - Do you have a routine that you do before going to sleep?
- Eating**
 - What time do you usually eat?
 - Who do you eat with? Would you feel comfortable taking pills in front of them?
 - Where do you eat? Could you bring your pills with you?
 - How do you feel about meal times?
 - Are there ways to take your pills on a full stomach without interfering with the social and other pleasures of eating?
- Comings and Goings**
 - What times do you usually leave the house?
 - What times do you usually come back home?
 - What other things do you do all about the same time every day such as watching TV programs, the kids leaving for school, etc.?

Medication name / # of pills

	Weekday	AM	Weekend
		6:00	
		7:00	
		8:00	
		9:00	
		10:00	
		11:00	

	Weekday	PM	Weekend
		12:00	
		1:00	
		2:00	
		3:00	
		4:00	
		5:00	

What is Adherence?

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.

PDF viewer interface showing page 3 of 3. The main content is a "A Day in the Life of a Pill" timeline with a sidebar titled "What is Adherence?".

A Day in the Life of a Pill

What is Adherence?


CORRECT

Timeline showing correct pill-taking times: 7:30 AM, 7:30 PM, 7:30 AM.





INCORRECT


Timeline showing incorrect pill-taking times: 7:30 AM, 1 PM, 7:30 AM. Red arrows indicate missed doses.

Client Site Videos




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.





DE'BRONSKI'S STORY 





REAL STORIES ABOUT MEDICATION ADHERENCE 




SUPPORT WORKS 



SMART COUPLES 



HOW TO USE A CONDOM 

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.*

GUIDE TO NAVIGATING THE STEPS TO CARE ONLINE TOOLKIT

STEPS to Care is an online toolkit designed to support diverse agencies with three evidence-informed strategies to improve initial and ongoing engagement in HIV care: **Patient Navigation, Care Team Coordination, and HIV Self-Management.**

Accessing the STEPS to Care Online Toolkit

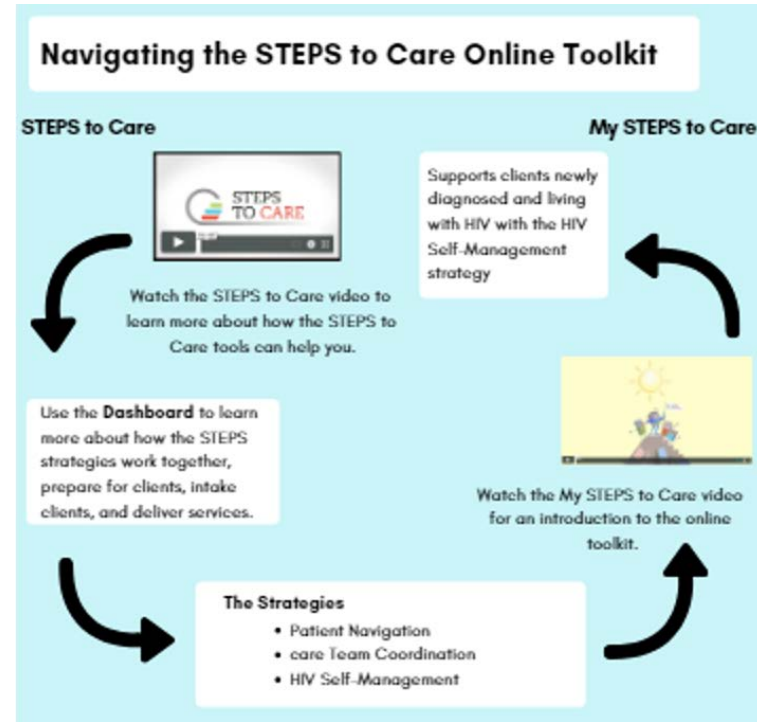
To access the STEPS to CARE Online Toolkit, visit **EffectiveInterventions.CDC.gov** and follow these steps:

Care & Medication Adherence

STEPS to Care

Resources & Tools

STEPS to Care and My STEPS to Care



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

Authors: Mary Irvine, Aisha Wilkes, Julie Rwan, Athi Myint-U, Graham Harriman, Katherine Penrose, Patricia Bessler, Cari Courtenay-Quirk, and Lydia O'Donnell

Other Contributors:

CDC

Chezia Carraway

Monique Carry

Chela Hall

Jeffrey Herbst

Darrel Higa

Jerris Raiford

David Whittier

EDC

Deb McLean

Maya Lagu

NYC DOHMH

Stephanie Chamberlin

Beau Mitts

CUNY ISPH

Denis Nash

Community Advisory Board members and staff of pilot agencies.

Claiming CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

<http://ryanwhite.cds.pesgce.com>



Thank you!

Aisha L. Wilkes
Prevention Research Branch/DHAP/NCHHSTP
Centers for Disease Control and Prevention
404-639-6473
awilkes@cdc.gov

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

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.

