The Road to Dissemination

Documenting the Journey from Planned Approach to Intervention Implementation

Part 2 – March 28, 2023

INTEGRATING HIV INNOVATIVE PRACTICES (IHIP)

Purpose: To support the coordination, dissemination, and replication of innovative HIV care strategies in the Ryan White HIV/AIDS Program (RWHAP) through the development and dissemination of implementation tools and resources and provision of TA.

Key Support:

- Implementation tools and resources (targethiv.org/ihip)
- Capacity building TA webinars
- Peer-to-peer TA on the featured interventions
- Support in the development and dissemination of implementation tools and resources
  - Webinars
  - One-on-one TA
- Helpdesk (ihiphelpdesk@mayatech.com)

The Road to Dissemination — Documenting the Journey from Planned Approach to Intervention Implementation

A four-session webinar series facilitated by ACOJA Consulting for RWHAP grant recipients and other HIV services providers

Session 1 : February 28, 12-1 PM ET

Session 2 : March 28, 12-1 PM ET

Session 3 : April 25, 12-1 PM ET

Session 4 : May 23, 12-1 PM ET

Register: https://bit.ly/IHIP-Road-to-Dissemination

INTRODUCTIONS

Ask the Audience:

- What's Your Name / Pronouns?
- Where do you Work?
- What is your Role?
- What Interested you in this Webinar Series?

PURPOSE OF IMPLEMENTATION MANUALS

- Document the Process
- Learn from the Journey
- Foster Dissemination & Replication
- Support Sustainability
- Learn from the Process
- Pivot, Adjust, Adapt
- Create Additional Funding Opportunities During the Project
- Improve Project Outcomes

iHiP Webinar Series

Session One:

Why this Destination? Getting Travelers and Stakeholders Onboard

Session Two:

Starting the Journey: Mapping a Route to your Planned Destination

Session Three:

Detours: The Only Certainty is Change

Session Four:

You've arrived! Creating your Travel Log

JOIN US!
Fourth Tuesdays! Noon – 1:30PM (ET)
February through May 2023

WHERE WE ARE

Session 1: Why this Destination? Getting Travelers and Stakeholders Onboard

- Understand where we're going with an overview of the journey.
- Identify your team (travelers) and collaborators (key stakeholders).
- Work together to learn the different modes of travel (learning and communication styles).

Session 2: Starting the Journey: Mapping a Route to your Planned Destination

- Planning tools and tips.
- Mapping your route - Planning before you go, with key considerations for documenting each stop.

SESSION 1: OVERVIEW

INTRODUCTION: Purpose of Implementation Manuals (IM), Audience, Overview

BACKGROUND | INTERVENTION: Describe site, need addressed, intervention, population, frameworks

PRE-IMPLEMENTATION ACTIVITIES: Gaining buy-in , Hiring staff, Collaborators, Promoting the Intervention, Planning for Sustainability, Planning Costs

PURPOSE OF IMPLEMENTATION MANUALS: Document the Process, Learn from the Journey, Foster Dissemination & Replication, Support Sustainability AND

Learn from the Process, Pivot, Adjust, Adapt, Create Additional Funding Opportunities During the Project, Improve Project Outcomes

SESSION 1: KEY TAKE AWAYS

- Gain Buy in
- Welcome and engage the reader
- Describe the intervention and its intent
- Discuss the need for the intervention
- Provide relatable background information that leads reader to want to learn more

SESSION 2: STARTING THE JOURNEY

Mapping a Route to Your Planned Destination

- Planning tools and tips.
- Small group activity: Mapping your route - Planning before you go. Discuss key considerations for documenting each stop along the way.
- Review *Pre-Implementation activities, Implementation* and *Evaluation* sections of Intervention Manual.

PAST, CURRENT, OR PLANNED PROJECTS

Ask the Audience:

Is this your First or Second Session?

If First: Any past, current or upcoming projects? What is/was your role?

If Second: Key takeaways to share? Updates?

WRITING WITH STYLE: 12 BASIC RULES

1. Start with an outline (see iHiP!)
2. Write as you speak
3. Choose words carefully
4. Don’t exaggerate
5. Pay attention to grammar
6. Pay attention to spelling
7. Stick with active voice
8. Keep your voice out of it
9. Limit the adjectives
10. Avoid using 1st person
11. Avoid abbreviations and acronyms
12. Prove it

PRE-IMPLEMENTATION ACTIVITIES (1 OF 2)

Gaining Buy-in

Potential stakeholders/funders to leverage

Hiring Staff

Staff requirements and recommendations

Job descriptions

Partner Organizations | Collaborators

Roles and responsibilities

Memoranda of Understanding

WHO TO KNOW BEFORE YOU GO

Gaining Buy-in

Who is going? Who is paying?

Bookings

Travel method, Accommodations

Itinerary

Fellow Travelers | Group Tour

Solo or Tour Group? Travel Agent?

Contract, Reservations

PRE-IMPLEMENTATION ACTIVITIES (2 OF 2)

Promoting the Intervention

Marketing and communications plan

- ❑ *Promotional content/products*

Planning for Sustainability

- ❑ *Intervention Plan & Implementation Guide*
- ❑ *Protocols and tools (intake forms, acuity scale, need assessment tool, evaluation tools)*
- ❑ *Documenting outcomes & lessons learned*

Planning Costs

- ❑ *Budget – funding, revenue*
- ❑ *Leveraged resources – in kind from partners*

WHAT TO KNOW BEFORE YOU GO

Sharing the Experience

Plan to document before, during, and after

- ❑ *People, places, and experiences*

Keeping Memories Alive & Future Plans

- ❑ *Note to future self: Do's and Don'ts*
- ❑ *Travel Blog?*
- ❑ *Highlights and lessons learned*

Planning Costs

- ❑ *Budget – let the buyer beware*
- ❑ *Leveraged resources – best value*

INTERVENTION IMPLEMENTATION (1 OF 2)

Core Components of the Intervention

Core activities and intended exposure (i.e. dosage, duration)

Intervention Flow Chart

Adaptations made During Implementation

WHO TO KNOW BEFORE YOU GO

Places to go! Things to See!

What will you do? How long will you be at each stop?

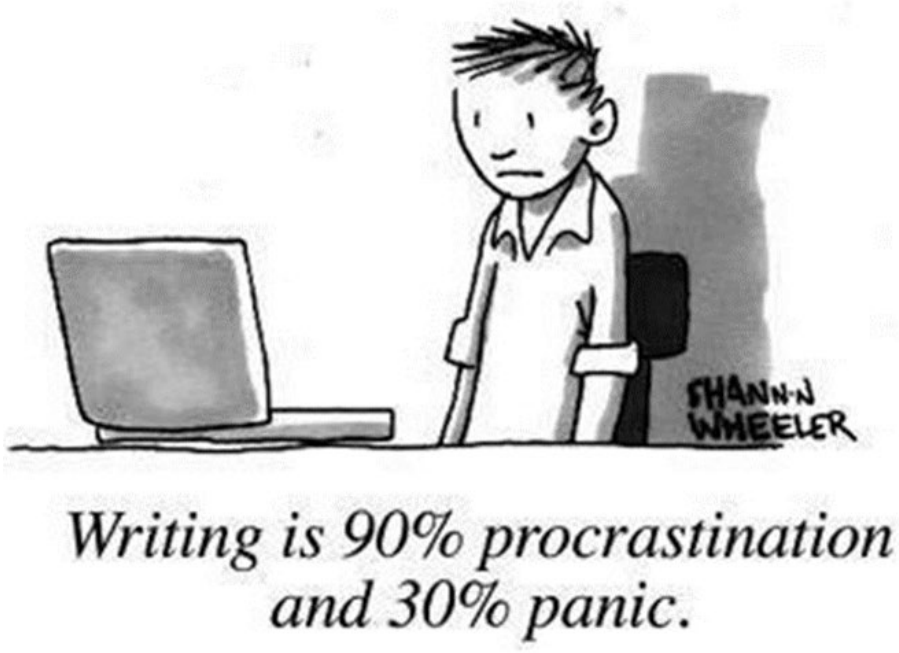
Making a Road Map

Roads taken, Travel method, Accommodations

Road Blocks and Detours?

Unplanned highlights?

SAMPLE WORKFLOW



Handbook:

[Tools and Tips for Providing Transitional Care Coordination]

HIV Continuity of Care Model
NYC Services to People with HIV During and After Incarceration

Goal	Type	Location	Description	Provider	Timeframe
Identification	Rapid HIV Testing	Jail Health Clinic	Opt-in universal testing	Correctional Health Services (CHS) Medical	On jail admission and on request
	Intake Exam	Jail Health Clinic	Self-report status	CHS Medical	On jail admission
	Early Intervention Services Health Education/ Risk Reduction	Jail Dorms	Group sessions, Condom Demonstrations/ Distribution HIV testing	CHS/Transitional Health Care Consortium (THCC)	First month of Incarceration Condoms on request Condoms on release
Comprehensive care	Treatment and Care	Jail Health Clinic	Primary HIV Care & Treatment including ARVs as appropriate	CHS Medical	On jail admission and on follow up as clinically indicated
Individual Session During Jail Stay	Health Education Non-Medical Case Management	Jail Health Clinic	Treatment Adherence Counseling	CHS Medical	Day 2 and on follow up as clinically indicated
	Discharge Plan	Jail Health Clinic, Program Office	Assessment, Resource identification, service plan	CHS THCC (self-report)/Medical (newly diagnosed)	Day 2 and weekly as indicated
Transitional Care Coordination	Health Insurance Assistance	Jail Program Office	Facilitate health insurance and ADAP applications	CHS THCC	Day 2 and on follow up as indicated
	Court Advocacy	Jail/Court	Provide health information and identify resources to facilitate treatment in lieu of jail time	CHS THCC/ Community courts, advocates	From day 2 to court date
	Discharge Medication	Jail, Court, Community office	Seven-day supply of medication; 21-day prescription	CHS THCC (known) Medical (newly diagnosed)	On release
	Patient Navigation	Jail, Court, Community	Accompaniment, transportation, finding people lost to follow up	CHS THCC, community partners	From release to linkage to care
Linkage to Care	Medical visit	Community	Health exam and services	Community medical provider	Within 30 days of release from jail
Maintenance in Care	Care Coordination	Community	Medical Case Management, treatment adherence, patient navigation, tracking maintenance in care	Care Coordination programs in community	From Linkage to Care to fully engaged in care
	Coordination of Medical and Social Services	Community	Assessment and placement for housing, Assistance with health insurance and ADAP	Care Coordination programs in community	From Linkage to Care to fully engaged in care

INTERVENTION IMPLEMENTATION (2 OF 2)

Partner Activities

- **Participant events**
- **Partner appreciation events**

Intervention Implementation Costs

- **Documentation and reporting - streamlining hiccups**
- **Leveraging in-kind sources**

Planning for the Unexpected

WHO TO KNOW BEFORE YOU GO

Who Went Where? How Long?!

- **Did some travelers have different side trips?**
- **Meet up places?**

Cost of Travel Planning

Making reservations, mapping the route, Detours taken, discounts?

Road Blocks and Detours?

Unplanned highlights?

PARTNER LIST / DIRECTORY

Multi-purpose spreadsheet

For Funder, external communication:

Community Service Providers	Address1	Address2	Telephone	Service Type	Basis

For Team, internal communication and tracking:

Community Service Provider Org	Address1	Address2	FN	LN	Telephone	Email	Service Type	Basis	2022 MOU	LOS date

SAMPLE MOU WITH HRSA LANGUAGE

Appendix I. Sample MOU with HRSA Language

*The following is a sample MOU from a prior SPNS initiative. This sample MOU has been provided to help guide the process of creating a site-specific MOU.

SAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN CORRECTIONAL HEALTH SERVICES

This Memorandum of Understanding ("MOU") describes the intended working relationship between Correctional Health Services ("CHS"), located at XXX Tel: XXX-XXX-XXXX and _____ ("**Service Provider**") with an office at _____ Tel: _____ (each a "**Party**" and, collectively, the "**Parties**").

This MOU is a good faith agreement that demonstrates a plan for collaboration which will facilitate the referral for, and provision of, effectively coordinated and integrated services for people incarcerated in xxx county or city jail, their families, visitors and/or people returning to the community after incarceration ("patients") in need of health-related services or service referrals and is not intended to be binding on the Parties.

The Parties agree that they will endeavor to conduct the following:

1. CHS will make efforts to refer patients to the Service Provider for the purpose of linking patients to health providers in the community. The Parties will endeavor to accept referrals from each other in accordance with eligibility criteria.
2. The Service Provider will endeavor to participate in a collaborative program to outreach to inmates, their partners/families at the central visit center, and at other special events in order to explain the services that the Service Provider offers within its community area.
3. CHS staff may request joint participation with Service Provider in a patient case referral ("Joint Participation"). Joint Participation may include, but not be limited to, case conferences and staff risk assessment prior to making and/or accepting referrals. Further, CHS may conduct referral follow-up to insure adequate participation.
4. CHS maintains specific protocols for patient assessment, interviews, referrals, linkages, and confirmation of referrals with providers. These protocols are supplemented with detailed memoranda of understanding with other community-based partners to ensure that discharged inmates have access to HIV secondary prevention and other services (i.e. primary care, medical and mental health services, social services, respite or support services). CHS protocols are guidelines for the Service Provider to follow and will be provided by CHS, if requested by the Service Provider, for the Service Provider's benefit.
5. All referrals made should be confirmed by the Service Provider, contacting offices to set up the appointment and to confirm the appointment was kept. The service provider will seek any needed consent from enrolled participants to provide follow-up information regarding continuity of care (i.e. appointments made and kept) to CHS.

[Care and Treatment Interventions booklet]

EVALUATION PLAN

Process Evaluation

Measures

Outcome Evaluation

Measures

Logic Model

WHO TO KNOW BEFORE YOU GO

Places you went! Things you Saw!

Did you make it to each stop? Did you stay as long as planned at each stop?

Trip Log

What went according to plan?

What would you skip or do another day or time?

Travel Blog

LOGIC MODELS

- Logic models are tools for planning, describing, managing, communicating, and evaluating a program or intervention.
- They graphically represent the relationships between a program's activities and its intended effects, state the assumptions that underlie expectations that a program will work, and frame the context in which the program operates.
- Logic models are not static documents. They should be revised periodically to reflect new evidence, lessons learned, and changes in context, resources, activities, or expectations.

Source: https://www.cdc.gov/dhdsp/docs/logic_model.pdf

LOGIC MODELS (cont)

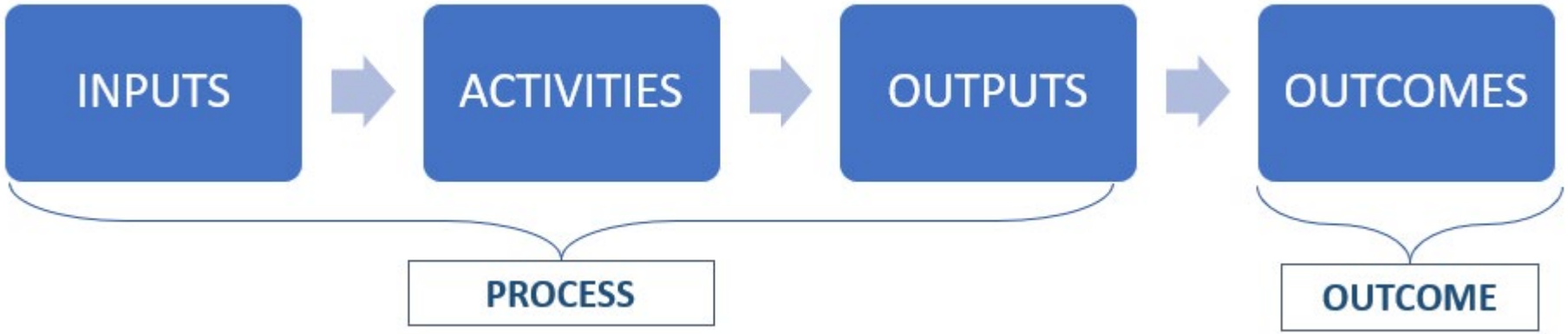
Logic models increase the likelihood that program efforts will be successful because they:

- Communicate the purpose of the program and expected results.
- Describe the actions expected to lead to the desired results.
- Become a reference point for everyone involved in the program.
- Improve program staff expertise in planning, implementation, and evaluation.
- Involve stakeholders, enhancing the likelihood of resource commitment.
- Identify potential obstacles to program operation so that staff can address them early on.

COMPONENTS OF A LOGIC MODEL

A basic logic model typically has two "sides"—**process** and **outcome**.

- The process section describes the program's inputs (resources), activities, and outputs (direct products).
- The outcome section describes the intended effects of the program, which can be short term, intermediate, and/or long term.



- Assumptions under which the program or intervention operates are often noted in a box below or on the left side of the logic model diagram.

Source: https://www.cdc.gov/dhdsp/docs/logic_model.pdf

LOGIC MODELS AS AN EVALUATION TOOL

A logic model is often used to guide evaluation planning.

It can help:

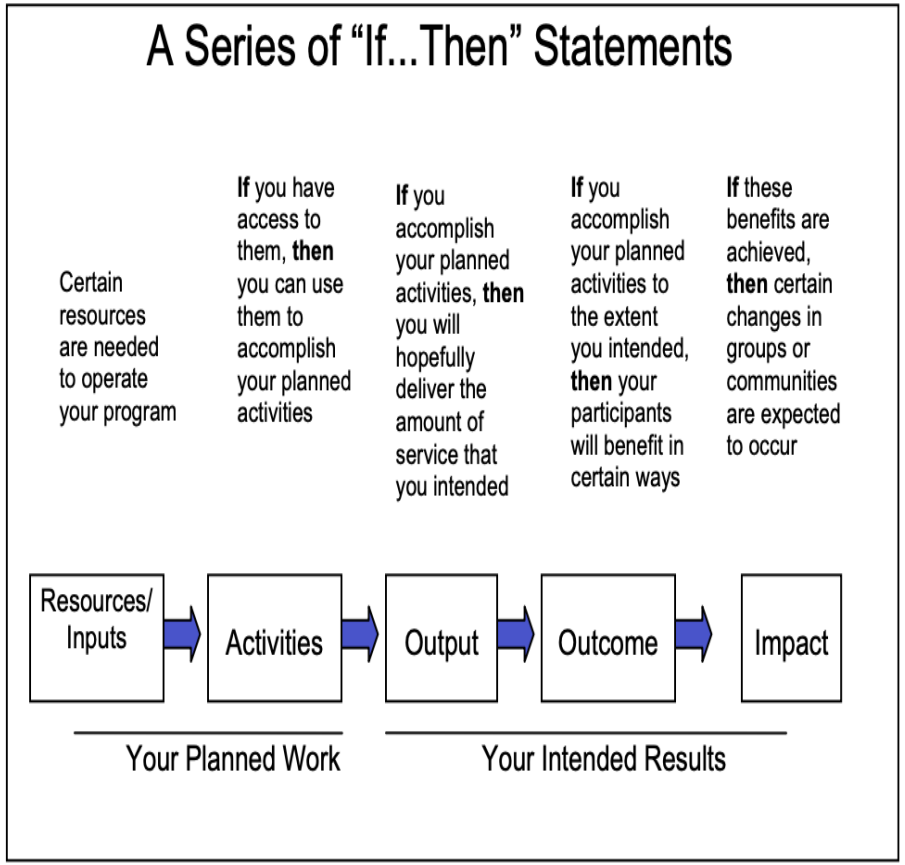
- Determine what to evaluate.
- Identify appropriate evaluation questions based on the program.
- Know what information to collect to answer these questions—the indicators.
- Determine when to collect data.
- Determine data collection sources, methods, and instrumentation.

Source: https://www.cdc.gov/dhdsp/docs/logic_model.pdf

USE THE “IF, THEN” APPROACH

“If/then” statements can help you identify and connect activities and anticipated outcomes.

Example: **“If** we have program funding and participating clinics, we can inform our clinic partners of the need to implement clinical practice guidelines and sponsor training for clinic teams on the chronic care model, which will **then** increase the number of clinic teams who are aware of clinical practice guidelines and who implement the chronic care model.



Source: https://www.cdc.gov/dhdsp/docs/logic_model.pdf

SMART OBJECTIVES

S—Specific

Concrete, detailed, and well defined so that you know where you are going and what to expect when you arrive

M—Measurable

Numbers and quantities provide means of measurement and comparison

A—Achievable

Feasible and easy to put into action

R—Realistic

Considers constraints such as resources, personnel, cost, and time frame

T—Time-based

A time frame helps to set boundaries around the objective

Care and Treatment Interventions (CATIs) Manual

Appendix A: Logic Model

Resources	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
◆ TCC Staff (transitional care coordinator, administrative supervisor, clinical supervisor) ◆ Local jail facility ◆ Community partners ◆ Intervention champion and support and buy-in from agency and jail administration ◆ Standard of care community case managers or social workers who can work with clients in collaboration with the transitional care coordinator for transition to standard of care ◆ Approval to work in jail system (MOU) and access to jail-based resources (assigned/ dedicated officers, supportive jail medical staff, dedicated space) ◆ Phone and laptop ◆ Access to Electronic Health Record in the jail and community and RW service data collection reporting system	◆ Pre-implementation activities – Train TCC staff – Protocol and MOU development – Establish supervision system for TCC staff and coordinate with jails and medical facilities ◆ Implementation activities in the jail – Identification of eligible participants – Develop transitional care plan – Connect clients with services to utilize post-release – Conduct health education sessions – Assist client in accessing HIV medications – Conduct health liaison activities ◆ Implementation activities post-release – Provide post-release linkage to HIV care – Provide post-release follow-up and support in achieving goals outlines in the transitional care plan – Provide addi-tional referrals, accompani-ments, appoint-ment reminders, and coaching as appropriate	◆ Linkage agreements in place with community providers ◆ # eligible individuals identified ◆ # eligible individuals offered TCC services ◆ # individuals who accept TCC services ◆ # clients who have a transitional care plans completed ◆ # clients released from jail/eligible for community-based activities ◆ # clients who received health liaison services ◆ # outreach attempts made to clients (post-release) ◆ # clients prescribed ART ◆ # referrals made to community partners ◆ # clients transitioned to the standard of care ◆ # referrals/ resources kept	◆ Increase in client HIV knowledge ◆ Increase in client awareness of community resources and ways to access resources ◆ Increase in adherence to existing ART prescription ◆ Increase in client access to benefits counseling and community resources ◆ Increased relations with jail medical staff and correctional officers	◆ Integration of TCC staff in both clinic/ agency and jail workflow ◆ Increase in number of clients released from jail during business hours ◆ Increase in number of clients released to alternative sentencing programs ◆ Increase in number of clients with a scheduled HIV primary care appointment within 48 hours of release ◆ # clients linked to HIV primary care in 30 days post-release	◆ Increase in long-term HIV medication adherence ◆ Increase in HIV viral suppression ◆ Improvement in long-term retention in HIV care – Housing stability and food security – Engagement in behavioral health treatment (substance use and mental disorders) ◆ Increase in client satisfaction with care ◆ Increase linkage to care coordination for those identified as in need of social supports

Care and Treatment Interventions (CATIs) Manual: Dissemination of Evidence-Informed Interventions. Transitional Care Coordination: From Jail Intake to Community HIV Primary Care (2020). Intervention Manual, pages 16-19; Appendix A (Logic Model) and Appendix I (Sample MOU with HRSA Language).

https://targethiv.org/deii/deii-resources

SMALL GROUP ACTIVITY

- Mapping your route - Planning before you go.
- Discuss key considerations for documenting each stop along the way.

Return to the Full Session for Wrap-Up

SMALL GROUP ACTIVITY WORKSHEET

Work together to complete a sample Logic Model using the following Goal Statement as your foundation: **TO REDUCE HIV RATES AMONG ADOLESCENTS IN ABC COMMUNITY.**

1. Complete the worksheet on Google Docs
2. Report out about the process you and your group used and your Logic Model components.
3. Report back on completed worksheet with group.

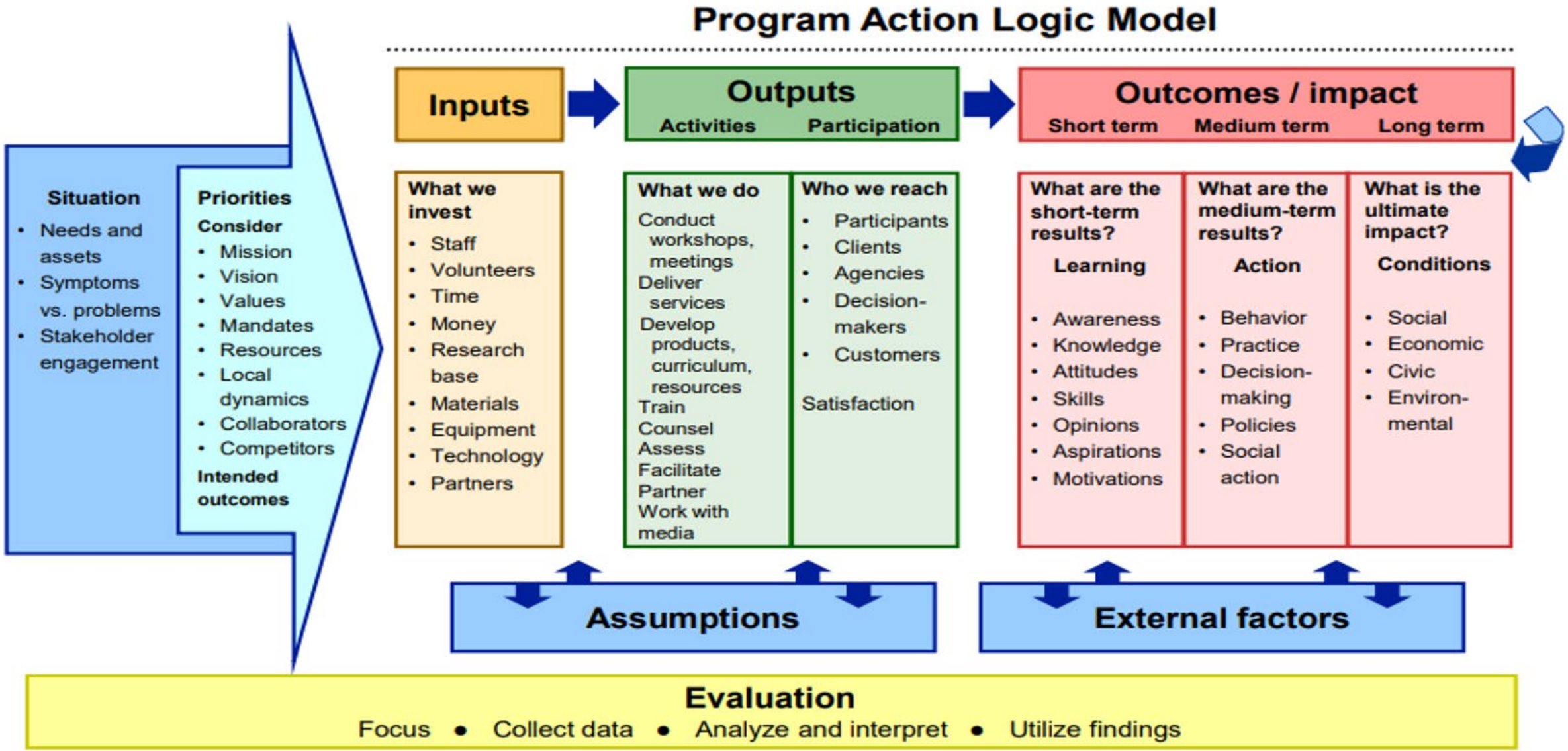
SMALL GROUP ACTIVITY - STEPS

STEP	ACTIVITY
STEP 1	Brainstorm. Review the literature. Agree upon the basics of a program you might develop to achieve the stated goal. Come up with a few activities (think SMART objectives)
STEP 2	Determine what resources/inputs would be needed to implement the activities (e.g., products, capacities, or deliverables that result from the activities)
STEP 3	Think about what changes might occur because of the activities and outputs – first think about what might happen quickly (immediate), what might take some time (intermediate) and what are more distal outcomes (long-term outcomes)
STEP 4	Think about what assumptions and contextual factors may exist that are out of control of the program but may help or hinder achievement of the outcomes
STEP 5	Go back and confirm that the model is 'logical' by using the 'if-then' test. What is your theory of change?

PROGRAM DEVELOPMENT

PLANNING • IMPLEMENTATION • EVALUATION

fyi.extension.wisc.edu/programdevelopment



Fillable **Logic Model Table Template for Word** can be downloaded from:
https://fyi.extension.wisc.edu/programdevelopment/files/2020/05/LogicModel2020-graphic-2.pdf

Program: Longitudinal Pilot Study for Primary Care Suicide Prevention in Adult Males Logic Model
Situation:

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
- Educate physicians and medical student trainees on suicide prevention strategies	- Create training series on suicide prevention strategies for physicians and medical student trainees, and hold 6 1-hour trainings	- Longitudinally follow-up with primary care patients between patient appointments throughout the year using text message surveys	- Increased physician and medical student trainee knowledge of suicide prevention and suicide prevention pilot program	- Increased longitudinal understanding of physician and medical student trainee comprehension and implementation of suicide prevention program	- Educate the current and future generations of healthcare professionals on suicide prevention strategies
- Collect longitudinal behavioral health outcome data from Northwell Health primary care patients beyond the primary care appointment	- Build an online system to house pilot data and to send text message surveys to patients longitudinally	- Enroll 100 primary care patients in longitudinal follow-up pilot study	- Increased opportunity for virtual suicide risk assessment among primary care patients using mHealth strategies	- Increased longitudinal data on primary care patient health outcomes beyond the primary care visit	- Improve the health of communities and provide the highest quality clinical care to patients by reducing patient suicide rates
- Develop suicide risk assessment and stratification procedures	- Identify at-risk suicidal patients between primary care appointments using surveys and provide real-time follow-up resources	- Provide follow-up resources to patients when risk threshold is met or surpassed	- Increased patient awareness of health behavior outcomes and Northwell resources	- Increased understanding of feasibility and acceptability of a primary care based suicide prevention program	- Scale up a system-wide suicide prevention program

Assumptions
- Physicians and medical student trainees will participate in trainings and implementation of program
- Patients will be adherent to program messaging and longitudinal surveys

External Factors
- Barriers to recruitment and retention (participant burden, attrition)
- Technological issues related to text message messaging and surveys
- Round-the-clock staffing difficulties

Rev. 7/09

Logic Model Courtesy of Danielle Miller, student Hofstra University, Spring 2023 Public Health Grant Writing

SUSTAINING INTERVENTIONS

Through collaborative partnerships, shared lessons and adaptions, and development of durable Implementation Manuals, interventions can evolve and endure.

SESSION 2: KEY TAKE AWAYS

- Keep the readers' interest
- Give them adaptable tools and approaches
- Recognize roadblocks and detours
- Provide relatable information about problem solving that leads reader to want to know more

References, Resources, and Tools for Your Team!

SESSION 3: DETOURS: THE ONLY CERTAINTY IS CHANGE

MAPPING A ROUTE TO YOUR PLANNED DESTINATION

Change happens!

- Documenting change and adapting your approach.
- Planned vs. actual scenarios of change (real or imagined).

PLEASE JOIN US: APRIL 25TH 12-1:30P ET

REFERENCES, RESOURCES AND TOOLS

IHIP Tools and Resources

Implementation Manual Template and Instructions: https://targethiv.org/library/ihip-spns-implementation-manual-template-and-instructions

Tools + Tips Handbook: Cruzado-Quinones, J., Jordan, A. O., & Cagey, R. (2016) Tools + Tips for Providing Transitional Care Coordination: Handbook, Health Resources Services Administration Integrating HIV Innovative Practices

https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination

SPNS Care and Treatment Interventions (CATIs) Curriculum: https://targethiv.org/deii/deii-resources

Additional Resources and References

Logic Model:
https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main

True Colors: Miscisin, M. (2010). *Showing our true colors* (3rd edition). True Colors International https://edis.ifas.ufl.edu/publication/WC234

Learning styles: Adapted from McWhorter, K. T. (2003). Study and critical thinking skills in college (5th ed.). New York: Addison Wesley Longman, Inc. https://www.suu.edu/academicsuccess/tutoring/pdf/learning-styles-self-assessment.pdf

Collaborations: Jordan AO, Lincoln T, Miles JJ Public Health is Correctional Health is Community Health: Collaboration is Essential, Public Health Behind Bars, Greifinger, 2ed Springer Nature 2022 https://link.springer.com/chapter/10.1007/978-1-0716-1807-3_33

Leveraging Past Initiatives: Cruzado-Quinones J, Cagey Huibregtse R, Jordan AO (2023) Transnational Trans Women Inspires and Informs Evidence-Informed Interventions Journal of Correctional Health Care, pre-publication Liebert publishers.

Contact Us

Jacqueline Cruzado
JACKIE@ACOJACONSULTING.COM

Alison O Jordan
ALI@ACOJACONSULTING.COM

Shelly Kowalczyk
SKOWALCZYK@MAYATECH.COM