Tailored Motivational Interviewing (TMI)

E2i Implementation Guide

An evidence-based intervention, adapted for the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program, that provides young Black men who have sex with men with brief motivational interviewing sessions to encourage engagement in HIV care and treatment.

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RYAN WHITE E2i HIV/AIDS PROGRAM

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Authors

Intervention developer (Behavior Change Consulting Institute)
Sylvie Naar, PhD

E2i Coordinating Center for Technical Assistance (The Fenway Institute and AIDS United)
Hilary Goldhammer, SM
Sean Cahill, PhD
Richard Cancio, MPH
Linda Marc, ScD, MPH
Mabel Sheau Fong Low, MPH
Massah Massaquoi, MPH
Alicia Downes, LMSW
Reagin Wiklund
Neeki Parsa
Hannah Bryant, MPH
Joseph D. Stango
Bryan Thompson
Tess McKenney
Alex Keuroghlian, MD, MPH

E2i Evaluation Center (Center for AIDS Prevention, University of California San Francisco)
Kimberly Koester, PhD
Starley Shade, PhD
Mary Guze, MPH
Beth Bourdeau, PhD
Andres Maiorana, MA, MPH
Carol Dawson-Rose, RN, PhD, FAAN
Greg Rebchook, PhD
Janet Myers, PhD, MPH

Health Resources and Services Administration, HIV/AIDS Bureau
Demetrios Psihopaidas, PhD MA
Nicole Chavis, MPH
Stacy Cohen, MPH
Antigone Dempsey, MEd

THE FENWAY INSTITUTE

AIDS United

UCSF Center for AIDS Prevention Studies
Prevention Research Center
Division of Prevention Science

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EXECUTIVE SUMMARY

Tailored Motivational Interviewing (TMI) is an evidence-based intervention developed by HIV and motivational interviewing (MI) experts in collaboration with community members to improve health outcomes among young people with HIV, including Black gay, bisexual, same-gender loving, and other men who have sex with men (MSM). TMI provides brief MI counseling sessions using a collaborative conversational style that guides rather than directs a client to change. Sessions encourage clients to engage in HIV care, take HIV medications as prescribed, and improve other health-related behaviors.

This Implementation Guide was developed for *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, which tested TMI within Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) settings and evaluated its impact. Additional easy-to-use implementation tools, tips, and resources to support replication of TMI in the RWHAP and other HIV service organizations can be found in the ***TMI E2i Toolkit***.

INTRODUCTION TO THE IMPLEMENTATION GUIDE

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What is Tailored Motivational Interviewing?

Tailored Motivational Interviewing (TMI) delivers brief motivational interviewing (MI) counseling sessions customized to encourage people with HIV to engage in HIV care, take HIV medications as prescribed, and improve other health-related behaviors. TMI is also designed to address barriers and concerns specific to young people of color, including Black, Indigenous, and Hispanic/Latinx people. TMI providers can come from a wide range of backgrounds and disciplines, including peers (i.e., people with HIV who represent the priority population), physicians, psychologists, state medical providers, social workers, paraprofessionals, and more. This Implementation Guide focuses on TMI delivered by peer providers for Black gay, bisexual, same-gender loving, and other men who have sex with men (MSM).

Purpose of the Implementation Guide

The purpose of this Implementation Guide is to provide a starting place and framework for implementing TMI by peer providers in the Ryan White HIV/AIDS Program (RWHAP) and other HIV service organizations. This Guide is part of the ***TMI E2i Toolkit***, a comprehensive collection of helpful resources for implementing TMI.

Implementation Guide Background

This Guide was developed under the RWHAP Part F Special Projects of National Significance (SPNS) *Program entitled Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, a four-year initiative (2017-2021) funded by the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) of the U.S. Department of Health and Human Services. E2i was designed to improve HIV health outcomes for people with HIV who experience persistent gaps along the HIV care continuum, such as engagement in care, retention in care, adherence to antiretroviral treatment (ART), and viral suppression. Black MSM with HIV are among the priority populations most in need of interventions that promote high quality and culturally-tailored services.

The E2i initiative chose to pilot the implementation of TMI because of its demonstrated effectiveness in improving HIV health outcomes for young Black MSM.[1-3] Through a competitive request for proposals, three HIV service organizations in the HRSA HAB RWHAP were selected to implement TMI between 2018 and 2020. These sites reported implementation and client outcome data to a team of evaluators who then analyzed these data. The stories, experiences, and evaluation outcomes of these E2i sites are integrated and highlighted throughout this Guide.

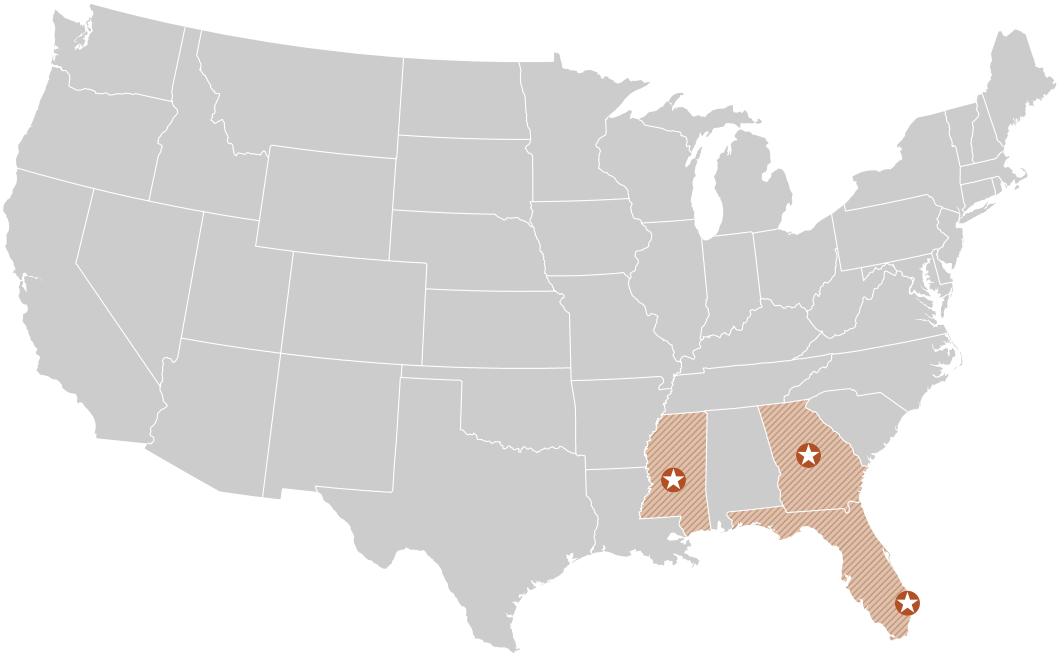
[1]Outlaw AY, Naar-King S, Parsons JT, Green-Jones M, Janisse H, Secord E. Using motivational interviewing in HIV field outreach with young African American men who have sex with men: A randomized clinical trial. Am J Public Health. 2010;100(S1): S146-S151.

[2]Naar-King S, Outlaw A, Green-Jones M, Wright K, Parsons, JT. Motivational interviewing by peer outreach workers: A pilot randomized clinical trial to retain adolescents and young adults in HIV care. AIDS Care. 2009;21(7): 868-873.

[3]Naar-King S, Parsons JT, Murphy DA, Chen, X., Harris DR, Belzer ME. Improving health outcomes for youth living with the human immunodeficiency virus: A multisite randomized trial of a motivational intervention targeting multiple risk behaviors. Arch Pediatr Adolesc Med. 2009; 163(12): 1092-1098

The E2i Implementation Sites

FIGURE 1. Locations of the three sites that implemented TMI through the E2i initiative.



Broward House (Fort Lauderdale, Florida)

- Community-based organization
- Recipient of RWHAP Part A funding
- ~900 clients with HIV a year
- 80 employees provide HIV services
- Most common services accessed by clients with HIV: health education (100%), health/support referrals (90%), non-medical case management (61%)

COMPASS Cares/HOPE Center (Macon, Georgia)

- Clinic providing HIV care; affiliated with county health department
- Recipient of RWHAP Part B and C funding
- >1,000 clients with HIV a year
- 30 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: health education (94%), non-medical case management (71%), medical transportation (23%)

University of Mississippi Medical Center (Jackson, Mississippi)

- University-based clinic providing HIV care
- Recipient of RWHAP Part B and C funding
- 2,100 clients with HIV a year
- 25 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: non-medical case management (100%), health education (50%), health/support referrals (27%)

Implementation Science Evaluation

E2i used an implementation science approach to evaluate TMI. The evaluation aimed to answer the following questions:

- "What does it take to implement TMI in HIV service organizations?"
- "To what extent is successful implementation related to better HIV outcomes for the clients?"

E2i evaluators collected TMI client data from the three sites throughout the initiative to measure engagement in care, prescription of ART, retention in care, and viral suppression. They also collected and reviewed site staff surveys, client encounter forms, site visit reports, and meeting notes in order to learn more about the key factors for: successful implementation, challenges encountered by the interventionists, and adaptations made to meet the needs of local settings and priority populations. The major findings from the evaluation are reported throughout this Guide. For additional detail on the theoretical approach and methods, see ***Appendix A***. See also the ***TMI E2i Toolkit*** for additional evaluation findings reported in manuscripts.

TMI OVERVIEW

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Goals

- The primary goals of TMI are to improve engagement and retention in HIV care.
- TMI also addresses adherence to ART as well as other health behaviors for which self-management is relevant, such as substance use and sexual activity.

Description

- TMI consists of brief counseling sessions that encourage clients with HIV to engage in HIV care while also addressing medication adherence and other health-related behaviors.
- TMI is based on MI, "a collaborative conversation style for strengthening a person's own motivation and commitment to change."[4,5] MI may also be thought of as guiding a client to change, rather than directing them to follow change.
- TMI is MI customized for young people with HIV. TMI is also designed to address barriers and concerns specific to people of color, including Black, Indigenous, and Hispanic/Latinx people.
- The design of TMI prevents providers from giving "too much information," while enabling them to guide the client in identifying goals to support behavioral change.

Priority Population

- TMI is appropriate for people with HIV who are newly linked to HIV care, re-entering HIV care, or struggling with adherence to medication.
- Young Black MSM may especially benefit from TMI.[1-3]

TMI Enrollment at the E2i Sites

177 men

25–33 years old

97% Black, **2%** Hispanic/Latino

100% MSM

[4]Miller WR, Rollnick S. Motivational Interviewing: Helping People Change. New York: Guilford Press; 2012.

[5]Naar-King S, Suarez M. Motivational Interviewing with Adolescents and Young Adults. New York: Guilford Press; 2011.

Rationale

» Linkage and re-entry to care are vulnerable times for people with HIV.

» TMI provides clients with increased motivation to begin and remain in care.

Intervention Background

MI is an evidence-based, patient-centered, and collaborative communication approach for addressing behavior change.[6,7] MI was originally developed based on the strategies used to help people recover from addiction to drugs or alcohol. The MI developers found that people are more likely to change their behavior when the person helping them shows empathy and supports self-motivated change. MI is also consistent with the following frameworks:

» **Transtheoretical Framework**,[6] which describes a series of five stages of behavior change that can result in long-term maintenance of behavior

» **Self-Determination Theory**,[7] which asserts that people develop internal motivation when they:

- feel connected to those who are kind and caring instead of those who are harsh and controlling,
- feel hopeful and confident, and
- believe their autonomy is being supported.

» TMI developers customized MI for people with HIV based on studies of HIV clinical interactions; they also developmentally tailored TMI for youth based on communication science studies. Previous research has found that TMI with peer providers demonstrated effectiveness across the HIV care continuum, and effectively addressed substance use and sexual risk behaviors.[1-3] TMI is being evaluated in a large-scale implementation trial with peers and other providers in ten adolescent HIV clinics in the United States.[8]

[6]Prochaska JO, Redding CA, Harlow LL, Rossi JS, Velicer WF. The transtheoretical model of change and HIV prevention: A review. Health Educ Behav. 1994;21(4): 471-48.

[7]Markland D, Ryan RM, Tobin VJ, Rollnick S. Motivational interviewing and self-determination theory. J Soc Clin Psychol. 2005;24(6): 811-831.

[8]Naar S, MacDonell K, Chapman JE, et al. Testing a motivational interviewing implementation intervention in adolescent HIV Clinics: Protocol for a Type 3, Hybrid Implementation-Effectiveness Trial. JMIR Res Protoc. 2019;8(6):e11200.

Duration

- TMI can range from a single brief encounter to multiple sessions based on client need and organizational context.
- Sessions that are held in home-based or office settings can last 45 minutes to an hour; sessions held in medical clinics or street-outreach contexts may take 15 minutes or less.

The E2i sites appreciated the flexibility of TMI's delivery process. Staff members reported that some clients needed only one session to become engaged in care, while other clients chose to continue with multiple sessions over several months.

Settings

TMI can take place in a range of settings, including:

- HIV primary care organizations
- Any other HIV service delivery setting (e.g., community-based organizations, AIDS service organizations) with well-established linkage and referral systems to HIV primary care

The E2i sites that implemented TMI included a community-based organization, an HIV clinic affiliated with the county health department, and a university-based HIV clinic.

Staffing

TMI staffing depends on the unique structure of each organization.

Core staff

At minimum, TMI requires:

- **TMI provider(s):** Peer counselors (i.e., people with HIV who represent the priority population), physicians, psychologists, state medical providers, social workers, paraprofessionals, and providers from other backgrounds and disciplines can deliver TMI. The person delivering TMI must be someone who is inclusive, non-judgmental, and willing to meet clients where they are. Anyone who provides TMI must receive specialized TMI training and ongoing coaching. More information on training and coaching is provided in the Planning Activities section below.

» **Clinical supervisor(s):** Behavioral health providers support TMI providers in addressing issues that arise during counseling, such as maintaining boundaries with clients, addressing secondary trauma, and other issues relevant to counseling clients.

For the E2i initiative, all TMI providers were peer counselors (also referred to as peer navigators and specialists), and the sites referred to the intervention as MI Peers. According to the E2i sites, peer counselors have several advantages over non-peer medical providers because of their shared backgrounds and experiences with clients. Peers are often better at building trust and rapport with clients, as well as predicting and understanding barriers to care. Peers may also have a communication style this is more understood and accepted by their clients.

Additional recommended staff

To successfully implement and deliver TMI, it is highly recommended that organizations also include the following staff:

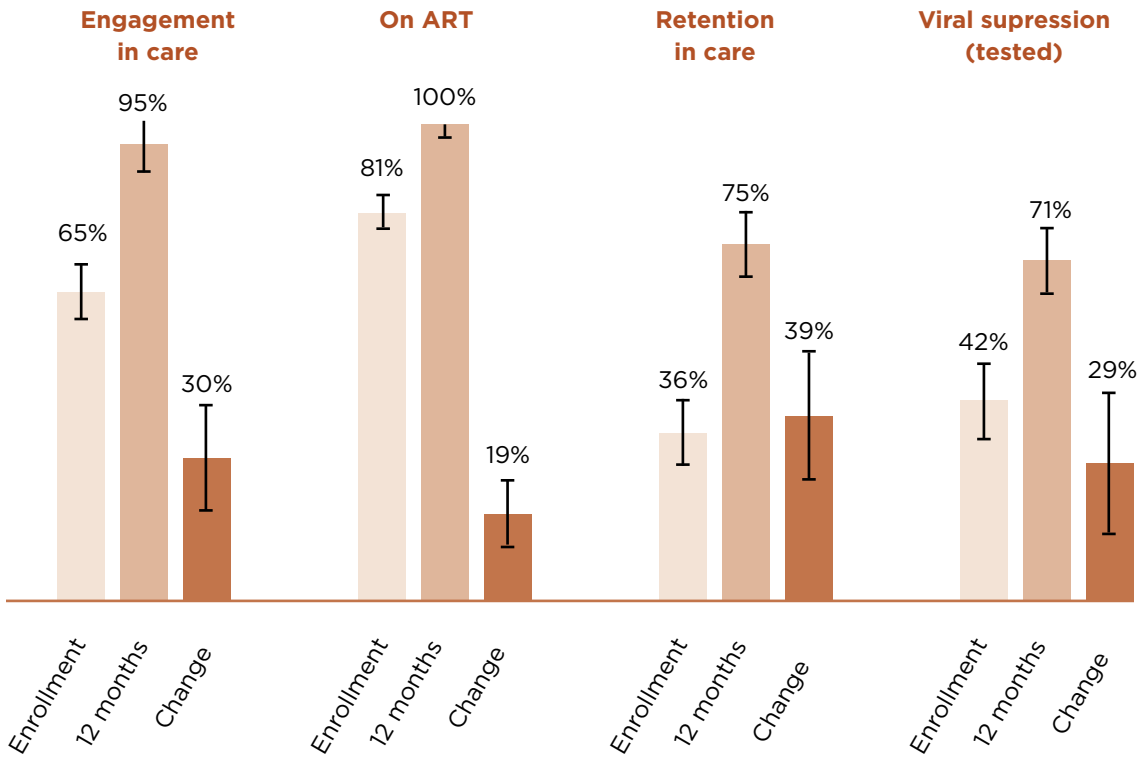
» **Case managers:** Social workers or other case managers help provide TMI clients with referrals to supportive services such as housing, food assistance, insurance coverage, substance use counseling, and mental health counseling. TMI providers may be trained to fulfill the role of case manager; however, if a client's case management needs are high, the TMI provider may find they have little time left to provide TMI.

The TMI teams at the E2i sites consisted of peer counselors, clinical supervisors, and case managers.

E2i EVALUATION: TMI HIV CARE CONTINUUM OUTCOMES

- **Enrollment:** During a 10 to 12 month period, 177 MSM enrolled in TMI across the three E2i sites. Each site enrolled between 41 to 74 men. The enrolled men were young (25-33 years), and nearly all (97%) identified as Black; 2% identified as Hispanic/Latino.
- **Outcomes:** E2i measured HIV care continuum outcomes of each client at time of enrollment in TMI and 12 months later. Among the 177 enrolled clients, engagement in care, prescription of ART, and retention in care improved significantly. In addition, viral suppression improved significantly among enrolled clients with viral load tests.

FIGURE 2. HIV care continuum outcomes among the 177 clients enrolled in TMI as part of the E2i initiative.



Note: E2i used the following HRSA definitions for HIV care continuum outcomes:

- *Engagement in care* = At least one primary HIV care visit in the previous 12 months
- *On ART (adherence)* = Having been prescribed ART in the past 12 months
- *Retention in care* = At least two HIV care visits in the past 12 months
- *Viral suppression* = Having an HIV viral load test in the past 12 months AND having a result of less than 200 copies/mL at the last viral load test

CORE ELEMENTS

CORE ELEMENTS

Core elements are the "active ingredients" essential to achieving an intervention strategy's desired outcomes. It is critical to closely follow the core elements when implementing an intervention in an HIV service organization; otherwise, the intervention may not work as intended.[9] All other activities, such as staffing arrangements and clinical workflows, can be adapted to fit the unique circumstances of an organization and the priority population(s). However, adaptations should not compete with or contradict the core elements of TMI. **TMI has two core elements:**

1. Motivational Interviewing (MI) for people with HIV

- MI is "a collaborative conversation style for strengthening a person's own motivation and commitment to change."[4,5]
- TMI is MI customized for people with HIV and is developmentally tailored for youth with HIV based on communication science studies. TMI is also designed to address barriers and concerns specific to Black MSM, Indigenous, Hispanic/Latinx, and other people of color.
- TMI communication skills reduce perceived stigma in the clinical encounter.

2. Addressing key behaviors for people with HIV

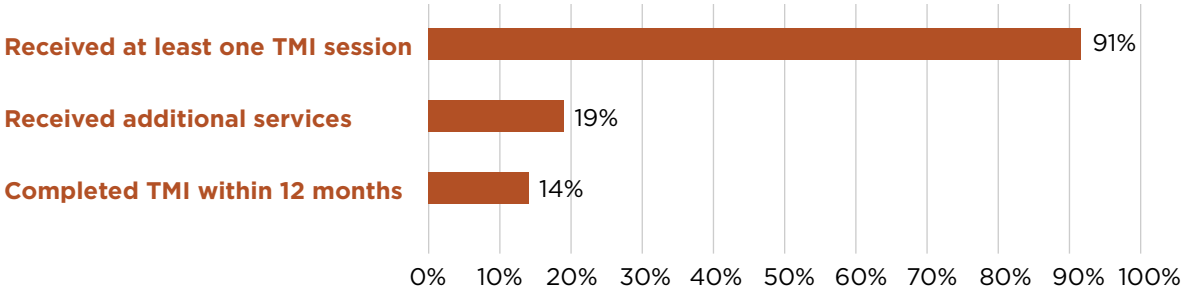
TMI can encourage clients to:

- Engage in HIV care
- Adhere to antiretroviral treatment
- Reduce or stop unhealthy substance use
- Reduce sexual risk behaviors

[9]Psihopaidas D, Cohen SM, West T, et al. Implementation science and the Health Resources and Services Administration's Ryan White HIV/AIDS Program's work towards ending the HIV epidemic in the United States. PLoS Med. 2020;17(11):e1003128.

E2i EVALUATION: TMI PARTICIPATION OUTCOMES

FIGURE 3. Participation outcomes among the 177 clients enrolled in TMI as part of the E2i initiative.



Among the 177 clients enrolled in TMI:

- **Attendance:** Nearly all (91%) received at least one TMI counseling session.
- **Number of sessions:** Each received between one and four TMI sessions.
- **Additional services:** About 20% received additional services besides TMI, such as appointment reminders and being accompanied by a peer to clinical visits.
- **Completion:** Less than one in five (14%) completed TMI within 12 months. The E2i sites defined completion as achieving and maintaining viral suppression.[10] Sites reported that clients would drop in and out of TMI due to life challenges such as housing instability, substance use disorders, and lack of transportation.

[10]Intervention staff at each site determined completion on a case-by-case basis.

PLANNING ACTIVITIES

PLANNING ACTIVITIES

This section provides recommended activities for planning to implement TMI. For helpful tools to support the planning of TMI, see:

Appendix B: General Best Practices for Planning to Implement an Intervention Strategy

Appendix C: TMI "Go Live" Worksheet

Identify TMI Providers

- A TMI provider is someone who excels in communication skills, has empathy for people with HIV, and is knowledgeable about HIV care and outreach.
- Peers who have overcome barriers to managing their HIV care and are interested in working to help others are good candidates for becoming TMI providers. Recruitment for peer providers can happen via word of mouth within your organization, from community advisory boards and planning councils, or at venues where people with HIV go for services.
- Health care professionals, such as physicians and psychologists, can also effectively deliver TMI.

Train TMI Providers

TMI training

Learning to provide high-quality TMI is of the utmost importance, and becoming a skilled TMI provider takes time. Organizations should build in sufficient time (several weeks to months, depending on the existing skillset of the provider) and resources for training, coaching, and monitoring the skills of TMI providers.

To become a TMI provider, one must first complete an initial experiential training followed by ongoing individual coaching sessions and fidelity monitoring.

The process includes:

- A two-day in-person (or videoconference, if needed) workshop with a focus on experiential training
- A minimum of six individual or small group coaching sessions over three months
- Quarterly fidelity monitoring using recorded interactions or observation of a standard patient interaction if recordings are not feasible
- Annual one-day booster training

Coaching sessions are 45-60 minutes long and include: 1) eliciting provider motivation to improve MI skills; 2) completion of role play simulation with coding and feedback based on a 12-item ***MI Coach Rating Scale (MI-CRS)***; and 3) review of feedback form with tailored video clips of skill examples. The MI-CRS yields four evidence-based competency levels – beginner, novice, intermediate, and advanced. TMI providers must achieve at least intermediate competency to be cleared to see clients. TMI providers whose scores fall below the intermediate level during fidelity monitoring will be given a remediation plan developed by the trainer, local supervisor, and TMI provider that typically includes experiential activities.

Training and coaching can occur through either of the following options:

1. **Centralized training option:** With this option, all TMI training and coaching occurs through ***Behavior Change Consulting Institute***, a non-profit group of diverse trainers who are licensed to deliver TMI training.
2. **Local training option:** With this option, TMI providers receive training and coaching from someone local (e.g., someone who works in their organization) who has achieved an advanced level of competency as an MI counselor, such as someone trained through the ***Motivational Interviewing Network of Trainers*** (MINT), and has attended TMI training from Behavior Change Consulting. In this scenario, the coaching occurs in person, though the coach still uses the MI-CRS described above.

At one E2i site, TMI peer counselors received TMI coaching and clinical supervision from an onsite certified MI trainer. At another E2i site, TMI peer counselors were supervised by a case manager (a licensed clinical social worker) who also provided them with TMI coaching and fidelity monitoring. Having onsite coaching may have reduced time delays and increased the frequency of fidelity monitoring.

Additional training

Depending on their experience, TMI providers may also need training and education in other topics related to their work. Examples of helpful training topics include:

- HIV infection and treatment basics
- HIV medication adherence education and counseling
- Screening and referral for substance use disorder counseling and treatment
- Screening and referral for mental health care
- Trauma-informed approaches
- Peer specialist certification

Additional professional development and training are important for new hires, especially if hiring peers who have not yet had professional work experience. E2i has found the following training topics to be very useful for peers:

- *Self-care and resiliency*
- *Restorative and healing justice*
- *Facilitation skills*
- *Trauma-informed care*
- *HIV "101"*

*Organizations that offer training and resources on these topics include **Black Emotional and Mental Health Collective** (BEAM) and **AIDS United**.*

Train Clinical Supervisors

In addition to TMI training and coaching, TMI providers also need an onsite clinical supervisor who can support them in issues relevant to counseling clients. Ideally, the clinical supervisor has also been trained in TMI to help ensure adherence to the program requirements.

Develop an Outreach and Recruitment Plan

To identify potential clients for TMI, organizations can do the following:

In-reach

- Ask for referrals of potential clients from medical providers, case managers, and other staff that serve people with HIV.
- Search organizational databases of clients for people who meet your enrollment criteria (e.g., clients who are newly diagnosed, out of care, struggle with adherence, have not achieved viral suppression). Develop a process to recruit these clients.

TMI peer counselors at one of the E2i sites received in-house referrals from medical providers, pharmacy staff, case managers, and housing program staff. In addition, all new clients received TMI as a standard of care.

Outreach

- Develop printed and electronic recruitment materials to increase awareness of TMI. Recruitment materials should summarize the intervention, specify eligibility, provide contact information, and mention incentives, if any.
- Enlist the help of peer staff to develop recruitment messaging and strategies.
  - What social media platforms does the priority population use?
  - What kinds of messages and images appeal to the priority population?
  - What are strategic places to post flyers and hand out brochures?
- Distribute recruitment materials in waiting rooms, exam rooms, pharmacies, HIV testing sites, House and Ball Community events, nightclubs, and community-based organizations that serve the priority population.
- Co-host outreach events with community partners.
- Post about TMI on websites and social media.

The House and Ball Community celebrates all forms of gender and sexual expression, while providing many youth and adults with a chosen family structure. Balls are extravagant and competitive social events co-organized by leaders in the community. During House Balls, participants compete in a variety of artistic categories. HIV service organizations can partner with the local House and Ball Community to host events and get the word out about TMI.

Incentives

Consider offering incentives for attending TMI counseling sessions. Incentives may include non-cash redeemable gift cards to local stores, or practical items like pill boxes and backpacks.

Community referrals

Organizations can develop partnerships with other community agencies to create bi-directional referral systems. Partners may include housing agencies, food assistance programs, health departments and other HIV testing sites, criminal justice partners, mental health and substance use treatment and counseling agencies, and other community-based organizations.

Design a Process Flow

The TMI process flow is flexible and can be based on an organization's unique programs, resources, and staffing.

- Collaborate with all relevant staff to clarify the roles of TMI team members: who is doing what, when, where, and how.
- Write down or draw a map or diagram to illustrate the proposed process flow.
- Identify private space(s) to meet with clients.
- Ask for input and feedback from all staff affected by the TMI process.

One of the E2i sites used a centralized phone extension to triage clients to appropriate providers, resources, and services, including TMI. All staff were trained to answer these calls, ensuring that all callers received helpful and appropriate assistance at any time of day.

Address Barriers to TMI Session Attendance

Clients may face multiple barriers that keep them from attending sessions. They may live far away from the clinic, lack transportation, or have jobs that do not allow flexible hours. Due to busy schedules and unstable living conditions, clients may also forget to attend appointments. Consider the following strategies to overcome these barriers:

- Offer early morning or evening hours
- Offer drop-in times
- Visit clients in their homes
- Identify safe spaces to meet in the community, such as a park, bus stop, or food bank
- Offer virtual meeting options (phone, text, videoconferencing platforms)

To overcome TMI attendance barriers, peer providers at the E2i sites met with clients through phones and videoconferencing or anywhere a client felt comfortable. Meeting locations included parks, bus stops, bridges, food banks, and client homes. At one site, TMI peer counselors also allowed clients to drop-in without an appointment.

- Provide transportation services, gas cards, bus passes, and car service vouchers
- Hold sessions immediately before or following medical or lab appointments
- Send frequent, personalized reminder calls, texts, and private messages via social media. Ask clients for updates to phone numbers at every encounter.

To increase communication channels, the TMI peers at one E2i site collected all forms of contact information from clients, including phone numbers, social media handles, email addresses, and mailing addresses. Peers also taught clients to communicate through the clinic's patient portal.

Develop a Sustainability Plan

Sustainability refers to the ability to maintain programming and its benefits over time. A helpful resource for building capacity for sustainability is the ***Program Sustainability Assessment Tool*** developed by the Center for Public Health Systems Science at the Brown School, Washington University in St. Louis. This tool helps program planners achieve the following:

1. **Understand** the factors that influence a program's capacity for sustainability
2. **Assess** the program's capacity for sustainability
3. **Review** results from the Assessment
4. **Plan** to increase the likelihood of sustainability by developing an Action Plan

Achieving sustainability typically involves both applying for grants and accessing available reimbursement options. Some state Medicaid programs cover peer support services, although states vary in terms of services covered, certifications needed, and other restrictions. RWHAP-funded organizations may be able to cover TMI under the Treatment Adherence and Health Education/Risk Reduction service categories, and can receive technical assistance on health coverage options from the ***Access, Care, and Engagement Technical Assistance (ACE TA) Center***.

- *One of the E2i sites successfully integrated TMI throughout the organization by placing TMI within their client services program and doing significant in-reach with the organization's medical providers. They also trained all agency staff to use TMI principles. Training all providers can lessen gaps in service when there is staff turnover. Moreover, TMI can be applied to interactions with clients in any setting, including during case management or primary care visits.*
- *A different E2i site integrated the TMI program into the case management department, allowing for smoother referrals and collaborative team care. All of their case managers have also been trained in TMI.*

E2i EVALUATION:
TMI IMPLEMENTATION OUTCOMES

To learn more about how TMI was viewed by the leadership and staff members at the E2i sites, E2i collected data from the people implementing the intervention. The data included: (1) an organizational survey completed by key site staff once during the planning period, and every six months during implementation; and (2) a review of site documents created during implementation, including site visit reports, meeting notes, and cost workbooks (See *Appendix A*).

Measure (definition)	Results at the E2i sites
Acceptability: how well staff and leadership regard the intervention	All sites found TMI very acceptable throughout the duration of E2i. Each site believed that TMI was a good fit for their organization's mission and goals.
Adoption: the intention, initial decision, or action to implement the intervention	Two sites reported consistently high adoption of TMI. One site gradually increased adoption of TMI over time and completed its participation in the E2i initiative with high adoption.
Appropriateness: the compatibility of the intervention to address a particular issue or problem	All sites reported that TMI was highly appropriate and filled a service need at their organization.
Feasibility: the extent to which the intervention can be successfully carried out	Feasibility varied among sites: One site considered TMI highly feasible from beginning to end. The other two sites took until the end of E2i before they saw TMI as highly feasible. The delay in feasibility may have been due to the length of time it took for peers to gain proficiency in MI skills.
Fidelity: the degree to which a site felt able to (a) implement the intervention as it was intended by the program developers, and (b) monitor progress	Fidelity varied among sites: One site reported high ability to have a full implementation team and to assess fidelity; the other started with high fidelity that decreased slightly over time, around the time of COVID-19 pandemic restrictions.
Penetration: the integration of the intervention within the organization	All three sites reported high levels of penetration of TMI activities into their organizational operations over time.
Cost: the costs associated with planning and implementation, such as: personnel, training, supplies, incentives, and outreach activities	Costs included both direct and in-kind expenses. The average expenditures for each site were: • *Planning period:* $41,235 • *Recruitment:* $376 per client enrolled • *Implementation activities:* $2,743 per client enrolled • *Supervision and management:* $1,165 per client enrolled These numbers do not necessarily reflect what it would cost to implement TMI at other HIV service delivery organizations. Costs per client would be lower in settings where more people could be recruited into the intervention.

IMPLEMENTATION ACTIVITIES

IMPLEMENTATION ACTIVITIES

TMI Session Logistics

- TMI clients receive one to six or more sessions from a TMI provider based on their needs and an organization's capacity to deliver TMI. Many clinics have found that two to six sessions work best.
- Sessions last anywhere from 15 to 60 minutes.
- Sessions often take place in a clinic or office space, but can also be held in client's homes, during street outreach, in a park, in a café, on the phone, and on videoconference/virtual platforms, as long as a quiet and private space can be found.
- At the end of the session, the client and TMI provider complete a "Change Plan" worksheet that establishes goals, outlines steps to change, anticipates barriers, and identifies supports and facilitators. The client takes a copy of the worksheet as a tool for reinforcing behavior change.

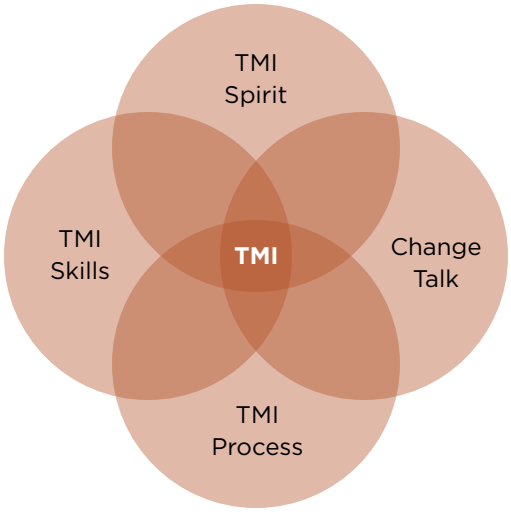
All E2i sites developed "step down" plans to transition clients from TMI to independently engaging in care. At one site, clients could request to stay in TMI for up to a year in order to meet their health care goals.

Fidelity Monitoring

Every three months, TMI providers complete a fidelity monitoring session with their MI coach to ensure they are maintaining or improving their competency level. The coach observes a standard session or listens to recordings, uses the MI-CRS to assess the TMI provider, and provides feedback. TMI providers whose scores fall below the intermediate level during fidelity monitoring are given a remediation plan.

TMI Components

TMI sessions encourage engagement and retention in care, medication adherence, as well as other behavioral changes as needed. TMI has four overlapping components to help achieve these goals: Change Talk, TMI Spirit, TMI Skills, and TMI Processes.



Change Talk

Change talk refers to anything a client says that favors movement toward a particular goal. In contrast, counter change talk refers to anything said by a client that does not favor movement towards a goal.

There are five types of change talk:

- **Desire:** *"I want to…"*
- **Ability:** *"I can…"*
- **Reasons:** *"Because…"*
- **Need:** *"I need to…"*
- **Commitment:** *"I will…" or "I did…"*

A client's goal might be to attend HIV care appointments. Examples of change talk for this goal might be:

- **Desire:** *"I want to remember to go to my HIV doctor's appointments."*
- **Ability:** *"I can put my appointments in my phone's calendar, with two reminder notifications."*
- **Reasons:** *"Because I need to take care of myself; my mother is worried about losing her only son."*
- **Need:** *"I need to see my doctor every month to stay healthy."*
- **Commitment:** *"I plan to go to my next three doctor's appointments, starting this week."*

TMI Spirit

TMI Spirit represents TMI's collaborative and empathic style of interaction. It has four interrelated components.

- **Spirit 1: Partnership.** Provider and client are side-by-side in a collaborative and guiding relationship.
- **Spirit 2: Acceptance/Autonomy.** Provider supports client's autonomy by emphasizing acceptance of and respect for the client's freedom of choice.
- **Spirit 3: Compassion.** Provider is dedicated to promoting the welfare of the client.
- **Spirit 4: Evocation.** Provider recognizes that the client has inherent wisdom and strength for change that can be drawn out.

TMI Skills

TMI providers become competent in using these four skills:

Skill 1: Emphasizing Autonomy with "You" Statements.

- Emphasize personal choice. For example, *"Yes, you're right. No one can force you to take medications."*
- Promote personal responsibility with positive "you" statements. For example, *"You really want to take ownership of your health."*
- Clarify your role as a guide. For example, *"I am not here to tell you what to do, but to see how I can support you."*

Skill 2: Providing Information in a TMI style (Ask-Tell-Ask)

- **Ask:** Get permission or assess the client's knowledge or interest. For example, *"What do you know about how the HIV medications work?"*
- **Tell:** Provide a small chunk of information (e.g., education, test results, recommendations). For example, *"HIV medications prevent the virus from multiplying, which helps reduce the amount of virus in your body."*
- **Ask:** Elicit the client's understanding, reaction, or ideas for next steps. For example, *"Is this new information or something you already know?"*

Skill 3: Using Reflections for Change Talk

Reflections are statements of understanding based on what the client has said. There are many types of reflections:

- **Simple:** Paraphrases or uses client's exact words. For example, "*You know what you need to do."*
- **Complex:** Adds meaning. For example, "You want to take care of your health your way."
- **Double-sided:** Echoes the client's ambivalence. For example, *"On the one hand, it's hard to do something you don't like doing. On the other hand, you're going to take care of yourself."*
- **Feeling:** Reflects positive feelings about change or negative feelings about not changing. For example, *"You feel good about taking care of yourself."*

TMI peer counselors report that using TMI skills may seem counterintuitive and awkward at first, but if you keep going, you will see the results.

» **Affirming:** Bolsters strengths and/or values. For example, *"You already have some ideas about what you're going to do."*

» **Summarizing:**

- Draws together key client statements from the discussion. For example, *"Let's summarize what we've talked about so far..."*
- Gives the client an opportunity to add or correct information. For example, *"What have I missed?"*
- Provides a foundation for moving forward. For example, *"What do you want your next step to be?"*

Skill 4: Using Open Questions to Elicit Change Talk

Examples of open questions to elicit different types of change talk are:

» **Desire:** *"What would you like to work on?"*

» **Ability:** *"What are some difficult things you have done before?"*

» **Reasons:** *"Why would you want to make this change?"*

» **Need:** *"Why is this something you need to do?"*

» **Commitment:** *"What is one thing you can do in the next week?"*

Managing counter change talk and discord with STOP-DROP-ROLL:

When working with a client who engages in counter change talk, is passive or chatty, or is strongly disagreeing or arguing, TMI uses the method "Stop-Drop-Roll."

» **Stop** whatever you are talking about.

» **Drop** to calm the situation down.

- Express empathy/describe (reflect) feeling.
- Affirm values and strengths.
- Example: *"You're feeling frustrated, but you're thinking ahead too." If discord, apologize. "I am sorry it feels like we are harassing you."*

» **Roll** by supporting autonomy.

- Example: *"You have a lot to manage, and your job is your priority. The next step is really your decision."* (Emphasize personal responsibility and personal choice.)
- If discord, shift focus.
- Example: *"You know yourself best. If you're willing, I'd like to understand more about what's going on in your life."* (Emphasize personal choice, shift focus.)

TMI Processes

TMI providers use four processes to direct the flow of conversation with clients during a session. The order of processes can change, as needed.

Process 1: Engaging

» Goals:

- Establish rapport and TMI spirit
- Understand the client's dilemma or struggle
- Explore the client's values and goals

» How it is done:

- Support autonomy with the client as the expert
- Conversational style with a two-to-one reflections-to-question ratio
- Begin to build motivation by reflecting change talk

Process 2: Focusing

» Goals:

- Explore both the client's and the TMI provider's agenda
- Clarify the behavior of interest

» How it is done:

- Use the focusing funnel – explore (e.g., health), fine tune (e.g., symptoms), get specific (e.g., take HIV medications)
- Meet the client "half way" by using open-ended questions to explore the client's agenda, and by using Ask-Tell-Ask to share your agenda

Process 3: Evoking

» Goals:

- Evoke the client's intrinsic motivation
- Guide the client to talk themselves into change
- Evoke change talk

» How it is done:

- Recognize change talk when you hear it
- Reinforce change talk (reflect/affirm, ask for more)
- Elicit change talk when you don't hear it

Process 4: Planning

» Goals:

- Develop a plan for change
- Determine steps that are consistent with the client's level of motivation (importance and confidence)
- Develop "if-then" (backup) plans for potential barriers

» How it is done:

- Use the planning funnel – go from general to specific (e.g., engage in HIV care to attend next HIV care appointment)
- Remember to use the "if-then" plans

Clients with HIV, especially those who are newly diagnosed, are not always ready to open up about their lives to a new person. TMI peer counselors from the E2i sites recommend taking as much time as needed to build trust and help clients feel comfortable talking about personal issues. One peer counselor offered this advice: "Always let your clients lead you … and take ownership of their own goals."

Below is a sample outline for using TMI processes during a session.

1. Engaging with the Client

» Deliver opening statement describing the purpose of the session, highlighting client choice about any change

» Use open questions and reflections to build rapport and reinforce change talk, for example:

- *"What have you been up to since the last time we met?"*
- *"What would like to get out of this session today?"*

» Elicit and discuss the client's view on target behavior

» Provide information in TMI style (Ask-Tell-Ask) when needed

» Summarize discussion

2. Focusing the Conversation

» Discuss the focus for the rest of the session using open-ended focusing questions, for example:

- *"Of all the different things you mentioned when it comes to (target behavior), what would you find the most helpful to discuss first?"*
- *"If it is ok with you, I want to discuss (target behavior); or is something else more pressing to you at this moment?"*
- *"If you were going to change one thing about (target behavior), what would it be?"*

» Summarize the discussion

3. Evoking Change Talk

» Use open questions and strategies to elicit change talk, for example:

- *"Of all the different things you mentioned when it comes to (target behavior), what would you find most helpful to discuss first?"*
- *"What are some reasons for changing (target behavior)?"*
- *"What would be the best thing that would happen to you if you changed (target behavior)?"*

» Reinforce with reflections

» Summarize and ask key question to lead to planning

4. Planning for Change

- Ask for permission to discuss a plan for next steps
- Use open-ended planning questions to elicit a plan, including "if-then" plans, for example:
  - *"What steps are you willing to take, in the next week, to reach your goal?"*
  - *"When and how will you start your plan?"*
  - *"What might get in the way of your plan and how will you handle it?"*
- If the client is not ready to change target behavior, consider a plan for another TMI session
- Provide a menu of options with Ask-Tell-Ask if necessary
- Continue to reflect change talk, and listen for the reemergence of counter change talk
- Elicit commitment language and reinforce with reflections
- Express hope and optimism
- Provide a final summary (where the client started, where they ended, their change talk, an affirmation – in any order)

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

The E2i sites that implemented TMI encountered barriers and facilitators to achieving their implementation goals. They also made changes to the original intervention to meet the specific needs of their clients and staff members. Here is a summary of adaptations and lessons learned. Additional information about the sites' experiences can be found in the Program Spotlights below.

- **Peer providers:** Site staff members referred to the intervention as MI Peers instead of TMI. The title MI Peers was preferred because it places an emphasis on peer delivery of the TMI sessions. Hiring peers to provide TMI counseling sessions can increase the cultural responsiveness of TMI; however, some of the E2i sites found it challenging to identify peers, appropriately compensate peers for their time, and provide sufficient supervision to peers. TMI programs that hire peers should ensure that the budget allows for adequate supervision and a competitive salary.
- **Peer responsibilities:** Asking peers to "wear other hats" beyond TMI can get in the way of serving more clients with TMI sessions. During supervision and team meetings, it is important to ask peer providers about the time they spend on TMI sessions versus other tasks. How can a balance be achieved?
- **Achieving MI proficiency:** It can take weeks to months for a TMI peer counselor to reach an intermediate level of competency in MI skills. It also may take time to gain access to an expert MI trainer who is available for coaching and booster sessions. TMI programs should take this additional time into consideration when planning for TMI.
- **Fidelity monitoring:** Quarterly fidelity monitoring is critical for assessing and maintaining the MI skills of TMI providers, and ensuring that TMI providers are delivering the intervention according to the principles of MI. Time and energy constraints limited the E2i sites' ability to consistently conduct fidelity monitoring. It is unclear, therefore, whether the TMI peer counselors were consistently maintaining competency in MI skills. Putting TMI under the 'continuous quality improvement' umbrella can facilitate ongoing fidelity monitoring.
- **Onsite MI training and coaching:** Having a certified MI trainer onsite or affiliated with the clinic/organization can make it easier to provide coaching, booster sessions, and fidelity monitoring.

- **High levels of client need:** Many clients struggled with housing instability, transportation costs, and substance use disorders. Clients with a high level of need require additional services beyond TMI to become engaged in care. Organizations can consider using TMI sessions to help clients engage in case management, substance use treatment programs, etc.
- **Flexible scheduling:** Adding a TMI session before or after a client's medical appointment can increase convenience and save travel time for some clients; however, other clients prefer to not stay longer than the medical appointment time. It is important to remain flexible with how and where TMI sessions occur.
- **Recruitment strategies:** Stationing TMI peer counselors in a visible location within a clinic helps to remind other staff providers to refer clients to TMI. Giving TMI peer counselors access to the electronic health record system can also help them more easily identify and recruit clients who are lost to follow-up or are otherwise potential candidates for the intervention.
- **Social support groups:** Two of the sites identified a need to offer support groups to TMI clients to bolster social support and increase motivation to change behaviors. Because of the COVID-19 pandemic, however, only one site was able to launch a monthly support group, and this group had to shut down when the pandemic began.
- **Harm reduction model.** Because the sites were already using harm reduction principles for client care, they perceived TMI as a good fit. As with harm reduction, TMI meets clients "where they are," and focuses on client-initiated goals.

PROGRAM SPOTLIGHTS

PROGRAM SPOTLIGHT

Broward House

Organizational Background

Located in Broward County, South Florida, the mission of Broward House is to improve the quality of life for people with HIV by combating HIV stigma, increasing knowledge, and providing paths to wellness. As a recipient of RWHAP Part A funding, Broward House offers an array of wraparound services to over 900 clients with HIV each year, including outpatient substance use disorder treatment, mental health counseling, housing assistance, case management, and HIV/STI education and testing. Broward House directly links clients to HIV primary care services through its partnership with the two medical clinics run by Community AIDS Network.

Implementation Goals and Context

Broward House's TMI goals are to increase linkage and engagement in care, adherence to medication, and viral suppression among Black MSM who are newly diagnosed with HIV, out of care, not virally suppressed, or inconsistent with care. Black MSM have the highest burden of HIV among all MSM in the county. Broward House's TMI program consists of two peer specialists who operate within the same department as the case management, mental health, and HIV prevention teams, and who work in partnership with the Community AIDS Network primary medical clinics to create cohesive and comprehensive care. Although Broward House initially intended to hire only peer staff who fully represented the clients served (i.e., Black MSM), they found a Black female peer specialist to deliver TMI who had equal success in engaging clients in services through the TMI model.

Recruitment and Delivery

Broward House uses a centralized phone extension to triage clients to appropriate providers, resources, and services as needed. All staff are trained to answer these calls, ensuring that all callers receive helpful and appropriate assistance at any time of day. TMI is one of the key referral services offered through this triage system. TMI program staff also recruit clients through in-house providers, case managers, and the HIV testing program, as well as outreach to the state department of health, community organizations, jails, food banks, and hospitals. Peers use the mobile outreach van and host recruitment tables at events and locations frequented by Black MSM.

To deliver TMI, peer specialists will meet anywhere a client chooses and feels comfortable, including the clinic, a park, bus stop, bridge, and food bank. After a thorough assessment, and as part of their TMI change plans, clients are linked directly to a medical provider and may also receive warm handoffs to a variety of Broward House's programs. TMI clients typically receive two to six TMI sessions over a six-month period, with each session lasting about 30-45 minutes. If a client requests to engage longer, the peers will accommodate the client for up to a year to help the client succeed in meeting their goals. After discharge from TMI, peers will meet with a client an additional three times to check in on their progress; many clients are also retained in case management.

Broward House peers and other providers meet clients "where they are." TMI is a good fit for Broward's harm reduction model because of its focus on client-initiated goals. Peers report seeing a tremendous "turn around" for several clients with complex histories and needs, including clients experiencing homeless, engaging in sex work, and struggling with addiction.

Adaptations and Innovations

- **Integration of TMI with other programs:** Broward House has actively worked to integrate TMI with their other programs. For example, they created groups and activities specifically designed for Black MSM to reduce stigma, expand support, and bolster recruitment. Broward House also started inviting TMI "graduates" to become peer advocates through Community Promise, a Centers for Disease Prevention and Control (CDC) intervention through which role models share their stories in writing and video so others can be inspired.
- **COVID-19 Pandemic:** To adjust to the COVID-19 pandemic, peer specialists shifted to communicating with clients by phone, telehealth, or social media. They later began seeing a limited number of clients in person following safety protocols.

Program Integration

Broward House has successfully integrated TMI throughout the organization by placing TMI within the client services program, doing significant in-reach with the organization's providers, and training all agency staff to use TMI principles. Broward House has applied for a CDC grant in order to expand TMI to clients who are women.

Lessons Learned

- Always let your clients lead you. Rather than assuming you know what they need, TMI peer specialists reiterate the importance of saying: "How can we support you and what are your goals?" rather than, "You need to…" With this approach, they have seen clients demonstrate vulnerability and lead with honesty.
- There are as many paths to wellness as there are people. TMI peers at Broward House have learned to accompany each client on their path, rather than taking them down the same road they take everyone. This creates trust, which results in better health outcomes.
- Stick to the intervention and it will work. Although using TMI skills may seem counterintuitive and awkward at first, TMI peers report that if you keep going, you will see the results.

"TMI is an approach that has worked for our clients. Prior to implementing TMI, these clients were struggling. With TMI, we can see them really adhering to their medications and maintaining viral suppression." —Broward House staff member

Contact Information

Broward House
2800 North Andrews Avenue, Wilton Manors, FL 33311
954.568.7373 ext. 7373 • info@browardhouse.org
www.browardhouse.org

PROGRAM SPOTLIGHT

COMPASS Cares/HOPE Center

Organizational Background

COMPASS Cares (also known as the HOPE Center) is housed within the Houston County Health Department in Macon, Georgia, and, as a recipient of RWHAP Part B and C funding, provides primary care and supportive services for over 1,000 people with HIV. A large percentage of COMPASS Cares clients, especially those with new diagnoses of HIV, are young Black MSM. Although COMPASS Cares serves 13 counties in a mostly rural area of central Georgia, they are able to offer transportation assistance and referrals through strong partnerships with local universities, community-based HIV organizations, and other medical providers.

Implementation Goals and Context

COMPASS Cares integrated TMI into their case management department and named the program H.E.A.T., which stands for HIV, Engagement, Adherence, Together. Through implementation of TMI, the H.E.A.T. team's goals have been to increase engagement in care, adherence to medication, and viral suppression among Black MSM with HIV who are newly diagnosed, at risk of falling out of care, or who have adherence concerns. Although the team originally focused on recruiting clients between the ages of 17-29 years, they eventually expanded the age range to clients 17 and older. H.E.A.T. also helps clients identify and address social determinants that may impact health.

The H.E.A.T. team consists of three peer navigators/counselors (one of whom serves as the project coordinator), and one case manager who approves referrals for ancillary services. The peers recruit clients, deliver TMI sessions, and work collaboratively with the care team. Peers are supervised by a licensed clinical social worker who also provides TMI coaching and case review for fidelity monitoring.

Recruitment and Delivery

Peers receive in-house client referrals from medical providers, pharmacy staff, case managers, and housing program staff. All new clients receive TMI as a standard of care. Peer counselors also receive client referrals from contracted providers with privileges at the local hospital. To increase visibility of the program, peers have promoted TMI through social media platforms and at community events, mobile testing events, and other in-house activities.

To deliver TMI sessions, peers endorse a flexible approach to meet the clients' challenges with transportation and scheduling. Sessions may occur onsite, at a client's home, or by telehealth (videocall or phone call), which works well for younger clients. COMPASS Cares also provides transportation from all 13 county locations and incorporates sessions with other scheduled medical visits. Still, attendance has been a challenge. Although they initially used gift cards to incentivize session attendance, the H.E.A.T. team realized that clients could benefit from additional items such as pillboxes, backpacks, and educational materials to support adherence to medical care. The team also began pairing TMI sessions with lab appointments to minimize barriers.

Adaptations and Innovations

- **Discharge plans:** TMI allows for an objective determination of program completion and, if needed, transition into other services; however, TMI does not specify the criteria for a discharge plan. The H.E.A.T. team developed their own discharge criteria, which was that the client be virally suppressed, have completed a minimum of six TMI sessions, and be actively engaged in medical care.
- **COVID-19 pandemic:** During the pandemic, staff reached out to clients to encourage them to sign up for telehealth services using the patient portal app feature of their electronic medical record system. This platform allows clients to participate in TMI sessions with minimal interruption, and actually increased the number of clients coming back into care. Peers also connected with clients via telephone and offered limited in-person appointments following social distancing protocols.

Program Integration

COMPASS Cares has fully integrated TMI into the case management team, and has trained the entire case management, nursing, and medical staff in TMI. To sustain the intervention, the organization will continue to support TMI through program income, Coronavirus Aid, Relief, and Economic Security (CARES) Act funding, and a new RAPID Start Special Projects of National Significance (SPNS) project that integrates motivational interviewing into the delivery of services.

"Through TMI, we have had meaningful conversations with clients that raise their morale. We have seen clients take control of their lives and equip themselves with what they need to achieve an undetectable viral load."
—COMPASS Cares peer staff

Lessons Learned

- **Client contact:** Peers provide reminder calls and texts to clients about appointments but have found that some clients move outside the area and some frequently change their phone numbers. To address this issue, the H.E.A.T. team started to collect and use social media handles, email addresses, and mailing addresses. Peers also trained clients to communicate through an app built into the patient portal which links clients directly to staff and providers through video phone conferencing.
- **The benefits of peers:** The H.E.A.T. team believes that peers may be better able than medical providers to perceive misunderstandings and barriers to client-provider communication. Because their interactions with clients are based on shared experiences, and because they may have more open access to clients, peers can glean more information about actual and potential challenges for clients and may also communicate the health care team's messages to clients most effectively. It is essential, therefore, to hire peers who are not afraid to share their stories, and provide appropriate training and supervision to support peers in their work.

Contact Information

COMPASS Cares
180 Emery Highway, Macon, GA 31217
478.216.5783 • compasscaresservices.com

PROGRAM SPOTLIGHT

University of Mississippi Medical Center

Organizational Background

The University of Mississippi Medical Center (UMMC) Adult Special Care Clinic offers comprehensive care for approximately 2,100 patients with HIV, over 700 of whom are Black MSM. Located in Jackson, Mississippi, UMMC serves urban, suburban, and rural clients within a three-hour driving radius. Because the HIV clinic is located in the UMMC Medical Mall, clients can receive both primary medical and specialty care under one roof. UMMC is a recipient of RWHAP Part B and C funding.

Implementation Goals and Context

UMMC chose to implement TMI to improve HIV health outcomes among their Black MSM medical clients, ages 18 years and older, many of whom face complex barriers to medication adherence and engagement in care. TMI appealed to UMMC because of its flexibility in delivery method as well as its promise to intrinsically motivate their clients to improve their health behaviors. In addition, UMMC already had an onsite psychologist who is certified as an MI trainer. Finally, TMI was a natural fit for UMMC's existing peer navigation program.

UMMC hired two full-time peer counselors as TMI providers. Peers receive TMI coaching and clinical supervision from the onsite certified MI trainer and receive administrative supervision from a nurse practitioner. Rounding out the team is a linkage coordinator who helps identify clients and assist with transportation. All clients also receive non-medical case management to address basic needs and referrals to services.

Recruitment and Delivery

UMMC's TMI clients are recruited from internal sources. The peers review the clinic's schedule for eligible clients and then approach these clients while in the clinic; they also regularly receive warm hand-offs from medical providers and case managers. Most TMI sessions last 30–60 minutes and occur in a clinic counseling room. To accommodate the busy schedules of clients, peers offer to deliver the TMI sessions before or after a medical visit. They also keep "an open-door" drop-in policy that welcomes clients at any time, to the extent possible. Peers will also meet clients at their homes or at a private spot in a public location to mitigate stigma or transportation issues.

At the end of an initial TMI session, peers help their clients develop a behavior change plan (or "goal sheet") to take home. The plan articulates the client's goal, next steps if the goal is not achieved, and who to go to for support. Most clients are asked to attend at least two TMI sessions, and possibly more if recommended by the peer or requested by the client.

Adaptations and Innovations

- **Support group:** TMI's peer counselors saw a need for affinity-based support groups to provide social connections and peer-based support. Within a short time, UMMC launched a group for young MSM. Although not designed just for TMI clients, many of the TMI clients joined the group and engaged in some MI techniques during their group time.
- **COVID-19 Pandemic:** During the pandemic, the focus of TMI shifted to retaining current clients through telehealth, text messages, video chats, and when appropriate, in-person medication delivery while observing social distancing. The support group could no longer take place.

Program Integration

TMI has been fully integrated into UMMC's program by gaining support and buy-in from the entire clinic staff. UMMC has identified existing funding to cover current TMI staff after the E2i funding period ends and plans to train all of their case managers in TMI.

"Since starting TMI, we have seen several clients who were previously ambivalent or even dismissive about their HIV care become people actively improving their quality of health and life. One client is even enrolling in a nursing program so that he can be a help to others living with HIV." —UMMC staff member

Lessons Learned

- **Build rapport and trust:** Clients with HIV, especially those who are newly diagnosed, are not always ready to open up about their lives to a new person. At UMMC, the TMI peer counselors have learned to take the time needed to help clients feel comfortable and trust them enough to talk about personal issues.
- **Choose the right people to deliver TMI:** Peers are well-positioned to understand and relate to what their clients are going through because of shared similar backgrounds with clients. Regardless of peer status, the person delivering TMI must be someone who is inclusive, non-judgmental, and willing to meet clients where they are.

"TMI has helped us save lives, and that was the biggest goal. When you increase contact with someone, it motivates that person to live their best life, and increases their ability to achieve viral suppression." —UMMC staff member

Contact Information

University of Mississippi Medical Center
Adult Special Care Clinic, MD202
350 W. Woodrow Wilson Dr., Jackson, MS 39213
601.815.3408 • www.umc.edu

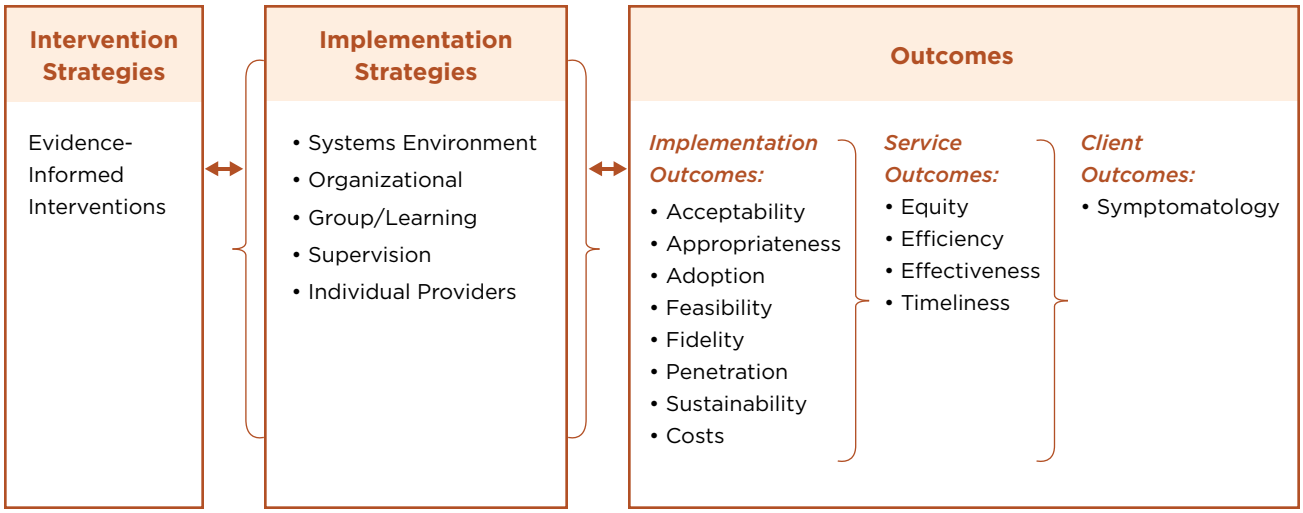
APPENDICES

APPENDIX A. IMPLEMENTATION SCIENCE AND EVALUATION: FRAMEWORK AND METHODS

The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco conducted the evaluation of the E2i program implementation. The evaluation used the Proctor Model Framework for Implementation Research.[11] This approach suggests that program assessment should include an understanding of the process of implementation and its impact on all people and systems that are involved in the implementation:

1. The core elements of the program (intervention strategies).
2. The efforts to put the program into place (implementation strategies).
3. How the program is viewed by the people involved (implementation outcomes).
4. How the program is delivered (service outcomes).
5. The impact on the participants (client outcomes).

The E2i Proctor Model



[11]Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76.

Six types of information were gathered over the three years of program implementation. These include:

Organizational Assessment: Every six months the program director completed a survey. This survey had questions about the organization (e.g., number of patients, types services provided, and staffing). It also included questions about program delivery and staff views of the program.

Proctor Concepts

- Implementation strategies (systems environment, organizational, group/learning, supervision)
- Implementation outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability, costs)

Document Review: Evaluators reviewed documents that were created during implementation and technical assistance activities. Documents were created by either the sites themselves or by Fenway/AIDS United and included grant applications, site visit reports, quarterly reports, monitoring call notes, cohort call notes, and presentations in meetings.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual patients)
- Implementation Outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability)

Observations: Sites participated in two Learning Session Meetings each year. Evaluators took notes on discussions and presentations. These notes focused on barriers and facilitators to implementation.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual patients)

Costing Data: Program managers and financial administrative staff completed two cost workbooks. One was for the three-month preparation/planning period and the first year of program implementation. The other was for the second year. These included personnel and expenses paid for by E2i as well as in-kind donations.

Proctor Concepts

» Implementation Outcomes (costs)

Intervention Exposure: Information was collected on participants who enrolled between September 2018 and December 2020. Demographic information was collected on enrollment forms. Intervention exposure forms were collected whenever staff had program-related interactions with participants. These forms included information like the date of the interaction, the staff person who had contact, type of interaction, activities completed, and outcomes of the activities.

Proctor Concepts

» Service Outcomes (fidelity, penetration, equity, efficiency, effectiveness, timeliness)

Medical Records: Medical records were collected on participants for the 12 months before enrollment in the program and for the 12 months after enrollment in the program. The information was specific to HIV-related medical care, such as: appointment dates; prescription of ART; viral load test dates; and viral load test results.

Proctor Concepts

» Client Outcomes (symptomatology)

Quantitative Analysis: Organizational assessment data was used to describe organization characteristics and readiness for implementation based on Proctor Concepts. Client level enrollment and intervention exposure data was analyzed using descriptive statistics to understand client demographics, proportions of clients receiving intervention services, and frequencies of exposures. When appropriate, proportion of clients completing the intervention was included. Repeated measures modeling methods were used to assess changes in HIV Care Continuum outcomes for clients enrolled in the intervention. This compared data from 12 months prior to enrollment to 12 months following enrollment. Costing data was analyzed to provide information on cost of intervention implementation per client enrolled.

Qualitative Analysis: Documents and observations were thematically analyzed using the Proctor Concepts. The intervention was the primary unit of analysis.

APPENDIX B. GENERAL BEST PRACTICES FOR PLANNING TO IMPLEMENT AN INTERVENTION STRATEGY

The following are **general** recommendations for planning to implement an intervention strategy in an HIV service organization. They are not specific to TMI.

Create a Planning Team

» Assemble a team of staff "champions" who are invested in the success of the intervention: who will meet regularly to drive planning, implementation, and sustainability; and who will remain committed to overcoming hurdles and moving implementation forward.

» Consider how to meaningfully involve at least one peer (a person who represents the priority population) in the planning and implementation of the intervention (see ***AIDS United's resources on meaningful involvement of people with HIV***).

» Hold weekly team meetings or daily "huddles" (i.e., short meetings at the beginning of the day to review client status and discuss recruitment and retention issues, etc.).

Engage Leadership and Staff

Implementing a new service into an established program may require changes in routines, job duties, and administrative procedures. It is essential to obtain buy-in and a firm commitment from the entire organization as early in the planning process as possible.

» Meet with executive leadership to discuss:

- How the intervention will support the organization's mission and goals
- The benefits of the intervention for clients and the organization as a whole
- The resources needed to implement the intervention
- The organizational systems and procedures that will be affected by implementation
- The importance of leadership communicating their commitment to the intervention to all staff
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

» Meet with staff members directly and indirectly affected by the intervention to discuss:

- The benefits of the intervention for clients and the organization as a whole
- How staff can help with recruitment and referrals
- Suggestions for outreach and implementation processes
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

Assess Community Needs

Early in the planning process, organizations should consider conducting an informal or formal needs assessment to better understand the needs of the priority population(s) and how to best tailor the intervention to their needs. Engaging with the local community also helps to establish trust, build recruitment visibility, and grow your referral networks.

Community needs assessment strategies include:

» Reviewing existing client data on engagement, adherence, retention, and viral load.

- What does the data tell you about the needs of your client population?

» Discussing the intervention with community members, providers, clients, and service agencies through forums, interviews, or focus groups. Ask for their input on the intervention:

- What can make the intervention appealing and accessible?
- What might be barriers to enrollment and participation? What can be done to overcome these barriers?

Train All Staff

When implementing an intervention for people with HIV, it is important to train all organizational staff in reducing stigma, identifying and addressing trauma, enhancing cultural humility, and providing affirming, culturally responsive care to all people with HIV, including lesbian, gay, bisexual, queer, transgender, and gender diverse people. Training and resources are available from ***TargetHIV***, ***AIDS Education and Training Center Program***, and ***National LGBTQIA+ Health Education Center***. Peer hires may also need additional training to acquire office skills and other professional competencies.

Conduct a Pilot Test

Prior to full implementation, conduct a pilot test under "real world" conditions to evaluate the feasibility and acceptability of the process flow, forms, and procedures.

- Consider piloting TMI with one specialist and a small group of clients first.
- Use a validated ***quality improvement method*** to guide your pilot test.
- After the pilot, communicate to all staff the results of the pilot: what worked, what did not work, and what changes were made to improve operations.

APPENDIX C. TMI "GO LIVE" WORKSHEET

Purpose

The purpose of the "Go Live" Worksheet is to:

1. Guide organizations in carrying out the intervention's planning steps and activities
2. Monitor progress in meeting implementation goals

Instructions

The team that is leading the intervention should identify a team member to complete this worksheet over time. Use the worksheet to:

- Develop and drive team meeting agendas
- Document decisions made by the team
- Track progress towards goals

Name of organization	
Name (Who is completing this worksheet?)	
Intervention Goal	To improve linkage, engagement, and retention in HIV care; TMI also addresses adherence to antiretroviral treatment and other HIV-related self-management behaviors, such as substance use and sexual activity
Core elements (These are essential to the intervention and cannot be changed)	**1.** Motivational Interviewing (MI) for people with HIV **2.** Addressing key behaviors for people with HIV
Eligibility criteria	**1.** Newly linked to HIV care, **2.** Re-entering HIV care, or **3.** Struggling with adherence to medication
Planning Activities	
Planning Team (Who is on the planning team?)	**1.**
	2.
	3.
	4.
	5.
Engaging Stakeholders (What strategies will you use to gain "buy-in" and feedback?)	**1.** Organizational leadership:
	2. Relevant staff:
	3. Local community members:
	4. Clients:

Priority population(s) (Who will you recruit for the intervention?)	**1.**
	2.
	3.
	4.
Geographic catchment area(s) (From which communities will you recruit clients?)	**1.**
	2.
	3.
Language(s) (In what languages will you deliver the intervention?)	**1.**
	2.
Recruitment and outreach (What are your recruitment strategies?)	**1.**
	2.
	3.
	4.
	5.

<table>
<tr><td rowspan="9">Intervention Staff
(Who will do what?)</td><td>Role/Task</td><td>Staff Responsible</td></tr>
<tr><td>Outreach/
Recruitment</td><td></td></tr>
<tr><td>Eligibility screening</td><td></td></tr>
<tr><td>Intake/Enrollment</td><td></td></tr>
<tr><td>TMI counseling</td><td></td></tr>
<tr><td>Sends reminder
text/calls</td><td></td></tr>
<tr><td>Clinical supervision</td><td></td></tr>
<tr><td>Case management</td><td></td></tr>
<tr><td>Coaching</td><td></td></tr>
<tr><td>Other:</td><td></td></tr>
<tr><td rowspan="2">Training for TMI providers and supervisors</td><td colspan="2">Will you use Behavior Change Consulting or a local option? (list local options if applicable)</td></tr>
<tr><td colspan="2">When do you expect your providers to achieve Intermediate Level MI status?</td></tr>
<tr><td>Training for TMI providers and supervisors
(Check when completed)</td><td colspan="2">☐ Initial experiential workshop
☐ Six individual coaching sessions
☐ Quarterly fidelity monitoring
☐ Annual one-day booster training
☐ Other training as needed (e.g., HIV treatment basics, screening, etc.)</td></tr>
<tr><td>Additional training</td><td colspan="2">☐ Train all staff on cultural humility/culturally affirming care for the priority population(s)
☐ Train all staff on trauma-informed care
☐ Educate all staff on the TMI intervention, its benefits and process flow</td></tr>
</table>

Incentives (What non-cash incentives and vouchers, if any, will you give clients?)	
Implementation tools (What tools will you develop? e.g., enrollment, referral, tracking, and client feedback forms)	**1.**
	2.
	3.
	4.
Community partnerships and referrals (Who will you partner with for recruitment and referrals?)	**1.**
	2.
	3.
	4.
Delivery space (Where will TMI providers meet with clients? Will telehealth be used?)	
Number of sessions per client (What will be the minimum and maximum number of sessions per client?)	

Discharge (How will clients formally complete the intervention?)	
Process flow (Describe the process for a client to go from recruitment to first primary care visit. Consider who, what, where, and how)	
Anticipated barriers (What barriers might you encounter for hiring, recruitment, and engagement? What barriers will clients face in making appointments? How can you minimize barriers?)	**1.**
	2.
	3.
	4.
	5.
Sustainability (What can you do to make your program sustainable?)	**1.**
	2.
	3.
	4.
	5.

Pilot the intervention (When and how will you conduct a pilot test of the intervention?)	
After pilot (What worked, what did not work? What changes will you make?)	
SMART goals (What are your **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-Bound goals for the year?)	**1.**
	2.
	3.
	4.
	5.

Implementation Activities	
TMI session delivery	☐ Send reminder calls/texts/emails to client ☐ Choose private meeting location ☐ Deliver TMI session ☐ Refer to the MI Coach Rating Scale to guide use of TMI Spirit and TMI Skills ☐ Complete or refer back to "change plan" worksheet ☐ Make referrals in conjunction with case manager, as needed ☐ Schedule a follow-up visit with client ☐ Other:
Staff Meetings	☐ TMI providers meet with clinical supervisor to address issues that arise during counseling ☐ TMI providers meet with case manager(s) to discuss referrals and address client needs ☐ TMI providers meet with other team members to discuss status of recruitment, outreach, internal referrals, etc.
Fidelity monitoring	☐ TMI providers receive quarterly fidelity monitoring from coaches ☐ TMI providers receive annual one-day booster training