Preview Guide and FAQs for Program Directors

The STEPS (Science-based Translation of Effective Program Strategies) to Care online toolkit was designed to support agencies with the implementation of three evidence-informed strategies that draw on the NYC Ryan White Part A HIV Care Coordination Program (CCP). The CCP program was identified by the Centers for Disease Control and Prevention (CDC) as a best-practice, agency-level intervention for improving retention in HIV care and reducing viral loads. StC is primarily recommended for this who are newly diagnosed, lost to care or irregularly in care, have difficult attending appointments, or have indications of Anti-retroviral Therapy (ART) challenges.

This Preview Guide addresses many of the common questions Program Directors have when considering or preparing to implement STEPS to Care (StC) strategies at their agency. The answers highlight both the strengths of StC and some of the challenges that agencies may face during uptake, staff preparation and implementation. This guide also provides information on how the StC online tools and resources can be used to support agencies during each of these phases.

Why Use STEPS to Care?

Q: What are the benefits of using STEPS to Care at my agency?

The three evidence-informed strategies supported by the StC toolkit have been field-tested in various settings, including hospitals and community agencies, as part of a best-practice intervention for improving linkage, retention and re-engagement in HIV care and ART adherence and viral suppression. These strategies are:

- **Patient Navigation**: Intensive one-on-one case management to improve linkage to care, re-engagement and retention in care. Patient Navigators work one-on-one with clients to encourage continued commitment and adherence to medical care and treatment. Through home visits, HIV education, and guidance with goal-setting, navigators ensure medication adherence, access to social services, improved communication, and prompt re-engagement in care.
- **Care Team Coordination**: Interdisciplinary team work to establish care plans and meet client needs across the care continuum. The role of the care team is to support information-sharing and collaborative decision-making to improve health outcomes for clients. Teams meet in formal and informal meetings to discuss client progress and needs, develop, monitor and update care plans, and identify and assign team member activities.
- **HIV Self-Management**: One-on-one education sessions and resources to empower clients to manage their own health. Through easy-to-use client resources available on the HIV Self-Management website (mystctools.org) and in a comprehensive workbook, navigators help clients build knowledge and skills for self-care, navigating the health care system, and independent health maintenance.

- This toolkit was pilot-tested with eight agencies as part of the development process and has been praised for its comprehensive content, the usefulness of the tools available, and ease of use.
- StC can help tailor care to client needs. For example, it supports the development of a Comprehensive Care Plan for each client to help plan, document and accomplish individual care goals and healthier outcomes.
- StC can improve how members of multi-disciplinary care teams interact and communicate with each other. The tools developed for the program provide a process that considers the medical, behavioral health and social support needs of clients.
- Agencies adopting StC strategies help clients gain access to a wide range of tools that enable them to learn about their condition, work with their navigator on strategies to improve medication adherence and overcome other barriers to care, and hear from other HIV-positive individuals. These tools are available online to be used by clients with their Patient Navigator and, later, in their own time.

Start-Up and Pre-Implementation

Planning for STEPS to Care in your agency

Q: I'm interested in adopting STEPS to Care at my agency. What's the best way to learn more about the program?

- The homepage and other introductory pages of the StC toolkit contain information on the three strategies supported by StC: Patient Navigation, Care Team Coordination, and HIV Self-Management. These pages also include an introductory video about the program, information about the staff involved, and an overview of the toolkit.
- You will also be able to access additional resources to help you learn more about StC, including additional information about each of the strategies and their key components and how they work together.

Q: My agency is already implementing some HIV services that are similar to the STEPS to Care strategies. Do we have to have a separate STEPS to Care Program?

- No, if you are already implementing similar services, the StC toolkit can provide you with resources to supplement or enhance the HIV services your agency already offers without having to create a separate program.
- For example, if you are already using a client intake form that is tailored to your organization and your client needs, you do not have to use the StC Intake Assessment Form. Alternatively, you can use it to update or enhance your form. For example, some pilot agencies have found their intake assessment to be too informal or incomplete and used the StC intake assessment form to enhance their assessment process.

> "*Before StC clients weren't getting a full intake assessment; our intake wasn't hitting all of the right items…a lot of time we didn't learn things until the third or*

fourth meeting; now with using StC intake assessment we are realizing that when we do a comprehensive assessment, we can help them better; we can identify barriers before they become a problem." – RN Case Manager

- The tools and protocols in the toolkit draws from an evidence-informed model of care that have been successfully pilot-tested. https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/cdc-hiv-hivccp_ei_retention.pdf
- As Program Director, we encourage you to first review the Agency Readiness Assessment and the Key Components Checklist found on the STEPS Strategies topic page and determine how the activities in the three STEPS strategies could enhance your current practices. You can then review all related materials in the toolkit and assess which tools would work best for your agency and which ones could be adapted for use.

Q: Once I've decided to implement STEPS to Care, how can I use the toolkit for planning and start-up?

- The online toolkit was designed to help Program Directors with all phases of planning and start-up, with many pre-implementation tools housed in Steps 1 and 2 on the Dashboard. These include tools related to staffing, budgeting and establishing policies and protocols for StC.
- In the Start with the Basics topic page, you will find the Agency Readiness Assessment and the Key Components Checklist. Download and complete these tools as a first step in planning. You can use the Key Components Checklist to identify the strategies and components of StC that match your agency goals and current practices. It can also help you identify specific StC tools and resources for staff to use.

"The best aspect of the model is that it serves as a guideline for agencies to choose which pieces of the model work best for their programs and their patient populations." – Project Director

- The toolkit contains short videos, downloadable forms and templates that you can adapt to align with your own agency-specific policies and procedures.

Reimbursement

Q: How can we use STEPS to Care to meet funding or reimbursement requirements?

- Through StC, your agency is providing services and activities related to patient navigation, care team coordination and patient education and health promotion (through the HIV Self-Management strategy). These are evidence-informed strategies that may meet some funding requirements.
- Reimbursement for HIV treatment services vary from state to state.

Getting Buy-in for STEPS to Care

Q: How can I get buy-in from agency stakeholders for adopting the STEPS to Care strategies?

- Agency stakeholders should know that StC supports three evidence-informed strategies—Patient Navigation, Care Team Coordination and HIV Self-Management—that are derived from New York City's effective HIV Care Coordination program.
- StC strategies and the online toolkit have been field-tested in various settings, including hospitals and community agencies.
- Through the Care Team Coordination strategy, StC can improve how members of multi-disciplinary care teams interact and communicate with each other. The tools developed for the program provide a process that considers the medical, behavioral health and social support needs of clients.
- StC is used to tailor care to client needs. Care team members collaboratively craft a Comprehensive Care Plan for each client. The plan is updated regularly and reflects client input.
- StC provides intensive navigational support to clients so that clients who are newly diagnosed or have fallen out of care are engaged in care.
- Through StC, clients gain access to a wide range of tools that enable them to learn about their condition, work with their navigator on strategies to improve medication adherence and overcome other barriers to care, and hear from other HIV-positive individuals. These tools are available online to be used by clients with their Patient Navigator and, later, in their own time.
- The toolkit contains concise and clear information summarizing the StC strategies on the homepage, including an introductory video about the effectiveness of the three program strategies. This easy-to-access information can be used to introduce agency stakeholders to the program.
- Several tools and resources that are found in the toolkit can be also printed or shared in group meetings to further clarify how StC works. These include:
    - The STEPS to Care Introduction video
    - Client Pathway and Provider Tools Chart (downloadable PDF)
    - Care Team Coordination topic page
    - Care Team Communication Strategies Video
    - Patient Navigation topic page and video
    - HIV Self-Management topic page
    - The STEPS Strategies topic page

Q: How do I get buy-in from Patient Navigators, case managers, and other staff responsible for implementing STEPS to Care?

- Include staff in orientation webinars and planning meetings during the pre-implementation period. Staff need to feel a connection to the work that will take place.
- Help staff to see how the staff tools and the client tools on Mystctools.org will help them keep clients engaged in care, improve communication with their care team, feel

empowered to take charge of their care, and possibly improve outcomes like client retention and viral load suppression.
- Discuss with staff how StC tools and trainings can facilitate their daily work and promote professional development.
- We encourage you to explore the many resources in the toolkit to determine which tools or topic pages may be most useful to share in order to gain buy-in from agency staff.

Q: How do I address concerns that STEPS to Care is duplicative of what we already have in place?

- You can explain that StC strategies and tools can serve as a supplement to the HIV services your agency already provides by providing new techniques and tools to enhance existing agency services and outcomes.
- Explain, for example, how, although you are implementing a patient navigation program, your agency can use tools available through StC to supplement these activities by adapting the Intake Assessment Form, using the HIV Self-Management website (mystctools.org) and workbook during client session or using the Comprehensive Care Plan to document client needs and action steps with the care team.
- Explain that StC does not mean your agency is running a separate, duplicative program, but rather is being used to enhance how care is being delivered to clients to improve client outcomes. You can use the Key Components Checklist to go over the agency practices that are supported by the StC strategies and to discuss and illustrate how the toolkit will be used to supplement what is already being done at the agency.

> *"When I'm in doubt I sign in to STEPS to Care and just read and notice other ways that I am able to service my client. My perspective of StC is that it is very informative and a wonderful tool to have handy, I have also created a tab for STEPS to Care in my charts and I file all the forms I use from StC. So, bottom line: I love it."* - RN Case Manager

Q: How do I get buy-in from our primary care providers, i.e. MDs and NPs, and keep them engaged in STEPS to Care?

- Share information about how the three strategies (Patient Navigation, Care Team Coordination, HIV Self-Management) are drawn from an evidence-informed model of care (https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/cdc-hiv-hivccp_ei_retention.pdf)
- Acknowledge that providers have limited time outside of providing clinical care and describe how StC provides strategies and guidance for optimizing meeting time between care team members.
- Acknowledge that the strategies supported by StC, such as Care Team Coordination, will improve the quality of communication between staff and PCPs and, in turn, the quality of care for clients; highlight how these strategies can enable PCPs and staff to develop as complete a picture as possible about the client and their care needs.

Preparing Staff for Implementation

Q: How can I start preparing my staff for STEPS to Care?

- First, familiarize yourself with the StC strategies and the various tools that are available in the toolkit to support uptake, training of staff and implementation. It's recommended that as a Program Director, you review all the topic pages in the toolkit.
- Consider your organization's technology needs. This will ensure that staff have full access to the StC toolkit and tools. Will staff have access to a computer or laptop, the internet, speakers, earphones and a printer, as needed?
- Once you are familiar with what is available in the toolkit, work with staff to identify and prioritize trainings and topics for them based on their roles and responsibilities using the Key Components Checklist.
- Hold group trainings (where staff access the online tools together) to cover those topics that may need the most preparation so staff have the opportunity to review materials together and ask questions.
- Invite feedback from staff on how tools might be adapted to better fit agency structure and activities.
- Using the Key Components Checklist, provide staff with a clear list of tools and pages (e.g., trainings, facilitators guides) they should use or review *prior* to their work with clients. Provide staff with a clear list of which tools (e.g., forms, protocols) they should use as they deliver the services and that are part of their job function.

Q: How do I respond to staff who say, "I don't see my exact role described in STEPS to Care. What does this mean for me?" or "I wear multiple hats. What job function should I follow for STEPS to Care?"

- Before answering these questions, familiarize yourself with the Staffing and Supervision topic page so you can describe the roles and responsibilities to staff.
- Explain that StC roles can be fluid and work with your staff to pick and choose from the tools based on what their responsibilities are.
- Do not let the staffing titles (e.g., Care Coordinator, Patient Navigator) limit which tools you and your staff use; explore all the topic pages and use what you need when you need it.
- Encourage staff to select tools that they need based on their job function vs. StC staffing titles.

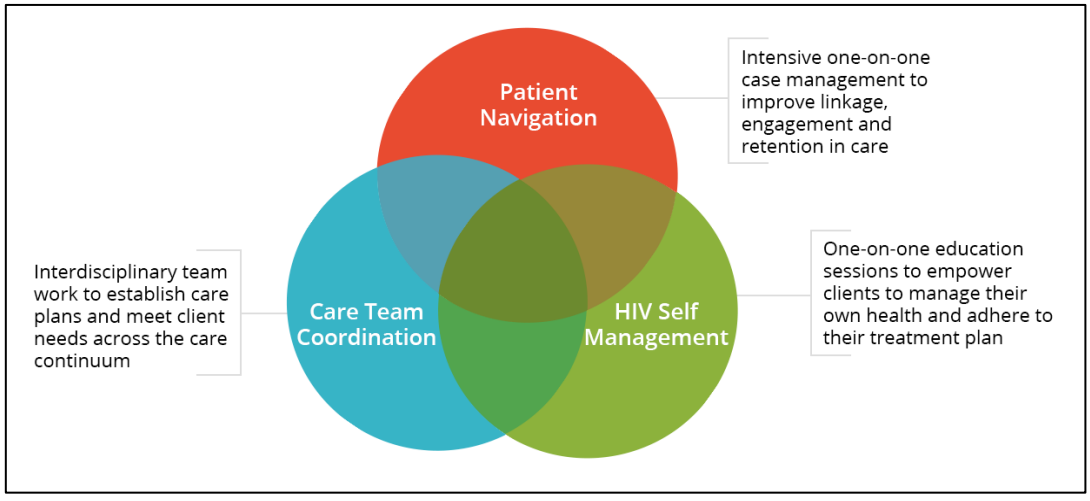
Q: How do I respond to staff that say, "I'm already doing a lot of these activities. How is STEPS different from what I already do? Is this something I'm going to have to do in addition to my other work?"

- Acknowledge that the StC strategies may sound similar to what they are already doing and that your agency can use the tools to further enhance the work rather than add to it. For instance, even if staff are already conducting intake with a client, the StC intake assessment could provide a new template for a more comprehensive intake

assessment process. Similarly, the Comprehensive Care Plan can be used as a new standard form for summarizing client needs and goals in consistent manner so that any team member at any point in time can have ready access. One pilot agency found that the adoption of the StC Care Plan by the case management team made it easy for new staff to quickly get up to speed on a client's status.

> *"We are changing the way we are doing things and seeing clients. When clients are enrolled in Ryan White, they were assigned to RN for case management and they weren't getting a full intake assessment; our intake wasn't hitting all of the right items…a lot of time we didn't learn things until the third or fourth meeting; now with using StC intake assess we are realizing that when we do a comprehensive assessment, we can help them better; we can identify barriers before they become a problem; we can look at their psychosocial needs before they even see a provider to do a lab review and medications….a year ago, when I talked to them about med, I would ask why aren't you taking your meds? Now it's being done in a proactive way." - RN*.

- Many of these tools are provided for agencies that do not have these structures in place, and you may not need the StC specific tool. So, if you are already using a client intake form that is tailored to your organization and your client needs, you do not have to use the STEPS Intake Assessment Form, as well. Program Directors should review all available materials and assess which tools they will use.
- Clarify that StC includes a set of three strategies that work in combination to improve client care and outcomes. Explain that, when used together, the strategies can help staff be more effective in helping clients to stay in care and achieve viral load suppression.



Q: In which unit of my organization should I implement STEPS to Care?

- Because StC is comprised of three strategies that work in conjunction, consider those units of your agency that currently carry out or plan to engage in any or all of the following activities:
    - **Patient Navigation**: Intensive one-on-one case management to improve linkage engagement and retention in care. Patient navigators work one-on-one with clients to encourage continued commitment and adherence to medical treatment. Through home visits, HIV education, and guidance with goal setting, navigators ensure medication adherence, access to social services, improved communication, and prompt re-engagement in care
    - **Care Team Coordination**: Interdisciplinary team work to establish care plans and meet client needs across the care continuum. The role of the care team is to support information-sharing and collaborative decision-making to improve health outcomes for clients. Teams meet in formal and informal meetings to discuss client progress and needs, develop, monitor and update care plans, and identify and assign team member activities.
    - **HIV Self-Management**: One-on-one education sessions and resources to empower clients to manage their own health. Through easy-to-use client resources available on the HIV Self-Management website and in the workbook, navigators help clients build knowledge and skills for self-care, navigating the health care system, and independent health maintenance.
    - The unit should serve clients who could benefit from improved linkage to care, retention in care, re-engagement in care and viral load suppression.
    - It is recommended that the unit have a primary HIV medical care provider co-located or strongly affiliated with case management/care coordination services.

Q: Do we need to implement STEPS to Care strategies within a medical clinic?

- While it is not a requirement, it is preferable to have medical providers at your agency to allow for ongoing and comprehensive sharing of client needs and services. It is best to obtain buy-in from providers before implementation.
- If you do not have medical providers on-site, it would be helpful if:
    - The agency provides medical care at same location (and under same organizational umbrella) as the case management/supportive services it offers, or
    - The agency has a formal business agreement or other legal relationship with one or more medical care provider(s) to provide primary medical care to clients as well as a formal structure for information- and records-sharing (e.g. medical records; social services being received).

Q: Do I need an EMR or EHR to implement STEPS to Care strategies?

- It is not absolutely necessary. However, having an EMR or EHR greatly facilitates information sharing on medical visits, lab results, case management and Patient Navigation updates. In addition, evaluation of program success through review of client viral loads and other test results is much easier when an EMR of EHR is in place. In the absence of an EMR or EHR, a care coordination team would need to rely on information-sharing through paper files and in-person updates at care team meetings.

Q: What clients will benefit the most from STEPS to Care?

- Those at greatest risk of poor HIV outcomes in the absence of enhanced support such as StC, including individuals who are:
    - newly diagnosed
    - previously lost to care (dropped out for >6 months) or never in care
    - irregularly in care (e.g., frequently missing appointments)
    - initiating a new ART regimen
    - demonstrating incomplete medication adherence or response to treatment (high viral load or low adherence as measured by self-report, pill count, etc.)
    - known to be facing a major care/treatment barrier (e.g., bereavement, relapse to substance abuse, interpersonal violence, homelessness or imminent risk of homelessness, recently released from incarceration/ readjustment to community),

Implementation

Training staff

Q: What kind of training will I find in the STEPS to Care toolkit?

- The StC toolkit is designed to provide flexible and on-going training for staff including:

    - On-boarding/orientation training: All new Patient Navigators and Care Coordinators can be trained using the materials available on the StC toolkit. We recommend Program Directors create their own onboarding curriculum and share that list with staff as part of orientation. For instance, all new field staff could be instructed to view the STEPS to Care Introductory video on the homepage, review tools on the Patient Navigation and HIV Self-Management topic pages, and complete all trainings on the “Working with Clients in the Field” page. We recommend that at start-up, Program Directors use the Key Components Checklist to create a “training” curriculum for staff based on their experience, roles and responsibilities. This curriculum should include a clear list of tools to review and/or use a schedule for completion, and ongoing meetings and supervision to discuss progress.

- On-demand individual training: The StC training materials can be used to fill in gaps in staff knowledge, or to support staff who need more intensive guidance. For example, a Patient Navigator struggling with creating strong care plans could be directed to view the Care Plan topic page, which includes a training on working with clients to establish a care plan that uses client-generated, specific, and measurable goals.
- Clinical supervision: StC materials can be used in staff meetings to foster discussion and build skills for your entire staff. For example, staff could view the Care Team Communication video as a group and use it to discuss what is working and what could be improved in your agency Care Team Meetings.

Q: How can I use the STEPS to Care toolkit to train and supervise my staff during implementation?

- Program Directors should review all of the tools and resources available in the toolkit during the pre-implementation phase so you can work with staff to identify the tools most relevant to their jobs (see also question above about preparing staff for StC).
- At start-up, use the Key Components Checklist to create a "training" curriculum for staff based on their experience, roles and responsibilities. This curriculum should include a clear list of tools to review and/or use; a schedule for completion, and ongoing meetings and supervision to discuss progress.
- It may also be helpful to create a standard list of trainings that all staff, regardless of their role, (e.g., all Patient Navigators and Care Coordinators) should complete before they start working with clients. Directors can choose which topics are especially relevant to their agencies, program, and staff in order to streamline the time it takes to complete the training process.
- During implementation, program directors or clinical supervisors should provide both formal and informal coaching and supervision to support staff in their continued use of tools. This can include regularly scheduled group or individual supervisory meetings.
- Hold regular supervision meetings (e.g., at least once a month) with staff to review what tools they have used and completed. Gather their feedback on content and usefulness to inform any changes or adaptations.

Q: How can staff find the right resources in the toolkit?

- All tools can be accessed through the Dashboard or the All Topics Page. Topics are arranged alphabetically on the All Topics Page; on the Dashboard, they are arranged by overall implementation steps.
- We recommend that at start-up, Program Directors use the Key Components Checklist to create a "training" curriculum for staff based on their experience, roles and responsibilities. This curriculum should include a clear list of tools to review and/or use a schedule for completion, and ongoing meetings and supervision to discuss progress. An orientation may be helpful to show staff how to find each tool.

- We also recommend that directors create their own tools lists using the Key Component Checklist to share with staff.

Using the STEPS to Care toolkit when meeting with clients

Q: Should I plan to use this toolkit every time I have a client meeting?

- No. You do not need to be connected to the StC toolkit website to deliver services to clients. The StC toolkit contains trainings as well as other tools (videos, forms, protocols) to prepare staff to deliver services and for staff to use with clients during implementation—however, with preparation, it is not necessary to have access to the toolkit website at each client meeting.
- Some agencies may find it easiest to download a copy of the tools they will use regularly (e.g., Care Plans, Missed Appointment Protocol) to a shared folder. Program Directors can customize and update the tools as needed, and staff will always know where to access the most up-to-date version. Staff can then print a copy to complete with clients, and securely store the completed hard copy with the client's medical records.
- Some of the tools are provided as PDF forms for convenience, but agencies are responsible for securely storing all client data in a secure location (such as a remote server for electronic records or locked file cabinet for hard copies). Data cannot be saved to the website (see below).
- There is a separate client-facing website that should be used by Patient Navigators when delivering HIV Self-Management sessions: Mystctools.org. This website is separate from the StC provider toolkit website. No information is collected or stored.

Q: Will I be entering client information into the STEPS to Care toolkit website?

- No. The toolkit website does not store client data. Be mindful if you use and save these forms, you should follow agency policy to protect client confidentiality.

STEPS and the HIV care continuum

Q: How can STEPS be used to address clients across the HIV care continuum?

Source: https://www.aids.gov/federal-resources/policies/care-continuum/

- Program Directors decide where StC will be implemented within the agency and service structure. Agencies that pilot-tested the StC toolkit used various approaches to integrate the strategies into the agency HIV care continuum. In some instances, StC was used early in the care continuum to engage newly diagnosed patients in care. In other instances, StC was used as an enhancement for patients who were prescribed ARTs but were sporadically in care and/or non-adherent. StC was also use to re-engage clients who had fallen out of care. The following are some examples of how StC was used across the care continuum.
    - **Patient Linkage to Care and Re-Engagement**: At one pilot agency, StC was integrated into their procedures for working with newly diagnosed patients. Case managers in the hospital's infectious disease clinic used the StC intake assessment tools to collect baseline summaries of clients' medical and social needs following their diagnosis. At another, StC was used primarily with patients who had a history of sporadic or irregular engagement in care. The agency's Mobile Engagement Team (MET) provided intensive outreach and re-engagement services to link people living with HIV who had not dropped out of care, incorporating all three key strategies--Patient Navigation, HIV self-management, and Care Team Coordination.
    - **Adherence to ART and Medical Appointments**: At another pilot agency, StC tools were used within a NYS Medicaid Health Home Program, a care management model serving a vast majority of NYS Medicaid enrollees who are HIV-positive, to engage and retain clients who were either new to or already enrolled in the Health Home Program. The Health Home was selected because it serves the majority of the agency's HIV-positive clients and had a care management team structure that could easily adopt a staffing structure that included Care Coordinators and Patient Navigators. HIV self-management tools were also introduced to patients to help them with adherence to appointments

and medications. At another pilot agency, Patient Navigation and HIV Self-management strategies were used to supplement HIV care services offered to patients who had a history of non-adherence to ART as well as sporadic or irregular care.

- **Retention in Care:** At another pilot agency, HIV Self-Management sessions were offered to patients before or after medical appointments at their Infectious Disease Clinic to try to increase retention. Patients selected for these sessions were patients who engaged in sporadic or irregular care, had a history of non-adherence to ART and patients who had previously been lost to care. Indeed, the HIV Self-Management tools and accompanying website were particularly well-received by pilot agencies as they sought resources for addressing patient barriers to adherence and keeping patients engaged in their care; the animated video and the patient workbook were particularly popular and used frequently.

Monitoring and Evaluation

Q: Are there tools that I can use to help me monitor progress at my agency as we implement STEPS to Care?

- Yes. For client-level monitoring, the Services Tracking Log can be used to track the number of services delivered to each client. In addition, there are several forms that can also be used to conduct process evaluation on how the three strategies are being implemented. These include:
  - Intake Assessment Form: can be used for demographic and clinical data collected during the intake or enrollment process
  - Adherence Assessment (Daily and Non-Daily versions): can be used to track levels of adherence
  - Reassessment Form: can be used to assess resolution of needs indicated at baseline, but can also be used in an ongoing process evaluation to see if psychosocial or instrumental/material needs assessed are then met with appropriate direct services or referrals
  - Referral/Appointments Tracking Log/Checklist: can be used to assess quality of follow-up on referrals, and to check the fit of referrals made or referrals completed with client needs identified/recorded in the Intake Assessment.
  - Comprehensive Care Plan: can be used to check how well services delivered match up with needs as noted in the Care Plan, to measure timeliness of service delivery, and to assess if goals in the care plan have been met.
  - Care Team Meeting Form: can be used to track whether or how often care team members are present for the meetings

- To monitor staff use of the StC toolkit, the Key Components Checklist can be used as a supervisory tool to identify/assign tools/readings/trainings to individual staff in various roles (e.g. Patient Navigators, Case Manager, etc.). During regular staff meetings or individual or group supervision, supervisors can then check in and discuss with staff their progress in using each of the assigned tools and answer any questions.

- The StC online toolkit was designed to house tools that can be used for training as well as ongoing implementation. Because it is not a linear, asynchronous online training program, but rather a toolkit of resources, individual progress through each page cannot be tracked. Similarly, external website analytics (e.g. Google) cannot track individual progress. Therefore, it is up to the supervisor to document staff progress through regular supervisory meetings. During the StC pilot period, Project Directors did this by holding regularly scheduled group supervisory meetings (at least once per month although we suggest more often in the beginning) to continuously coach staff on the use of StC tools. This helped to promote staff use of the tools and to keep them engaged.

- Finally, keep in mind that if the StC strategies are being used to supplement your agency's existing services, you can continue to use client and staff measures of success that you currently have in place for your HIV services.

Q: What are some outcome indicators for determining the success of STEPS to Care at my agency?

- StC is based on the NYC Ryan White Part A HIV Care Coordination Program (CCP), an evidence-informed "medical home" model that improves retention in HIV care and Viral Load Suppression while addressing the wider range of clients' individual medical and social service needs. A study on the CCP found that it increased engagement in HIV primary care and viral load suppression over and above the increases observed among comparable and CCP-eligible patients receiving usual care during the same period[i].
- The StC strategies can be used with patients across the HIV Care Continuum. To determine the success of the StC strategies at your agency, we recommend you use your agency's existing data collection and patient monitoring systems to track changes on the following outcomes:
    - Linkage/Re-Engagement: prompt connection or re-connection to HIV primary care for those either never in care or disconnected from HIV care for a period of over six months.
    - Retention: maintenance in HIV primary care, Percentage of clients with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the 6 month period and the last medical visit in the subsequent 6 month period.[ii]
    - Viral Load Suppression: achievement and maintenance of viral load levels ≤200 copies/mL. For those not yet achieving full suppression, significantly reduced viral loads over time and/or standardized self-report measures of treatment adherence may be considered as secondary outcome indicators.

Q: Can I monitor clients' use of Mystctools.org?

- Mystctools.org is designed to be an anonymous website where clients can feel free to explore the tools and topics without being "watched." Because of this, you will not be

able to see when clients have accessed the website outside of an in-person meeting with them. However, once Patient Navigators have established rapport with clients, self-report is a reliable way to determine if clients have used the website on their own.

- Many of the tools and worksheets on the website are designed for Patient Navigators to access with their clients during HIV Self-Management education sessions. Because some topics on the website address potentially sensitive issues (e.g., safety in relationships), it is important for Patient Navigators to introduce the topics with their clients during the sessions and complete any worksheets or tools together with them the first time. Patient Navigators should be very familiar with the Mystctools.org website and workbook prior to starting HIV Self-Management sessions with their clients. A full Facilitator's Guide to using the workbook is available on the HIV Self-Management topic page in the toolkit.
- At each session, Patient Navigators can check in with clients on their use of the website, tools, and information in between sessions.
- The Comprehensive Care Plan Form also includes a section for Patient Navigators and clients to determine goals for completion of various topics available on Mystctools.org.

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[i] Irvine, MK, Chamberlin SA, Robbins RA, Myers JE, Braunstein SL, Mitts BJ, Harriman GA, Nash D; Improvements in HIV Care Engagement and Viral Load Suppression Following Enrollment in a Comprehensive HIV Care Coordination Program. *Clin Infect Dis* 2015; 60 (2): 298-310. doi: 10.1093/cid/ciu783

[ii] HRSA Ryan White and Global HIV/AIDS Programs; Ryan White HIV/AIDS Program State Profiles. https://hab.hrsa.gov/stateprofiles/HHS-Indicators.aspx#5; accessed May 2017.