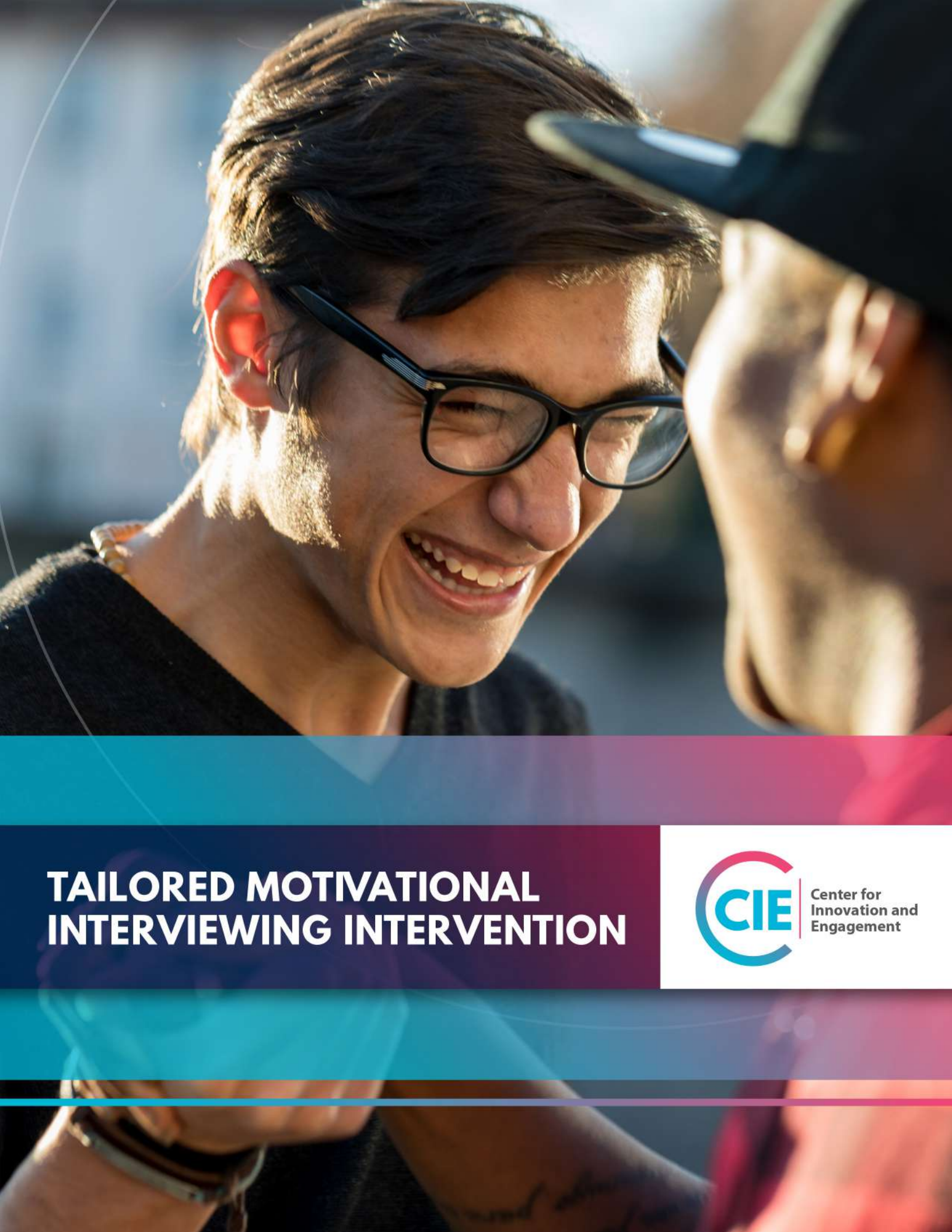

TAILORED MOTIVATIONAL INTERVIEWING INTERVENTION

Center for Innovation and Engagement

Background

The Health Resources and Services Administration's (HRSA's) Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people living with HIV who are uninsured and underserved. The RWHAP funds states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

NASTAD's Center for Innovation and Engagement (CIE) is funded by HRSA's HIV/AIDS Bureau (HAB), RWHAP Part F, Special Projects of National Significance (SPNS), under a three-year cooperative agreement entitled Evidence-Informed Approaches to Improving Health Outcomes for People with HIV. The purpose of this initiative is to identify, catalog, disseminate, and support the replication of evidence-informed approaches and interventions to engage people with HIV who are not receiving HIV health care or who are at risk of not continuing to receive HIV health care.

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Stock photos. Posed by models.

Intervention Snapshot

	Priority Population	Adolescents and young adults (ages 16 to 29) who have received a new HIV diagnosis.
	Setting	HIV Care Clinic
	Pilot and Trial Sites	University-affiliated medical department in Detroit, MI, Los Angeles, CA, Philadelphia, PA, Baltimore, MD, and Ft. Lauderdale, FL (2003–2007)
	Model	TMI helps to address the challenges faced by adolescents and young people who have received a new HIV diagnosis by assisting them to better use the health care system and address psychosocial barriers to HIV care and medication adherence. Intervention developers tailored the components of motivational interviewing to make them less time-intensive and more sustainable for providers and their staff.
	RWHAP Ending the Epidemic (EHE) Opportunity	In the TMI pilot, comparison of pre- and post-intervention scores showed that the youth cohort of 16- to 29-year-olds had large improvements in appointment adherence. In addition, youth showed a significant decline in viral load, with 33 percent of participants in the intervention group having an undetectable viral load at a six-month follow-up compared with 22 percent in the control group.
	Intervention Funding	The TMI intervention was funded by a HRSA HIV/AIDS Bureau (HAB), RWHAP Part F, Special Projects of National Significance (SPNS) grant with supplemental funding from the Adolescent Trials Network for HIV/AIDS Interventions (ATN) through the National Institute of Child Health and Human Development.
	Staffing	TMI intervention developers recommend using existing staff for implementation. The evidence indicates that, with appropriate training and MI competency, diverse staff can be used effectively to improve retention outcomes in youth.
	Infrastructure Needed	Connections with ancillary services (e.g., housing) to facilitate client referrals Certified trainers to facilitate skills-building sessions and ongoing fidelity, maintenance, and monitoring

Intervention Overview & Replication Tips

Why This Intervention?

Motivational Interviewing (MI) is a well-recognized, evidence-based intervention that has been adapted for adolescents and young adults (hereafter referred to collectively as *youth*) to promote behavior change and treatment engagement across different behaviors in multiple formats and disciplines.[1] Research in social psychology shows that in children and adults positive behaviors are strongly associated with motivation based on intrinsic factors (e.g., values, satisfaction) compared with extrinsic factors (e.g., rewards, guilt).[2] This type of behavior change intervention has also shown effectiveness in promoting positive health outcomes for youth who identify as part of racial and ethnic minority groups, particularly African Americans.[1,2]

The Tailored Motivational Interviewing (TMI) intervention uses evidence-based MI strategies to promote intrinsic behavior change in youth with HIV, ultimately leading to improved retention in care through the provision of an environment of acceptance, compassion, and autonomy.[1] TMI helps to address the challenges faced by adolescents and young people who have received a new HIV diagnosis by assisting them to better use the health care system and to address psychosocial barriers to HIV care and medication adherence. TMI intervention developers tailored the components of MI to make them less time-intensive and more sustainable for providers and their staff.

Behavior change promotions similar to TMI have been shown to effectively improve self-management and substance use for youth (ages 16 to 29) with HIV, increasing both appointment adherence and viral suppression.[2,3] In the TMI intervention pilot, a comparison of pre- and post-intervention scores showed that the youth cohort missed fewer appointments post-intervention, regardless of their assigned interventionists.

> **"They really feel a difference when someone interacts with them in a MI style. We hear them tell us 'this is the first time I felt listened to' or 'this is the first time I didn't feel judged.'"**
>
> – TMI INTERVENTION DEVELOPER

Interventionists were peer outreach workers or master's-level staff. Members of the cohort who were assigned a peer outreach worker showed an even larger improvement in retention outcomes (median effect size, d = 0.43) and attended significantly more intervention sessions (d = 0.44).[2] Youth ages 16 to 24 who participated in Healthy Choices, a large-scale, multisite, randomized controlled trial (RCT) that followed the TMI intervention pilot project, also showed significant improvements in rates of undetectable viral load compared with youth assigned to a control group ($\beta 1 = -1.072$, $P < .001$).[3]

Intervention at a Glance

This section provides an overview of the current iteration of the TMI intervention that is undergoing academic review by the Adolescent Trials Network. These steps represent the culmination of efforts by intervention developers to address identified barriers to the implementation of TMI since the original pilot project was conducted in Detroit, Michigan, in 2003. The intervention aims to improve youth retention in primary care and related clinical outcomes. The TMI intervention was primarily funded and evaluated by the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) Program grant with supplemental funding from the Adolescent Trials Network for HIV/AIDS Interventions (ATN) through the National Institute of Child Health and Human Development.

 Step 1	**Define Priority Youth Characteristics and Data Measures:** Understand the demographic and cultural characteristics of the youth you serve. In addition to gathering information about HIV-specific health outcomes and medication adherence, spend time collecting information about facilitators of and anticipated barriers to adopting and using MI, establishing baseline competency in MI strategies, and developing measures for evaluating intervention fidelity.
 Step 2	**Secure Leadership Buy-In:** Gauge the willingness of organizational leadership and existing staff to meet training requirements, integrate MI strategies into their work, and support additional staffing if necessary. Identify an agency champion to aid in advocating for program implementation and sustaining buy-in. TMI is designed to be integrated at all levels of an organization's client interactions. Discuss time commitments and workflows with staff to ensure that clinic services are not disrupted.
 Step 3	**Assess Staff Competencies and Readiness:** Conduct a multi-level assessment of baseline competencies in MI strategies and familiarity with barriers to care among the youth you serve. Create a thorough inventory of all staff who engage with youth to identify those with existing MI knowledge and those who require training. Determine whether a better understanding of community needs is required to effectively address barriers to care. Conduct a readiness assessment to identify the ability of staff to commit to training procedures and integrate MI strategies into their work.

Step 4

Develop a Youth Advisory Board:

Development of a youth advisory board is crucial to ensuring that strategies are aligned with the specific needs and communication styles of youth in your community. Take time to assess synergies and create partnerships with local agencies that already work with youth with HIV or offer the necessary ancillary services to address the needs of this population and help to meet their goals. These agencies may include drop-in youth centers, Gay Straight Alliance (GSA) advisors in schools, or others that provide supportive services to youth.

Step 5

Build a Community of Practice (CoP):

CoPs can be useful to organizations as they replicate TMI and other evidence-based interventions because they facilitate learning from the experiences of other organizations that have implemented similar strategies. Developing a CoP can be particularly useful if external training and facilitation become too costly and your organization wishes to develop internal expertise.

Step 6

Recruit TMI Trainers and Staff as Necessary:

Rather than changing the structure of a clinic's HIV care delivery, the TMI intervention relies on training staff to communicate with clients in an accepting, empathetic, and humanizing way. This requires effective training from facilitators who are well versed in both theoretical and practical approaches to MI. Replicators are encouraged to use the Motivational Interviewing Network of Trainers (MINT), which was created by the original intervention developers as a means of ensuring fidelity to core MI strategies. (See Additional Resources Box). Although the intervention is designed to work with existing staff, consider recruiting staff who are representative of the community you serve to address gaps in knowledge that you identified in the assessment of staff competencies.

Step 7

Train Staff:

The TMI intervention can be effectively implemented only if all staff who have contact with clients are trained. An initial 12-hour skills workshop delivered by members of MINT is crucial to ensure that both existing and newly recruited staff (if applicable) thoroughly understand how to apply MI strategies in their specific roles. Training sessions can be spread over several days, with an optional virtual component to minimize disruption to clinic services. MINT also provides ongoing virtual training sessions to assess and maintain intervention fidelity.

Step 8

Retain Youth with HIV in Care and Monitor Intervention Fidelity:

Integrate MI strategies on an ongoing basis across all client engagement points. After staff complete the initial 12-hour skills workshop and incorporate MI techniques into their work, the MINT team will provide a four-month "maintenance" period of ongoing support and feedback as a means of upholding the fidelity of the implemented strategies.

Cost Analysis

The TMI intervention was funded by a HRSA HAB RWHAP Part F SPNS grant with supplemental funding from the Adolescent Trials Network for HIV/AIDS Interventions (ATN) through the National Institute of Child Health and Human Development. RWHAP Part F supports the development of innovative models of HIV care and treatment to respond quickly to emerging needs of clients served by the program. HRSA's RWHAP Fact Sheet provides more context on the different parts. Additionally, RWHAP's Policy Clarification Notice 16-02 outlines details on allowable costs. (See Additional Resources Box).

The TMI intervention cost analysis was not available when this manual was developed. However, you can use the CIE Cost Analysis Calculator to create an estimate of the cost of implementing the intervention at your organization.

Resources Assessment Checklist

Before implementing the TMI intervention, your organization should walk through the following Resources Assessment (or Readiness) Checklist to assess your ability to do this work. If your organization does not have these components in place, you are encouraged to further develop your capacity so that you can successfully conduct this intervention. Questions to consider include:

- ❑ Does your staff understand HIV trends and intersecting health outcomes for youth in your community with newly diagnosed HIV?
- ❑ Does your staff understand the demographic, psychological development, and cultural makeup of youth in your community?
- ❑ Is your organization willing to address structural barriers and internal policies that create barriers for youth with newly diagnosed HIV who need care, or who are in care but not virally suppressed?
- ❑ Have you identified a champion in your organization who will advocate for the intervention at different leadership levels and promote buy-in?
- ❑ Are staff intrinsically willing to learn new skills and incorporate them into their day-to-day practice? Are they open to learning these skills through experiential learning and team-building exercises?
- ❑ Does your organization have funding streams available to recruit and sustain trainers through MINT?
- ❑ Is space available to host skills-building workshops and fidelity-maintenance sessions?
- ❑ Do you have an existing relationship with a community-based organization (CBO), AIDS service organization (ASO), or other community partners who work closely with and are trusted by youth with HIV? Are representatives of these organizations willing to work with you to plan and implement this intervention, including recruiting peer outreach workers as appropriate?
- ❑ Do you have HIV care educational materials and supplementary resources that are accessible and relevant to youth in your community? If not, do you have the capacity to develop these resources?

Setting the Stage

According to the U.S. Centers for Disease Control and Prevention (CDC), there is an estimated 1.2 million people with HIV in the United States.[4] During 2018, approximately 75.7 percent of people with HIV received HIV medical care, 57.9 percent were retained in care and 64.7 percent were virally suppressed.[5] Approximately 50,900 of the people with HIV are ages 13 to 25. Among all age groups of people with HIV, those in this age group are considered the least likely to be aware of their status.[6] CDC's estimates indicate that youth continue to disproportionately face challenges in accessing care and achieving improved health outcomes, particularly due to low rates of HIV testing and difficulty overcoming socioeconomic barriers to care.[6] At each stage of the HIV care continuum, from diagnosis to viral suppression, individuals are not entering care or are falling out of care. Improving client engagement and reengagement in care is a national priority, with targeted retention measures established by the National HIV National Strategic Plan (See Additional Resources Box), HRSA, and the Ending the HIV Epidemic (EHE) initiative among others.[7]

MI is based on communication strategies that are designed to strengthen intrinsic motivation by fostering compassionate and accepting environments in which clients receive care.[1] This type of behavior change intervention has shown success in improving health behaviors across a variety of adult populations when delivered by a diverse range of providers, including physicians, health educators, and mental health professionals.[3] The higher risk of poor retention in HIV care for youth relative to adults and the extensive research highlighting the associations between positive behavior change and intrinsic factors in both adults and youth (i.e., values, satisfaction) prompted the adaptation of MI strategies to promote behavior change and treatment engagement across multiple formats for youth.[2,3]

From 2003 to 2005, a university-affiliated medical department in Detroit, Michigan, implemented a pilot project aimed at assessing MI treatment fidelity and its impact on retention outcomes among youth (ages 16 to 29). Before implementing

the intervention, a clinical psychologist from MINT trained four interventionists (two peer outreach workers, two master's-level staff). Following the two-day training session, trainers used role plays, protocol-specific practice, and weekly coaching sessions to ensure that interventionists met or exceeded beginner competency in MI before seeing clients.

Clients were randomly assigned to peer outreach workers or master's-level interventionists. Each client received two 30- to 45-minute sessions (at baseline and six months later) that focused on retention in HIV care and on the creation of a plan addressing their health goals and barriers to achieving them. The pilot project highlighted the utility of MI strategies in improving retention outcomes, specifically appointment adherence and viral suppression, among youth involved in the intervention. Youth assigned to peer outreach workers showed even greater improvements in retention outcomes and had better attendance at intervention sessions than those assigned to master's-level staff, although both groups had significant improvements in outcomes. Findings also suggested that MI strategies can be effectively taught to and administered by staff with a variety of professional and educational experiences.[6]

Following the success of the pilot project, from 2005 to 2007 several HIV/AIDS care centers conducted a large-scale, multisite, randomized controlled trial (RCT). The trial, Healthy Choices, was implemented at five sites throughout the United States (Los Angeles, California; Philadelphia, Pennsylvania; Baltimore, Maryland; Ft. Lauderdale, Florida; Detroit, Michigan) to strengthen the evidence that MI improves retention outcomes in youth (ages 16 to 24). Youth were eligible to participate in the trial if they were able to complete questionnaires in English and if they exhibited at least one of three behaviors: substance use, condomless intercourse, or less than 90 percent adherence to antiretrovirals (ARVs). The interventionists were doctoral students in psychology or trained clinicians who participated in a two-day MINT training session before engaging with clients. After training, the interventionists participated in ongoing, weekly telephone supervision and regularly submitted videotaped client sessions to the MINT team for intervention-fidelity coding.[3]

Youth assigned to the intervention group each received four individual sessions to work on two of three behavior goals that were identified through screening at enrollment. In session one, interventionists used MI techniques to discuss the client's first goal, providing structured, personalized feedback aimed at building motivation and creating a plan to initiate change. Session two followed the same format but focused on the second goal. The remaining two sessions were geared toward reviewing and personalizing the client's behavior change plan, monitoring and encouraging progress, finding solutions to overcome barriers, and eliciting strategies to prevent the repetition of negative health-seeking behaviors. At six-month follow-up, youth assigned to the Healthy Choices intervention showed a significant decline in viral load, with 33 percent having an undetectable viral load compared with 22 percent of youth in the control group.[3]

Building on the evidence generated from these studies, in 2018 the intervention developers, with support from the Adolescent Trials Network, launched a hybrid implementation-effectiveness RCT known as the Scale It Up project. (This trial was still in progress when this manual was developed in 2020.) This type of hybrid trial adapts the intervention training components to make them less time-intensive and more sustainable for providers and their staff.

The Scale It Up RCT, which is being conducted at 10 sites in the United States (Memphis, Tennessee; Philadelphia, Pennsylvania; Brooklyn, New York; Miami, Florida; Baltimore, Maryland; San Diego, California; Birmingham, Alabama; Tampa, Florida; Los Angeles, California; and Washington, DC), focuses on ensuring intervention fidelity through improved training strategies and measurement of client outcomes.[1] The intent is to scale up MI in a series of multidisciplinary adolescent settings while balancing flexibility and fidelity. The teams that conducted the Detroit pilot project and the Healthy Choices RCT recommended the modified training strategies as a flexible adaptation of the intervention for HIV providers.

Description of the Intervention Model

The TMI intervention helps to address the challenges faced by youth (ages 16 to 29) who have received a new HIV diagnosis by assisting them to better use the health care system and to address psychosocial barriers to improve engagement in routine clinic visits and promote medication adherence.

When implementing TMI, consider utilizing the Exploration, Preparation, Implementation, and Sustainability (EPIS) framework for replicating evidence-based practices. EPIS provides overarching guidance on identifying critical factors to consider when adapting evidence-based practices to fit into existing workflows. The framework has been extensively peer reviewed and has proven effective in successfully implementing a variety of evidence-based practices.[8] Although many EPIS components have been integrated into the implementation steps that follow, users may benefit from exploring the framework while implementing the TMI intervention. The intervention is implemented in three phases:

1. Assess Gaps and Engage Stakeholders

a. *Define Priority Youth Characteristics*: The TMI intervention is designed to identify and leverage clients' strengths to promote intrinsic behavior change. Having a thorough understanding of the cultural and demographic makeup of the youth receiving care at your organization is an important initial step in implementing a TMI strategy.

b. *Define Data Measures and Systems*: Establish standard data measures and procedures to ensure client confidentiality and support ongoing evaluation of client outcomes. In addition to collecting information on HIV-specific health outcomes and medication adherence, to complete this step, consider:

- Collecting information on facilitators of and anticipated barriers to adopting the TMI intervention;
- The type of client information that will be collected to identify clients' social, structural, and psychological barriers to care;
- Procedures for storing and sharing information where appropriate; and
- Monitoring and evaluation measures to ensure ongoing intervention fidelity among staff.

Create a feedback loop that allows the care team to use information gathered during the assessments to adjust its strategies while maintaining fidelity to the mandatory intervention components.

c. *Secure Leadership Buy-In*: Engage organizational leadership and existing staff to ensure support for additional staffing and MI training sessions. Identify a champion in your leadership structure to ensure the necessary sustained buy-in and support from all relevant stakeholders, including agency directors, supervisors, frontline providers, and clinic staff. Ensure that leadership is well informed of the training requirements, staff time commitment, and fidelity reporting requirements that are crucial to the intervention's effectiveness. Identify staff who can and should be involved, as well as any additional staff who may be needed. Define parameters for the type of work experience that new staff should have. Address limitations that may hinder you from hiring staff who are representative

of your community. Keep in mind that the TMI intervention is designed to use existing staff as a way of promoting accessibility in different service-delivery settings. Spend time discussing sustainability promotion, integration of intervention training modules into clinic programs and policies, and budgeting for training sessions and ongoing technical assistance from external trainers.

d. *Assess Staff Competencies and Readiness*: Develop an inventory of staff competencies through a multi-level assessment of systemic, organizational, and provider characteristics. This means developing a thorough understanding of baseline competencies in MI as well as alignment with the cultural makeup of the youth your organization serves. Include an assessment of staff readiness to commit to the training requirements and integrate the behavioral skills they learn into their daily work. This step is crucial in gauging the type of competency gaps that exist within your team and addressing them intentionally during the implementation phase.

   If certain staff have credible MI experience, explore ways to help them facilitate the integration of MI strategies during implementation and aid novice staff in acquiring MI skills. If staff have time constraints or other readiness issues, discuss these with the MINT team and identify strategies for addressing them. Depending on resource availability, consider integrating peers into your service-delivery cascade as a way of providing services that are better suited to addressing the structural and social barriers faced by youth. If this is not possible, ensure that staff are well versed on the barriers to care experienced by the youth they serve, even if it involves additional training sessions or pursuing cross-cultural learning opportunities. Where possible, create leadership pipeline opportunities for youth engaged at your clinic.

e. *Develop Advisory Boards:* Engage with community organizations to help develop and provide ongoing feedback on intervention fidelity. Consider establishing a youth advisory board to ensure that strategies are aligned with the specific needs and communication styles of youth in your community. For example, to ensure effectiveness, TMI intervention developers partnered with the Children's Diagnostic Treatment Center in Broward County, Florida, to create an advisory board comprised of youth who had previously been involved in MI interventions.

f. *Develop Partnerships and a Community of Practice*: Assess synergies and create partnerships and linkage opportunities with organizations that (1) already work closely and have established trust with adolescents and young people with HIV in clinical or non-clinical settings, or (2) offer the ancillary services needed to provide a holistic response to social and structural barriers. Types of organizations to consider partnering with include youth-led groups, ASOs, and other CBOs that provide supportive services to youth with HIV. These partnerships will help you establish a CoP for learning implementation strategies from organizations that have adopted TMI or similar strategies. These organizations can aid in both ramping up and sustaining the TMI intervention and can offer an ongoing network of support to address barriers.[1] A CoP is also a cost-effective option for skills sharing if external facilitation becomes a financial burden.

2. Recruit and Train Staff in MI

a. *Recruit Trainers and Staff Where Necessary*: Successful implementation of the TMI intervention relies predominantly on embedding tactful, empathetic, and humanizing communication styles across an organization's care continuum to ensure that the needs of youth are being identified and met while creating a space that is welcoming to youth from diverse backgrounds. This type of intrinsic behavior change strategy requires thorough training and practice with trainers who are experienced in imparting these strategies to staff who may have a wide range of skills, competencies, and cultural backgrounds.

   Developers of the TMI intervention partnered closely with Behavior Change Consulting to develop the training curricula that have been adopted and disseminated by MINT at the local, national, and international levels. (See Additional Resources Box). Use MINT as a training resource to ensure fidelity to core MI strategies. Although the intervention is designed to work with existing staff, address gaps you may have identified in your existing staff infrastructure, including hiring peers or other workers with the appropriate cultural competency to readily engage with youth.

b. *Train Staff:* Appropriate staff training and competency building is the cornerstone of implementing the TMI intervention. Ensure that all staff engaged with youth have some degree of experience in specific TMI methods. This promotes consistency across your organization and reinforces the motivational goals set by youth throughout their engagement with the HIV care continuum. Make the training sessions as far-reaching as possible without disrupting the clinic workflow. Develop a clear structure for administrative supervision to coordinate the different components of staff training.

   The initial adaptation of the TMI intervention for youth involved a two-day intensive training session for interventionists of varying skill levels (peer outreach workers, master's-level staff, doctoral-level psychologists, trained clinicians). Train all staff who have an intrinsic readiness for change and a willingness to engage with youth in more compassionate ways as a means of improving their care delivery. The current adaptation of the TMI intervention involves the following steps:

   i. *Initial 12-hour Skills Workshop:* This step is delivered by members of MINT and is required but can be spread over four days. The training sessions are experiential and serve as a team-building activity for staff, making in-person sessions an important component. If necessary, in-person training can be supplemented by virtual sessions (up to six hours). Encourage staff to coach each other in small groups and engage in role-playing activities, using a series of standard client interactions to promote

experiential learning and group cohesion. Other group TMI methods are included to increase staff's intrinsic motivation to implement the strategies that they are learning.

The workshop emphasizes stigma-reduction communication by having participants practice expressing empathy and support for client autonomy; encouraging critical reflection and the examination of power dynamics; and introducing lifelong learning strategies. The workshop also includes tailored videos featuring scenarios that involve behaviors often attributed to youth with HIV.

ii. *Intensive Training Period:* During the first six months after the initial training sessions, participants engage in bi-monthly 15-minute virtual role-play exercises based on standard client interactions. These exercises are recorded to allow the MINT trainers to code and score interventionists' MI competency. The four competency scores and categories are (1) beginner, (2) novice, (3) intermediate, and (4) advanced. These exercises also enable MINT to provide feedback on both strengths and areas needing improvement.

In addition to the bi-monthly virtual role-play exercises, staff with a beginner or novice competency rating are required to engage in three virtual coaching sessions of one hour each. Each coaching session involves a standardized activity that allows the staff member to reflect on and reinforce behavior change methods. These sessions also include (1) a brief interaction to elicit discussions about provider behavior change and self-efficacy in regard to TMI implementation; (2) feedback on a staff member's two highest and two lowest ratings; (3) coaching activities specific to each of the lowest ratings; and (4) individual goal setting. The goal of these sessions is to ensure that staff have advanced to at least an intermediate competency level in implementing MI strategies. (Once a staff member reaches intermediate competency, these sessions become optional.)

iii. *Fidelity Maintenance*. Four months after the end of the intensive training period and quarterly thereafter, staff who are implementing MI strategies complete "standard client interactions" and receive prompt automated feedback on their strengths and areas for improvement. These interactions are based on standard client profiles developed from actual clinical encounters and are delivered by trained actors. The actor is provided with a client history and a specified target behavior that the staff member is to address.[1] Each session includes three "must say" statements to prompt the staff member to actively use TMI strategies.[1] Feedback can be tailored to be "global," so that the organization's leadership can disseminate it to staff as they see fit, or, where appropriate, provided individually to each participating staff member.

"[TMI] is an individual intervention to promote behavior change, but it is also a structural intervention because its health force is training for the End[ing] of the [HIV] Epidemic initiative."

– TMI INTERVENTION DEVELOPER AND FOUNDER OF MINT

3. Retain Youth with HIV in Care

With a trained intervention team and a support network of community partners, you are ready to engage youth with HIV using intrinsic behavior change strategies and stigma-reducing communication styles.

a. *Monitor Intervention Fidelity:* Begin monitoring after the initial 12-hour skills workshop and consistently monitor fidelity throughout the implementation of the TMI intervention. The aim is to identify barriers to implementation and find solutions to overcome them. In the original intervention pilot project, MI fidelity was assessed using the Motivational Interviewing Treatment Integrity (MITI) scale, which focuses specifically on interventionist behavior. The MITI scale gauges an individual's empathy and overall competency as a counselor by having trained coders listen to audiotaped recordings of client interactions and code them into four competency scores.[2] In its current iteration, MI fidelity is measured through "competency ratings" that are derived from the MI Coach Rating Scale using results from the recorded client-interaction exercises mentioned above. Trained independent raters at MINT code the recordings of standard client interactions and produce a score of 1 (beginner) to 4 (advanced) that indicates the staff member's competency in implementing MI strategies with fidelity.[1]

   Once the intensive training and fidelity-maintenance periods are complete, you can choose to select an internal staff member who will act as an ongoing coach for new or existing staff, preferably with lived experience, to ensure that MI strategies continue to be implemented consistently and effectively. Or, if you prefer, you may continue to engage with MINT as an external facilitator. Replicators are encouraged to contact MINT if they are interested in exploring this option.

   Meet without external facilitators to review client and systems data, address barriers and facilitators, and strengthen intervention fidelity where appropriate. As the intervention becomes more streamlined, identify TMI champions across your staff structure to maintain a culture of compassion and acceptance for the youth being served. Incorporate specific retention strategies used in previous iterations of the intervention, such as reminder phone calls or working closely with outreach staff to contact individuals who are hard to reach.[3]

Logic Model

Logic models are effective tools to assist in planning, implementing, and managing an intervention. Below is a logic model highlighting the resources, activities, outputs, outcomes, and impact of the Tailored Motivational Interviewing intervention referenced throughout this guide.

Resources	Activities	Outputs	Outcomes	Impact
• Diversified funding: Ryan White HIV/AIDS Program, other government agencies, foundation grants, private and in-kind sources • Partnerships with trusted providers and team members with long-standing community relationships and knowledge of community resources • Connections with ancillary services (e.g., housing) to facilitate client referrals • Certified trainers to facilitate skills-building sessions and ongoing fidelity maintenance and monitoring	• Establish staff and community resources • Develop an inventory of team cultural competencies and gaps and staff readiness for skills acquisition • Create partnerships and linkage opportunities with agencies that work with youth or can offer services to address youth needs • Train staff in MI skills and support ongoing fidelity maintenance and monitoring	• Youth with HIV retained in HIV primary care and ancillary services • Youth with improved goal-setting skills and increased motivation to engage in positive health behaviors	Among participating youth with HIV: • Use of stigma-reducing communication styles • Positive behavior changes and motivation to maintain adherence to care Within the implementing agency: • Significant increase in the number of appointments scheduled and kept • Decreased need for retention outreach efforts • Shift in organizational culture to build strong interpersonal skills within the organization and encourage better staff relationships • Creation or maintenance of a positive reputation with youth communities • Increased knowledge of youth's barriers to care • Stronger set of coordinated care services across the organization	• Increased viral suppression among youth with HIV • Increased appointment adherence among youth with HIV

Your Planned Work

Your Intended Results

Staffing Requirements and Considerations

Staff Capacity

TMI intervention developers recommend using your existing staff to implement TMI across your organization's HIV care continuum. Both the TMI pilot project and the Healthy Choices RCT used interventionists with specific experience (e.g., peer outreach workers, master's-level staff, doctoral-level psychologists) to gauge the ability of staff with different educational and professional backgrounds to implement MI strategies. The evidence indicates that, with appropriate training and MI competency, diverse staff can be used effectively to improve retention outcomes in youth. Evidence has also shown an even greater improvement in retention outcomes for youth who were engaged by peer outreach workers compared with interventionists who have master's-level credentials.[2] If you hire peers, to the extent possible, choose those who are representative of the youth communities you serve.

Strong administrative supervision is necessary during the ramp-up of TMI due to the ongoing training and fidelity-monitoring components that are required to ensure the intervention's effectiveness in achieving positive health outcomes for youth. Establish a supervision framework that is appropriate for your organizational structure and that facilitates staff training, time management, and efficient, streamlined implementation of MI strategies and support for young peers who benefit from intentional supervision.

Staff Characteristics

Core competencies of all staff should include:

- Experience working with youth with HIV;
- Understanding of youth resilience factors, communication preferences, and development frameworks;
- An attitude of acceptance, compassion, and support for autonomy;
- Understanding of structural ageism and how it leads to disproportionate health outcomes for young people with HIV;
- Ability and willingness to prioritize youth as experts in their own lives who have the autonomy to decide their own care outcomes and goals, and to provide feedback on how to structure programs to meet these clients' unique needs;
- Pre-established relationships with community organizations and resources (local and online) for youth;
- Commitment to learning something new and readiness for change; and
- Passion for applying creative solutions to improve the lives of youth.

Replication Tips for Intervention Procedures and Client Engagement

Successful replication of TMI involves working with community partners and other organizations to create a CoP, using an EPIS framework, conducting readiness assessments for staff, and providing clear administrative supervision.

- *Create CoPs:* CoPs are a strategy to promote the uptake and sustainability of evidence-based practices. In a CoP, a "community" is defined as a group of people who learn together and develop common practices based on shared goals, values, and trust.[1] A CoP has no formalized structure; the membership structure or method of communication is entirely dependent on the needs and availability of your organization and those with whom you wish to connect. CoPs should remain non-hierarchical and flexible to suit the needs of their members.

  CoPs can be useful to organizations as they attempt to replicate and sustain a TMI intervention because they facilitate learning from the experiences of other organizations that have replicated the same or similar strategies. Developing a CoP can be particularly useful if external training and facilitation become too costly or if your organization wishes to develop internal expertise in TMI for future dissemination. A CoP may be founded on:

  - A shared domain of knowledge, tools, language, and stories that create a sense of identity and trust to promote learning and member participation;
  - A community of people who create a social fabric for learning, sharing, inquiry, and trust; or
  - A shared practice made up of frameworks, tools, references, and documents that community members share.

- *Use an EPIS Framework:* The EPIS framework provides implementation guidance while identifying unique and common factors at the systems and organizational levels that need to be considered when replicating evidence-based practices. Existing literature has identified EPIS as a consistent, effective framework through which to replicate evidence-based practices, and it can serve as a useful resource when considering the best approach to establishing a skills-acquisition model for staff.[8]

The steps outlined in the **Description of the Intervention Model** section incorporate

many of the EPIS principles. However, it may be useful to become more familiar with the framework while replicating TMI. The stages of EPIS are:

- **Exploration:** Use to assess the existing health needs of clients or communities while identifying the best evidence-based practices to address them; then decide whether to adopt that practice. Consider necessary adaptations or modifications to the evidence-based practice to ensure effective implementation.
- **Preparation:** Use to identify facilitators of and potential barriers to implementation and to prime organizational personnel for the implementation phase. This phase includes developing a detailed implementation plan that capitalizes on facilitators, actively addresses potential barriers, and planning for implementation support (training, coaching, auditing, etc.).
- **Implementation:** Use to build on the first two phases and actively integrate evidence-based practices across the organization. Embed ongoing monitoring of implementation in the process and adjust implementation strategies where necessary.
- **Sustainment:** Focus on ongoing evaluation, adaptation, and support of the intervention within all structures of your organization to ensure the continued achievement of your desired public health outcomes.

- *Conduct Staff Readiness Assessments:* A readiness assessment is an analysis of an organization's capacity to undergo a transformational process or change. Conducting a readiness assessment is beneficial for identifying potential challenges that could arise when implementing new procedures, structures, or processes. Due to the intrinsic behavioral component involved in TMI strategies, staff need to be prepared and open to learning new communication styles and engagement strategies before committing to an MI training curriculum. Quantify the amount of time providers and other clinical staff must dedicate to the required training components and to incorporating MI strategies into their day-to-day work. Although a formal readiness assessment specific to TMI replication is not available, you can conduct qualitative interviews or surveys to assess staff willingness and ability to implement TMI. General parameters for gauging staff readiness include:[9]
  - The provider's belief that caring for clients at the facility is relatively manageable and that the new strategy will improve the provider's experience;
  - The relationship between the provider and the organization's administration and other clinicians is open and collaborative;
  - The provider actively participates in initiatives that promote evidence-based and leading clinical practices; and
  - The provider is willing to assume a leadership role while implementing an integrated care system by taking responsibility for key objectives and helping to promote the system to other providers within the organization.
- *Provide Clear Administrative Supervision:* Administrative supervision refers to a person or group that leads the coordination and follow-up of TMI-related training activities. Given the modular nature of the required training and the number of staff who could be involved, identify a point person who is responsible for coordinating logistics with MINT trainers or CoPs where applicable. The point person is also responsible for ensuring that staff implementing MI strategies with clients are attending their fidelity-monitoring follow-up sessions, meeting fidelity criteria, and receiving technical assistance they may need.

  Administrative supervision may also assist with gauging provider time constraints for TMI-specific activities, promoting the sustainability of the intervention once it has been integrated into the system, and providing ongoing support to providers and other clinical staff during the initial "intensive" skills-building sessions.

Securing Buy-In

Securing the support of leadership, staff, and other relevant stakeholders is an important step when implementing a novel intervention. The following strategies may help to secure buy-in for the TMI intervention:

- **Highlight existing TMI resources**: The existing array of training protocols, curricula, and other resources makes learning TMI intervention strategies flexible to the needs of staff. Using seasoned trainers such as those in MINT will ensure an adaptable training structure that fits your organization's needs while ensuring the fidelity of the intervention throughout its lifespan. Similarly, establishing a sustainability pathway suitable for your organization's needs can promote streamlined integration of the intervention into existing services.
- **Use an in-reach instead of an outreach approach**: This allows your organization to begin implementing the intervention with clients who are already engaged in services but need additional support, minimizing the time and resources needed to recruit clients.
- **Highlight the advantages your organization may receive by implementing the intervention:**
  - You can create or maintain a positive reputation in the community by offering positive experiences and affirming services to youth. This can lead to increased word-of-mouth referrals and to an increase in the number of clients you serve.
  - Working with a youth advisory board or youth-centered CBO offers an opportunity to learn more about barriers to care among youth (e.g., substance use disorder, parental consent). Peers can provide great insight on what questions to ask, how to harness community resiliency factors, and how to "dig deeper" to identify barriers to care.
  - The acquisition of behavioral skills inherent to the TMI intervention can help to promote a stronger culture of communication among your staff. This can help to shift the organizational culture to promote autonomy, support, and compassion as a means of creating better interpersonal relationships among staff.
  - The communication aspect of the intervention makes it flexible and easily integrated into all aspects of the HIV care continuum, resulting in a stronger, interwoven set of coordinated services.

"It really starts to shift the organizational culture in a way that people start to use it with each other. Even the way supervisors interact with their supervisees shows modeling of Motivational Interviewing. It becomes a way of communication with the world."

– TMI INTERVENTION DEVELOPER

Overcoming Implementation Challenges

As an initial step when considering the suitability of TMI for your organization, assess the potential barriers to implementing the intervention that you may experience. Anticipated challenges and possible solutions include:

- **Provider availability:** Using a provider with limited availability can create barriers to TMI skills acquisition during the intensive training period. Providers' schedules can be dynamic and can fill up quickly, making it a challenge to carve out time for training sessions. Organizational leadership and administrative supervision support staff can discuss scheduling options to reduce the time burden experienced by providers and other staff as a way of ensuring compliance with the required training. Where necessary, training sessions can be virtual or spread across multiple days to avoid clinic disruptions.
- **Staff have prior experience with MI:** Staff may believe they are already competent in MI. However, it is important that they receive training that adheres to the fidelity model and is consistent with the evaluated outcomes of the evidence-based practice highlighted in this manual. Gauge the type of training and experience staff have in MI strategies and ensure that they are certified in the MI style pertinent to TMI.
- **Staff turnover and participation in the required components of TMI:** Internal coaching of team members and engagement with CoPs can ensure that MI becomes established institutional knowledge that can easily be disseminated to new staff. To mitigate barriers to staff participation, discuss potential issues or ongoing barriers with MINT trainers and tailor required components of the intervention to staff needs.
- **Lack of buy-in at the leadership and managerial levels:** Without buy-in, effective organizational uptake of TMI will not occur. Identify an agency champion who can promote the intervention within the leadership hierarchy. Highlight the myriad benefits offered by TMI at both the individual and organizational levels while creating a clear plan of action to integrate TMI strategies into the existing care structure. Take the opportunity to engage CoPs in discussions about strategies they have used to create buy-in among leadership and staff.

Promoting Sustainability

Successful replication of the TMI intervention may require exploring a variety of funding sources, particularly those aimed at addressing the upfront expenses of staff training and fidelity maintenance or ongoing external facilitation and assistance with fidelity monitoring. HRSA's Ryan White HIV/AIDS Program Fact Sheet provides more context on the different parts that may support intervention costs, and RWHAP's Policy Clarification Notice 16-02 outlines details on allowable costs (see Additional Resources Box). Additionally, state and local health department resources may be available to support implementation.

Fidelity-maintenance strategies such as ongoing audit, feedback, and booster training sessions are particularly useful for sustainability, whether these are delivered by external facilitators or by well-trained internal coaches. Developing fidelity measures that can be used by external or internal facilitators is an important step toward ensuring that the intervention is maintained and remains effective. For example, use a standard client-interaction fidelity model to rate interventionists on their engagement with clients. The development and active utilization of CoPs have also been deemed useful in promoting the sustainability of TMI due to the culture of collaboration and shared learning that they foster. These communities can help to actively address ongoing barriers and can provide lower-cost resources for training and fidelity monitoring.[1]

SWOT Analysis

SWOT is an acronym for Strengths, Weaknesses, Opportunities, and Threats. A SWOT analysis is a structured planning method that can be used to assess the viability of a project or intervention. By conducting a SWOT analysis before implementing an intervention, organizations can proactively identify challenges before they occur and think through how to best leverage their organizational strengths and opportunities to improve future performance. A SWOT analysis of the TMI intervention identified the following:

STRENGTHS

The TMI intervention will readily retain youth with HIV in care and increase their viral suppression by:

- Creating an atmosphere of acceptance, compassion, and autonomy by using empathetic and intentional communication styles;
- Providing agencies and organizations as a place to refer youth with HIV;
- Creating an organizational culture with improved interpersonal communication between staff, ultimately improving the quality of service delivery for youth; and
- Providing an adaptable and flexible model of behavior change that can be used by all staff and can be integrated into existing infrastructure to leverage organizational strengths.

WEAKNESSES

Agencies will find it challenging to implement the TMI intervention without:

- Flexible and receptive clinical staff with a willingness to acquire a new behavioral skill;
- Current relationships with, or leads on, community stakeholders and current or potential service partners who participate in collaboratively defining the needs of youth and provide ancillary services;
- Stakeholder buy-in and funding to support staff training, ongoing intervention fidelity monitoring, and booster training sessions;
- Organizational willingness to prioritize youth experience and expertise in autonomously deciding their care outcomes and goals; and
- Receptiveness to youth feedback on how to improve programs to address their unique needs.

OPPORTUNITIES

The TMI intervention offers opportunities to:

- Establish relationships with youth-centered CBOs and other providers through the development of CoPs;
- Develop an organizational culture centered on empathy and encouragement that ultimately improves interpersonal relationships among staff;
- Foster flexible and adaptable behavior change across the HIV care continuum; and
- Provide ongoing knowledge exchange among staff regarding social and structural barriers to HIV care that are unique to youth communities.

THREATS

Threats to the success of the TMI intervention may include:

- Time constraints that prevent providers and other clinical staff from attending required training.

Conclusion

The TMI intervention uses evidence-based MI strategies to promote intrinsic behavior change in youth with HIV, ultimately leading to improved retention in care. This communication-centered approach to service delivery provides a compassionate and supportive environment in which youth can address the barriers they may face to remaining in care and promotes adherence to appointments and maintenance of viral suppression. The TMI intervention also leverages existing staff and care infrastructure while promoting collaboration with youth-centered CBOs and other youth-serving agencies to create a provider network that can more readily improve the lives of youth with HIV. Overall, the TMI intervention provides an adaptable model for clinics and other service-delivery settings to better serve youth, ultimately reducing the HIV incidence rate and the risks of HIV-related morbidity and mortality.

In the TMI intervention pilot, comparison of pre- and post-intervention scores showed that the youth cohort of 16- to 29-year-olds had large improvements in appointment adherence.[2] In addition, youth ages 16 to 24 who were randomly assigned to the Healthy Choices intervention showed a significant decline in viral load, with 33 percent of youth in the intervention group having an undetectable viral load at a six-month follow-up compared with 22 percent in the control group.[3]

Additional Resources

Motivational Interviewing Network of Trainers (MINT)
motivationalinterviewing.org/

HIV National Strategic Plan
hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2021-2025

Ryan White HIV/AIDS Program Fact Sheet
hab.hrsa.gov/sites/default/files/hab/Publications/factsheets/program-factsheet-program-overview.pdf

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice 16-02
hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

CIE Cost Analysis Calculator
CIEhealth.org/innovations

Behavior Change Consulting
behaviorchangeconsulting.org/

Improving Health Outcomes for Youth Living with the Human Immunodeficiency Virus: A Multisite Randomized Trial of a Motivational Intervention Targeting Multiple Risk Behaviors
jamanetwork.com/journals/jamapediatrics/fullarticle/382533

Motivational Interviewing by Peer Outreach Workers: A Pilot Randomized Clinical Trial to Retain Adolescents and Young Adults in HIV Care
doi.org/10.1080/09540120802612824

Testing a Motivational Interviewing Implementation Intervention in Adolescent HIV Clinics: Protocol for a Type 3, Hybrid Implementation-Effectiveness Trial
researchprotocols.org/2019/6/e11200/

Endnotes

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