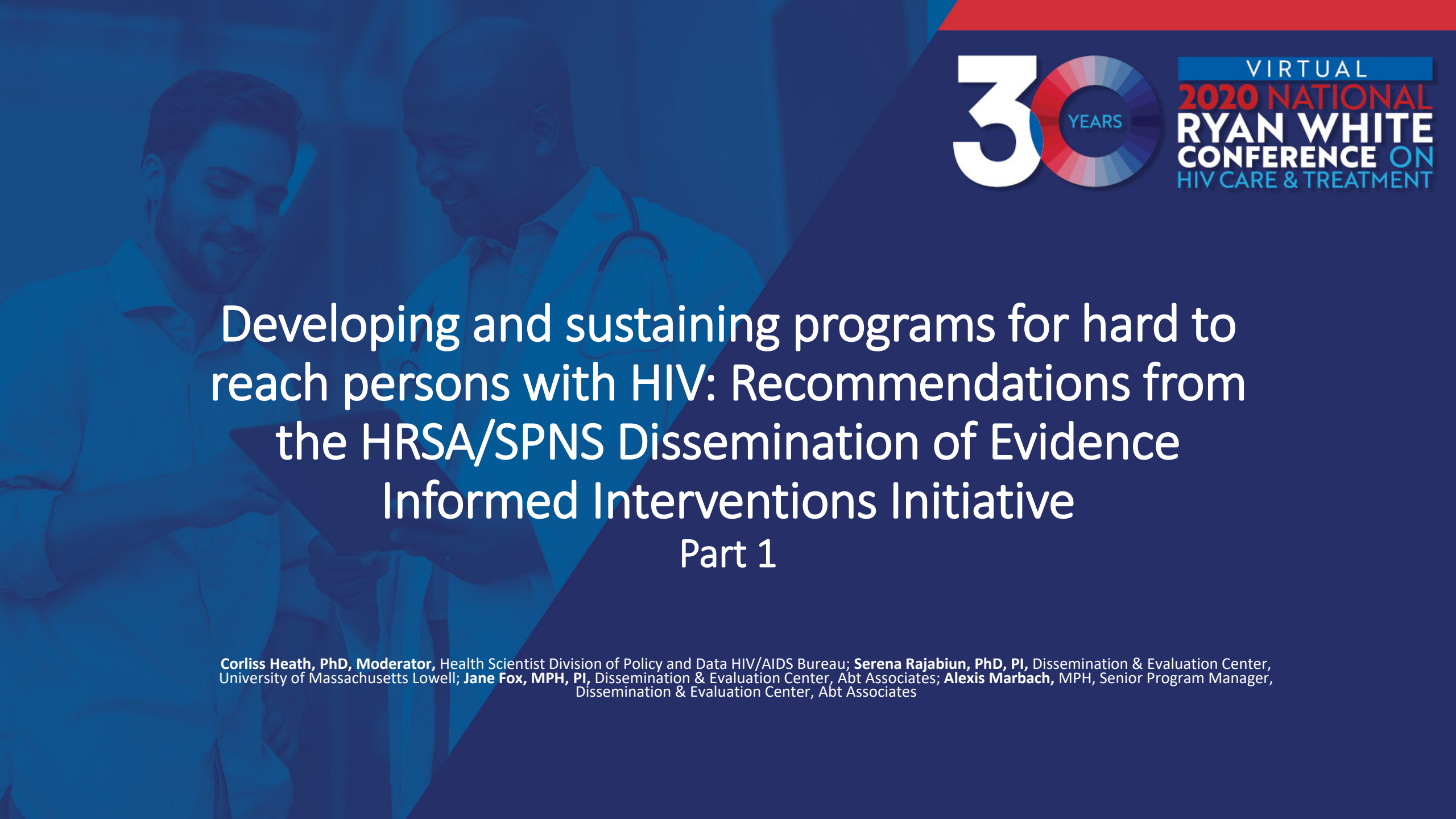

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Developing and sustaining programs for hard to reach persons with HIV: Recommendations from the HRSA/SPNS Dissemination of Evidence Informed Interventions Initiative

Part 1

Corliss Heath, PhD, Moderator, Health Scientist Division of Policy and Data HIV/AIDS Bureau; **Serena Rajabiun, PhD, PI,** Dissemination & Evaluation Center, University of Massachusetts Lowell; **Jane Fox, MPH, PI,** Dissemination & Evaluation Center, Abt Associates; **Alexis Marbach,** MPH, Senior Program Manager, Dissemination & Evaluation Center, Abt Associates

Disclosures

- Serena Rajabiun and Jane Fox have no relevant financial or non-financial interests to disclose.

- This continuing education activity is managed and accredited by AffinityCE in cooperation with HRSA and LRG. AffinityCE, HRSA, and LRG Staff, as well as planners and reviewers, have no relevant financial or non-financial interests to disclose. Conflict of interest, when present, was resolved through peer review of content by a non-conflicting reviewer.

- Commercial support was not received for this activity.

Institute Learning Objectives

This is part 1 of a series of workshops about the HRSA/SPNS Dissemination of Evidence Informed Interventions.

At the conclusion of this activity, the participant will be able to:

- Learn how to adapt and implement evidence-informed Care and Treatment interventions for cis-and transgender women of color, persons exiting jail, and persons with substance use disorders.
- Gain knowledge and skills to enhance staffing models, partnerships and organizational systems for implementing Care and Treatment Interventions.
- Describe challenges and facilitators in scaling up and sustainability of Care and Treatment Interventions in your service area.

Acknowledgments

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DEII Initiative Overview

- Replicates 4 previously-implemented SPNS initiatives with the goal of creating Care and Treatment Interventions (CATIs).
- 5-year initiative (2015-2020) represents the first attempt to bring innovative SPNS-supported interventions to scale across the field.
- Two cooperative agreements:
  - ITAC: AIDS United
  - DEC: Boston University and Abt Associates

Intervention Shorthand

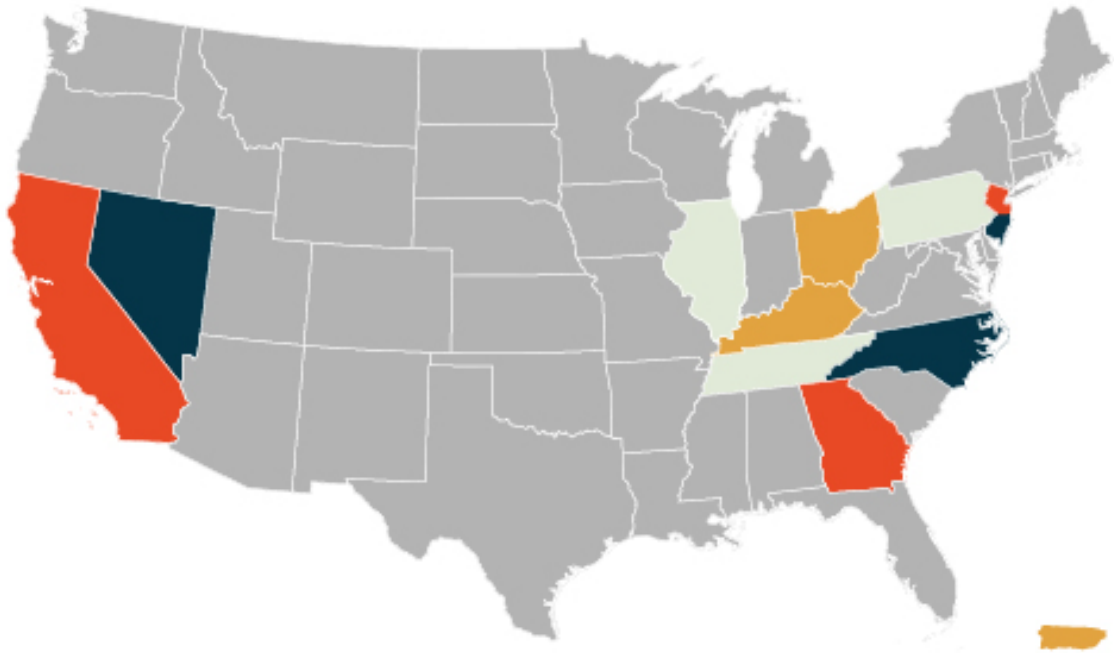
TCC

Peer

Bup

Patient Navigation

DEII Demonstration Sites



Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

- CENTRO ARARAT, Inc., FAITH Clinic – **Juana Díaz, PR**
- The MetroHealth System – **Cleveland, OH**
- University of Kentucky Research Foundation, through the Bluegrass Care Clinic at UKHealthcare and the Center for Health Services Research – **Lexington, KY**

Transitional Care Coordination from Jail Intake to Community HIV Primary Care

- The Cooper Health System Early Intervention Program – **Camden, NJ**
- The University of North Carolina at Chapel Hill, School of Medicine, Division of Infectious Diseases – **Chapel Hill, NC**
- Southern Nevada Health District – **Las Vegas, NV**

Enhanced Patient Navigation for Women of Color

- Grady Health System, Infectious Disease Program – **Atlanta, GA**
- Keck School of Medicine at University of Southern California – **Los Angeles, CA**
- Newark Beth Israel Medical Center, a part of the RWJBarnabas Health System – **Newark, NJ**

Peer Linkage and Re-engagement of HIV-Positive Women of Color

- AIDS Care Group – **Chester, PA**
- Howard Brown Health – **Chicago, IL**
- Meharry Medical College – **Nashville, TN**

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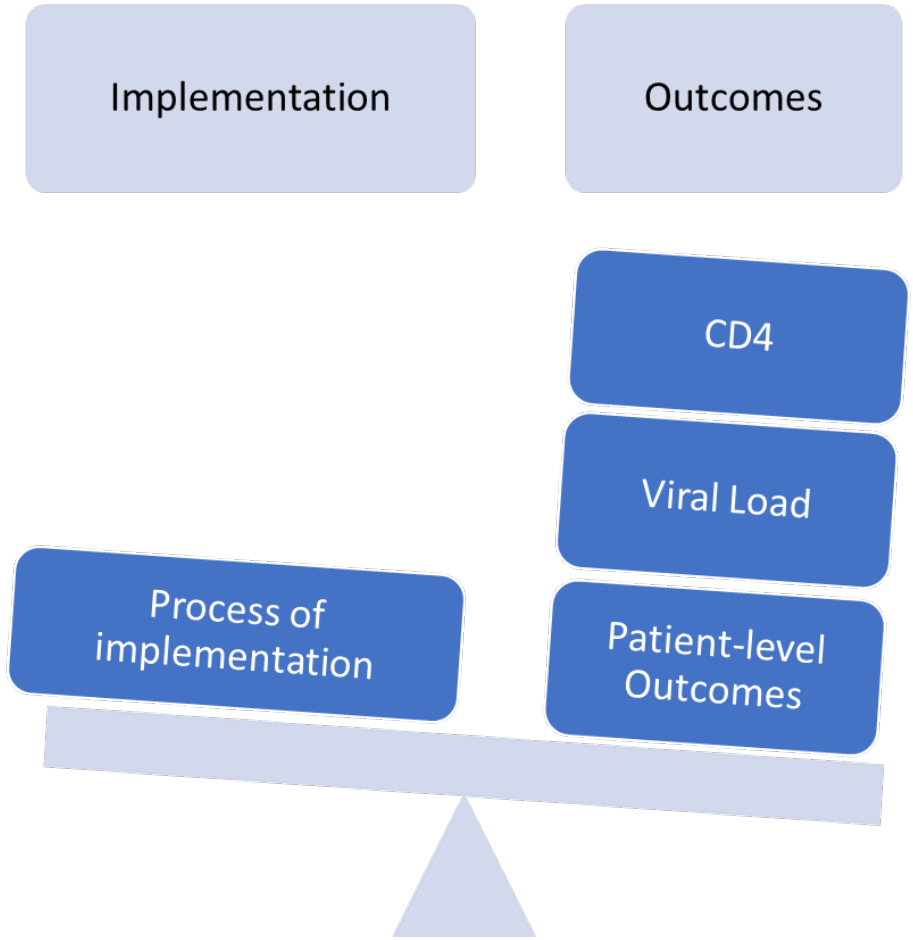
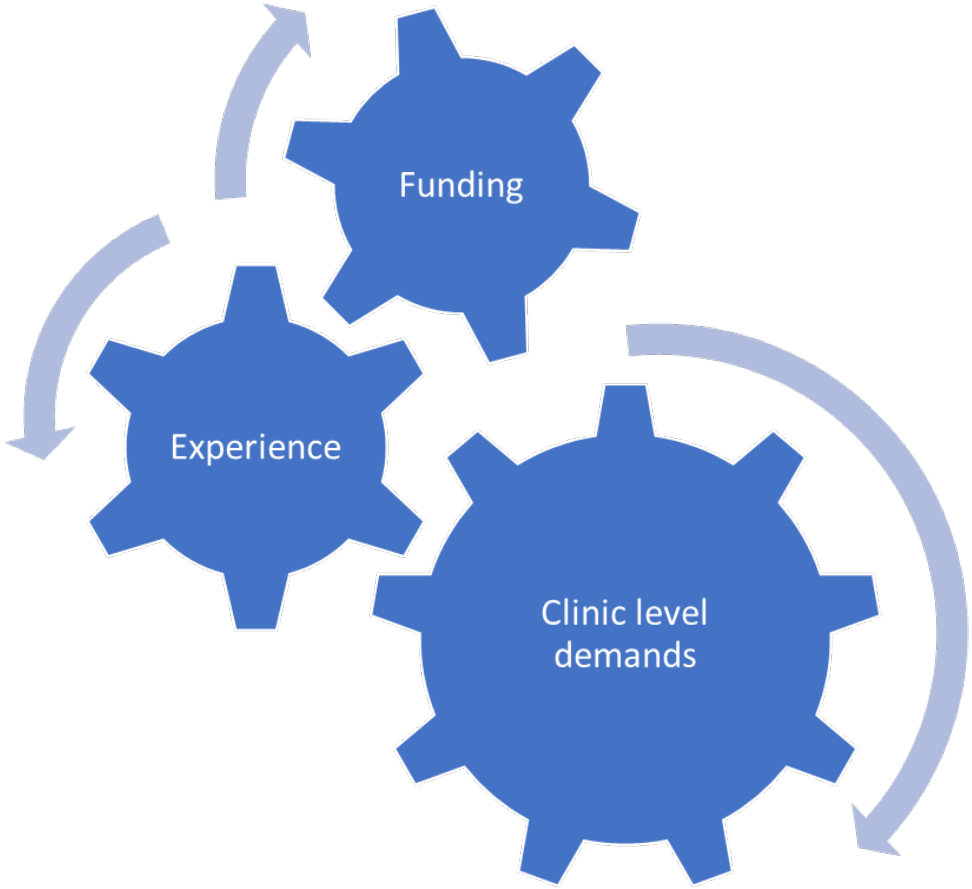
30 YEARS

Implementation Science: A shift in perspective

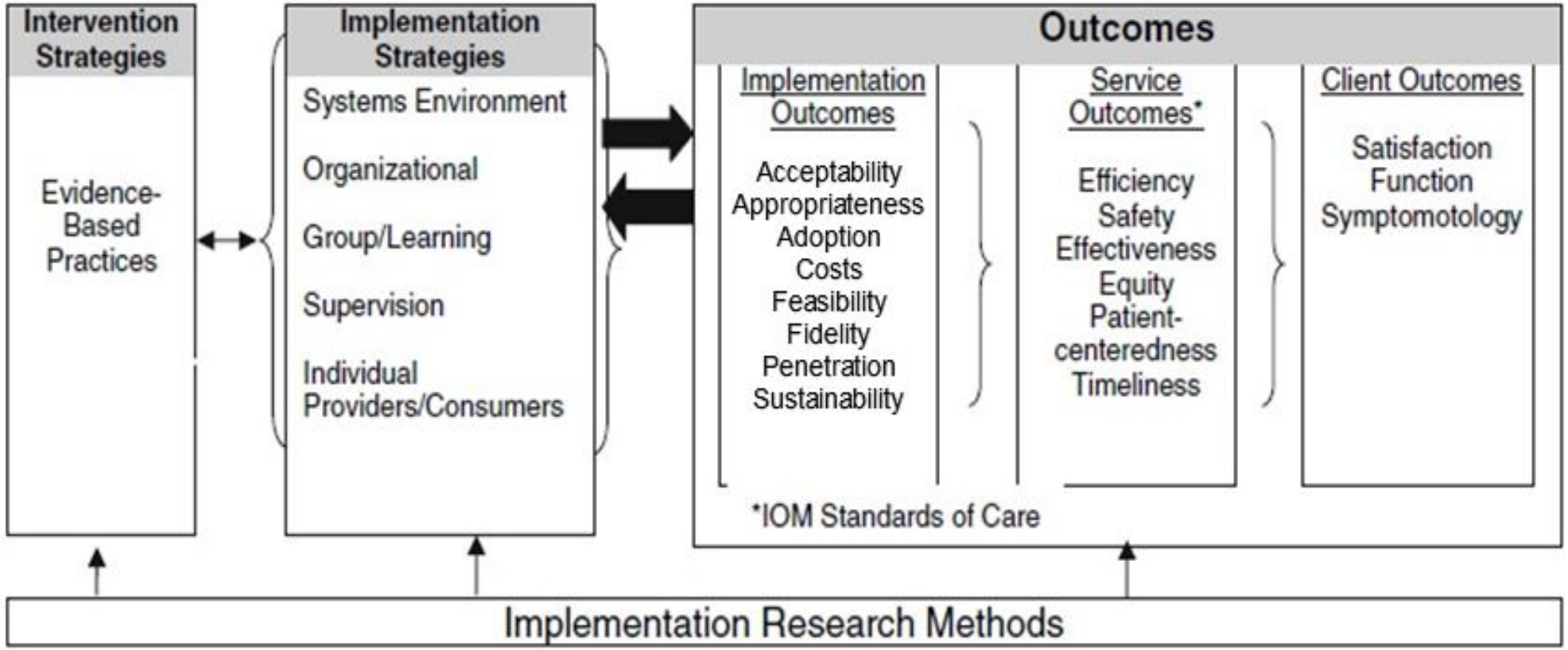
What are your evaluation priorities?



What are the drivers of your evaluation work?



Implementation Science Approach: Proctor Model



(Proctor et al., 2009)

Proctor Model Implementation Outcome Domains

- ***acceptability*** – To what degree are site providers, staff, and leadership willing and able to take on the full terms of the intervention?
- ***appropriateness*** – To what degree does the provider think the intervention is the appropriate intervention for the target population?
- ***adoption*** – To what degree are providers and staff willing to implement the intervention by following the protocol outlined in the implementation plan?
- ***cost*** – What does it cost to implement the intervention?
- ***feasibility*** – What are the barriers and facilitators to effective implementation of the intervention?
- ***fidelity*** – To what degree is the intervention being implemented as outlined in the implementation plan?
- ***integration*** – To what degree do sites integrate the intervention into their other ongoing efforts to improve outcomes along the HIV Care Continuum?

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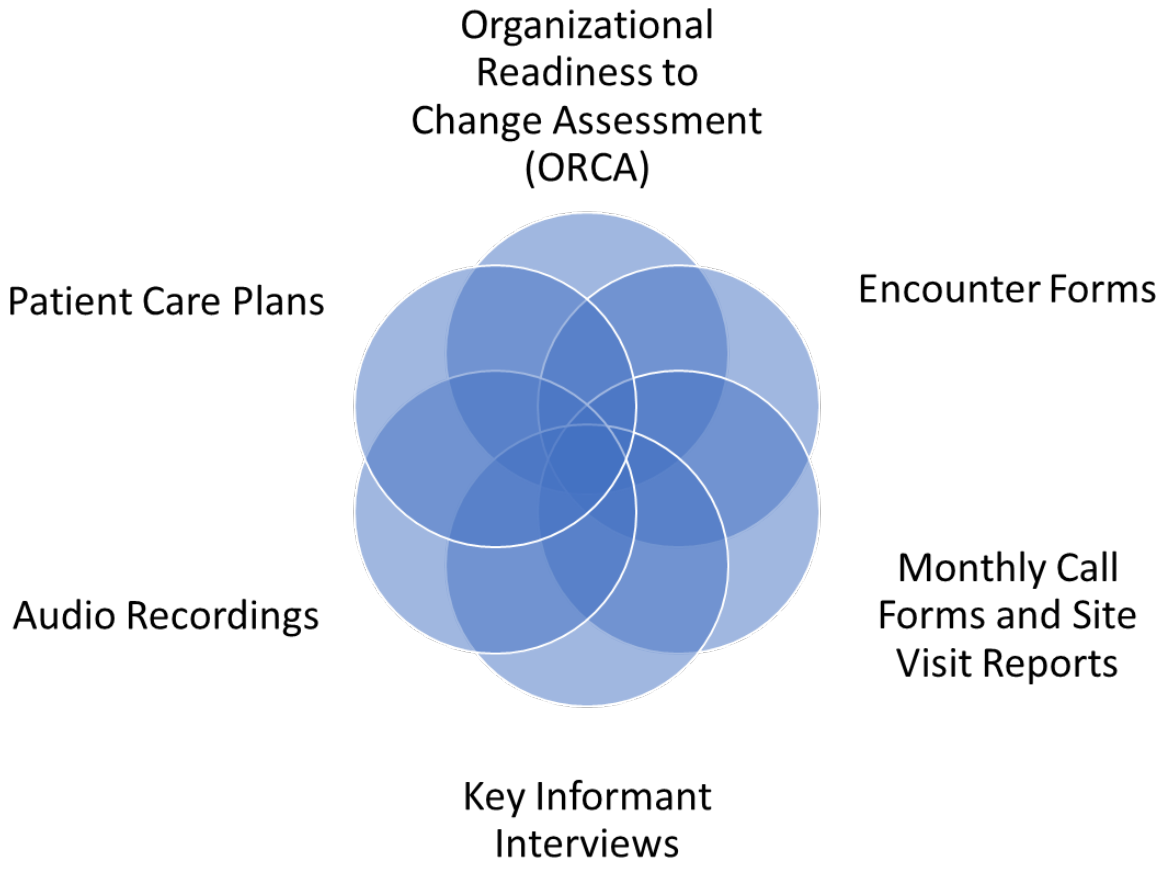
Implementation Science in Practice: Data Collection Tools

Implementation Outcomes: Data Collection Sources



Organizational Readiness to Change Assessment (ORCA)

- The scales are intended for diagnostic use, to identify needs or conditions that can be targeted by implementation activities or resources, and to provide a prognosis of the success of the change effort at the organizational level. (Helfrich, Li, Sharp, Sales 2009).
- Implemented during the pre-implementation phase at each demonstration site.
- Completed by a diverse range of site staff (administration, leadership, intervention team members)

- Knowing what we know now…
- Assess what you need to know from the ORCA – what constructs do you need?
- Complete once all intervention staff hired
- Conduct follow-up

Encounter Forms

- Filled out by the interventionists
- 1 encounter form per client per day
- Used to determine level of effort and tasks conducted & assess fidelity to the evidence-informed model e.g. completion of PN sessions, executing the steps in the care plan completion for Peer intervention
- 17,907 encounter forms were completed during DEII data collection

Knowing what we know now…

- Integrating the encounter form into the EHR makes it easier for intervention team members to quickly enter the data
- Reviewing encounter form data can help teams identify where/how they are spending their time, allowing for more efficient allocation of resources and tailored trainings

Frequent Encounter Activities 1

- TCC
  - Relationship building
  - Discussing medical appointments with the client
  - Providing appointment reminders
  - Finding client/conducting outreach
  - Conducting client intake and/or needs assessment
- Peer
  - Relationship building
  - Providing coaching on living skills
  - Providing appointment reminders
  - Discussing medical appointments with clients
  - Providing basic HIV treatment education, support, and advocacy

Frequent Encounter Activities 2

- Bup
  - Conduct monitoring appointment
  - Provide client support during maintenance or stabilization
  - Relationship building
  - Assist with obtaining transportation services
  - Provide appointment reminders
- Patient Navigation
  - Relationship building
  - Providing appointment reminders
  - Finding clients/conduct outreach
  - Other
  - Follow-up with provider to discuss client

Monthly Site Forms and Site Visit Reports

- Monthly site forms: Sites completed a form each month to collect data on implementation, staffing changes, local dissemination, de-identified case studies, and dissemination and sustainability efforts.
- Site Visit Reports: Completed by the sites prior to each site visit to frame the conversation

- Knowing what we know now…
- Create an online form (vs. using a word document)
- Even if you're not participating in an MSE/grant funded project, it's important to document your experiences and adaptations over time, to build a case for why the intervention is important and what it requires to funders, leadership, board etc. Take notes on a quarterly basis so you don't forget key details.

Audio Recordings

- Used to conduct fidelity monitoring: Measuring implementation fidelity, the degree to which an intervention is delivered as designed, by reviewing how the intervention staff perform intervention activities (Carroll, Patterson, Wood, Booth, Rick, Balain, 2007).
- Time span: April 2017 – March 2018
- Total audio recordings reviewed: 106
  - 30% of clients who have consented to being recorded are randomly selected to be recorded
  - Interventionists record every interaction they have with selected clients
  - Interventionists have 72 hours to upload recordings to the data system
  - 10% of uploaded recordings are selected to be reviewed

Audio Recordings

Knowing what we know now…

Collecting Recordings

- Barriers:
  - Fear of HIV-related stigma
  - Interventionist apprehension, especially in peers
- Facilitators:
  - Academic medical settings
  - Local evaluators familiar with audio recording protocols

Reviewing Recordings

- Barriers:
  - Measuring fidelity in a non-scripted intervention
- Facilitators:
  - Maintaining detailed notes of the interaction to measure quality
  - Training audio recording reviewers

Cost Analysis

- Cost data collected from monthly expenditures and invoices
  - Adjusted to account for cost of living across regions
- Types of costs
  - Start-up: staff, training costs, materials development
  - Recurrent costs: Fixed and variable costs
    - Labor
    - Non-labor: staff & client transportation
- Average cost r

Intervention	Cost per client per year
TCC	$3,185 ($2,884-$3,959)
Peer	$4,731 ($3,458-$7,260)
Bup	$2,834 ($2,343-$3,429)
Patient Navigation	$2,893 ($1,910-$4,442)

All costs are wage adjusted and in 2019 dollars

Staff Key Informant Interviews

- Qualitative interviews conducted with key intervention staff

- Domains of the interview:
  - Patient population
  - Implementing the evaluation
  - Patient centeredness and patient experience in the intervention
  - Integration of the intervention into the larger clinic setting

- Knowing what we know now…
- Modifications to the intervention to fit the local context & support integration into the organization

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Lessons Learned through Implementation Science

Before implementing, understand your internal capacity…

- You need to do a lot of the work on the front end, I guess, so that formative period where you're really figuring out how the local system works currently is...I mean, "vital" seems not even a strong enough word.. It's imperative to really understand what you're talking about…**You're not going to be helpful to clients if you're jamming up a system…**As keen as everyone always is to jump in with different pilot projects and stuff like that, I think you've got to really be aware of doing that grunt work in the first part of the whole process and really understanding what the system looks like, what can we change, and what cannot be changed, and really trying to ID what your obstacles are going to be and how you're going to address those obstacles.

TCC Intervention

…and the capacity of your community partners to support recruitment.

- I think the one thing I would say is that try to consider your referral sources. All possible referral sources. I mean, our initial plan was to use our database and run reports and have it spit out names. And we're like oh we'll have all the patients who don't come, it'll be great. But after we did that once or twice, then that was the low-hanging fruit. Then we're like, oh every time we run this now it's the same names. So there wasn't this whole new group of names waiting for us. So we had to expand our resources. We had to expand how we sought patients out. We started going inpatient, and finding people who maybe were admitted to the hospital who hadn't been here, we started using our home visit team, we started using the Community Health Workers, the docs, and at some point everybody was referring a few patients here, a few patients there, and we had enough to keep enrolling new faces. But our original plan didn't work out as we thought it would.

PN Intervention

Hire the right mix of staff

You know, I'm a big believer that academics and community have to be at the table at the same time, and I think something that's interesting about public health is, sometimes you get people who are academic elitists. And I get it, but they're not always the best choice when you're doing a project like this, and I think there's room for community to be at the table.

Now, I say that because there's challenges on both ends. When you have somebody who has never done the work but comes right out of school and has all the academics in the background, they don't always downshift very well, and it takes them a long time to really connect. Whereas, if you bring in community, they connect really fast, but they don't have all of the science behind it.

So either way, you have to spend a lot of time educating and really talking about how to blend in, and I call it "strategery." And finding currency. You have to be good at all of those things, and I have more success bringing in individuals from the community and then spending a lot of time with them cultivating their ideas and their approach to this population and education. I seem to get further.

TCC Intervention

An intervention manual isn't enough

INTERVIEWER: What did you think of the intervention manual?

INTERVIEWEE: Holy moly…That was like a thick packet that I had to go through, but I had an awesome, great teacher or leader, so it was pretty much an easy transition right into.

- It's just being knowledgeable about your community, being present, figuring out people's currency, because everybody has it, and being able to be creative in your approach to doing your work. While I download a group of resources, they really are just resources, right, and guidance. But there are nuances to everybody's environment that you have to consider. Mine is going to be different than Mississippi's, you know, or Chicago or wherever. But I think the basics are probably the same, and it's just being present and being engaged.

Bup Intervention

Train the team to understand their clients

Clients who enrolled in DEII interventions had multiple needs and co-morbidities, and intervention team members needed to be trained across multiple content areas to be adequately prepared to meet their clients where they were at.

Addressing intersectional issues is key to success:

- I think that recognizing that the work with people living with HIV is very difficult, and that that layered on top of the political climate and fear about changes in healthcare and stigma and the social issues, just acknowledging that that all is really challenging is sort of a bottom line.

Language matters:

- I can't think of much, but just, you know, be very careful with the words that they use. Even the doctors and physicians, they have to be very careful because they're such a vulnerable population that we have to just be very gentle with them as we transition them into care because it's very difficult and challenging as is. So, they already know what they're facing, they already know what they're dealing with.

Bup Intervention

Supervision: Protected time is different than respected time

- When reflecting on supervision, one peer supervisor commented:
  - That it's protected and regarded as a mainstay, a very necessary piece of things and not something that's "We can fit it in." It loses its value or something, it's read differently when it's something that we just squeeze in when we can

Engaging with testing efforts will support recruitment

Testing is key to identifying potential clients (and meeting the goals of the EHE).

- Well, we definitely need to test more. The testing is needed out there. We test as much as we can, but it's very difficult at times because, like I said, the staffing, we can't be at all different places, you know, testing, doing the TCC project, being out in the community, and being here to meet our patients. So, we need just a person to test more in the jail, do more of the education in the jail.

Persistence is key to retention

- So I think that the two women who are our navigators became like these amazing skip tracers. They very quickly sort of figured out how to intuitively know where the patients were, and this is a big building. We have five stories that we're using, and we have all kinds of weird nooks and crannies. We provide amazing services, but not everything is integrated in a really smooth way necessarily. [name] and [name] just figured out how to know, "Oh, there's a patient in the building that I want to try to connect with," and they figured out how to track them and find them in, you know, in an unobtrusive way and not in a confrontational way but in a supportive way, like, "Hey, here I am, I'm here to help you." And not even to help, because that's somewhat of a... Maybe that's not the right word. That word has some judgment to it, but more like a, "I'm here to be of service to you."

PN Intervention

Transition to the standard of care is determined by the client

- Because I am positive, because I had a lot of struggles at the beginning of this, I understand the need of getting the resources that you need. Bam, bam, bam, bam. Because this is an overwhelming process of life. You have to, and like I tell all patients, you have to make the virus live with you, you can't live with the virus. That virus invaded your body, you didn't ask for it to come. So, you have to be strong for you. You have to learn how to be strong. You have to learn how and know that you're going to have to change some things in your life, so you can make it**. Patients need that type of support. They need that type of encouragement… So now, you're looking at a patient that might lapse and some things because now they could feel abandoned again. "Oh, you told me you were going to be there, and now you're telling me I have to go to them." I transferred one of our clients to case management, and they dropped out of care for eight months**

Peer Intervention

…and it can be celebrated!

- Then they did a termination session and they successfully had two recognition lunches for those women that have finished the program, and we're yet to host another one. We're waiting for other people to finish. Another recognition session where we give them awards and gifts and lunch and just talking about the program and highlight their participation, as we found that to be very important to the self-esteem and empowerment of the women that we reached out to.

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30 YEARS

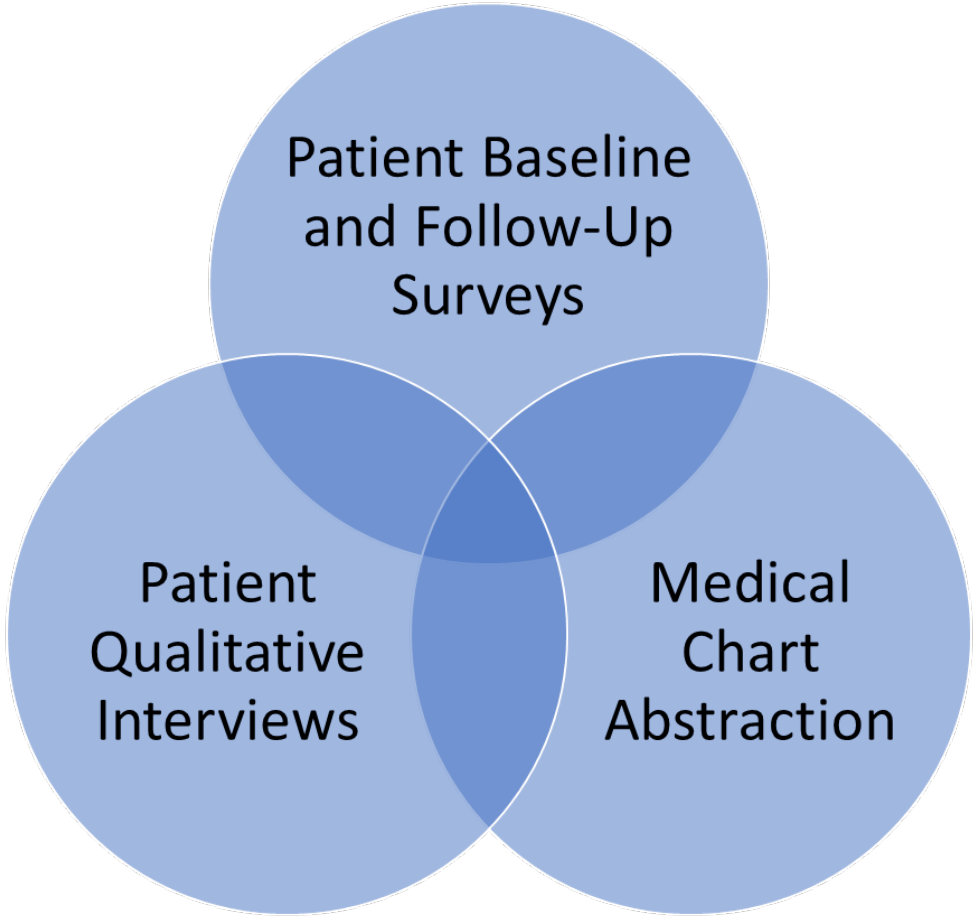
Client Outcomes

893 PWH consented & enrolled in the multi-site evaluation

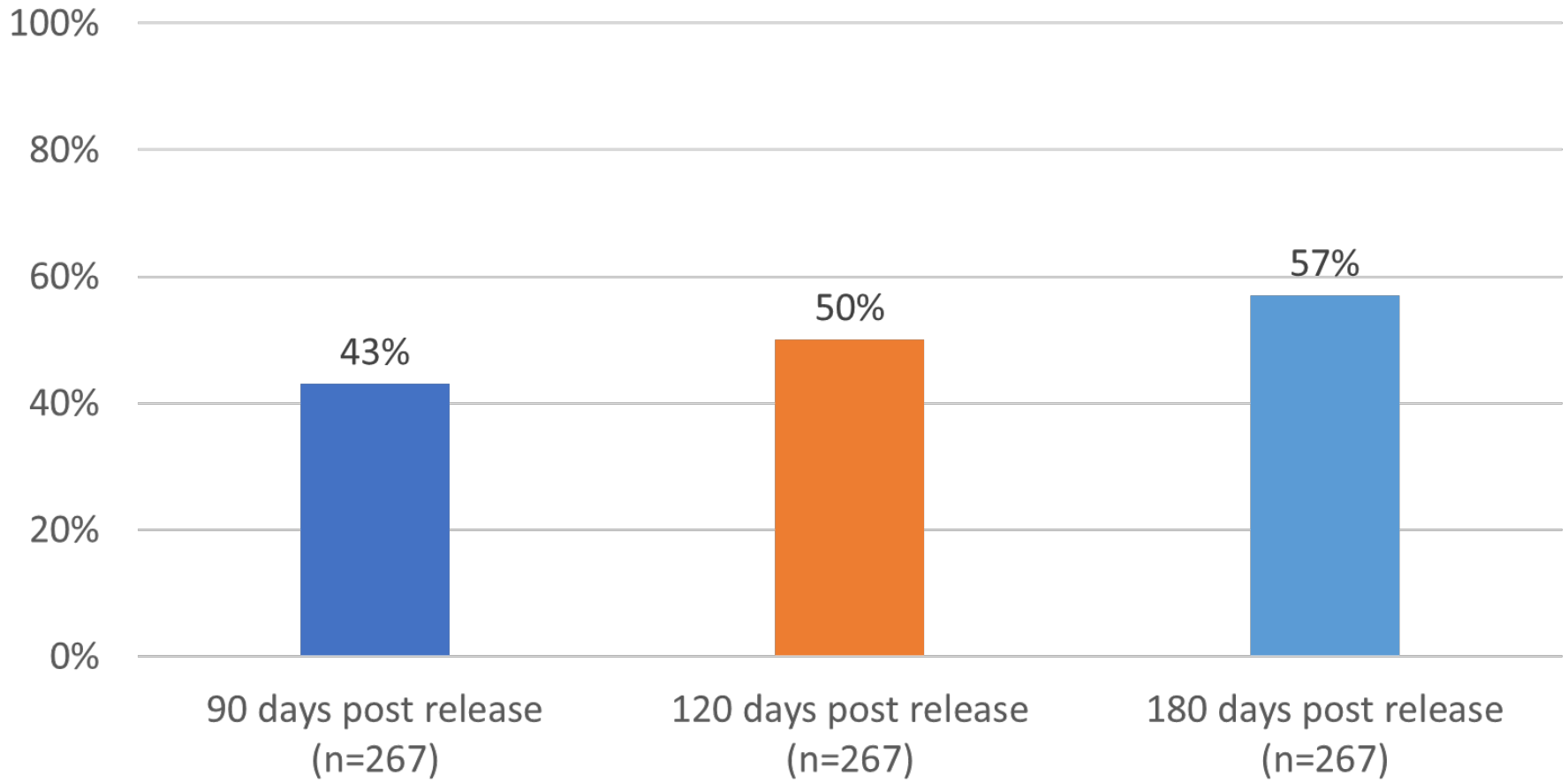
- Enrollment was open between November 1, 2016 – November 1, 2018
- Data was collected between November 1, 2016 – April 30, 2019

Intervention	PWH Consented and Enrolled
TCC	267
Peer	197
Bup	97
Patient Navigation	332

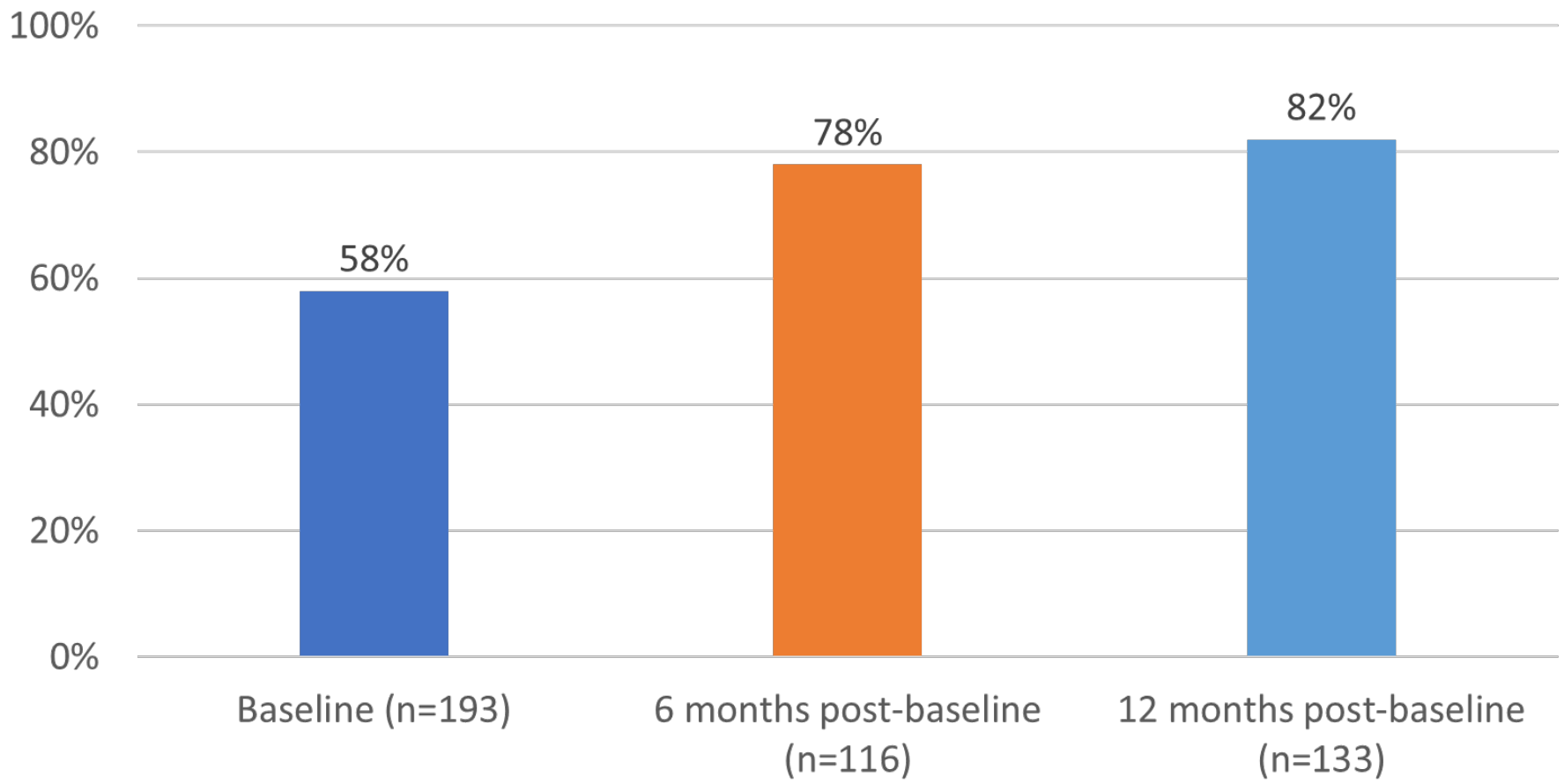
Client Outcomes: Data Collection Sources



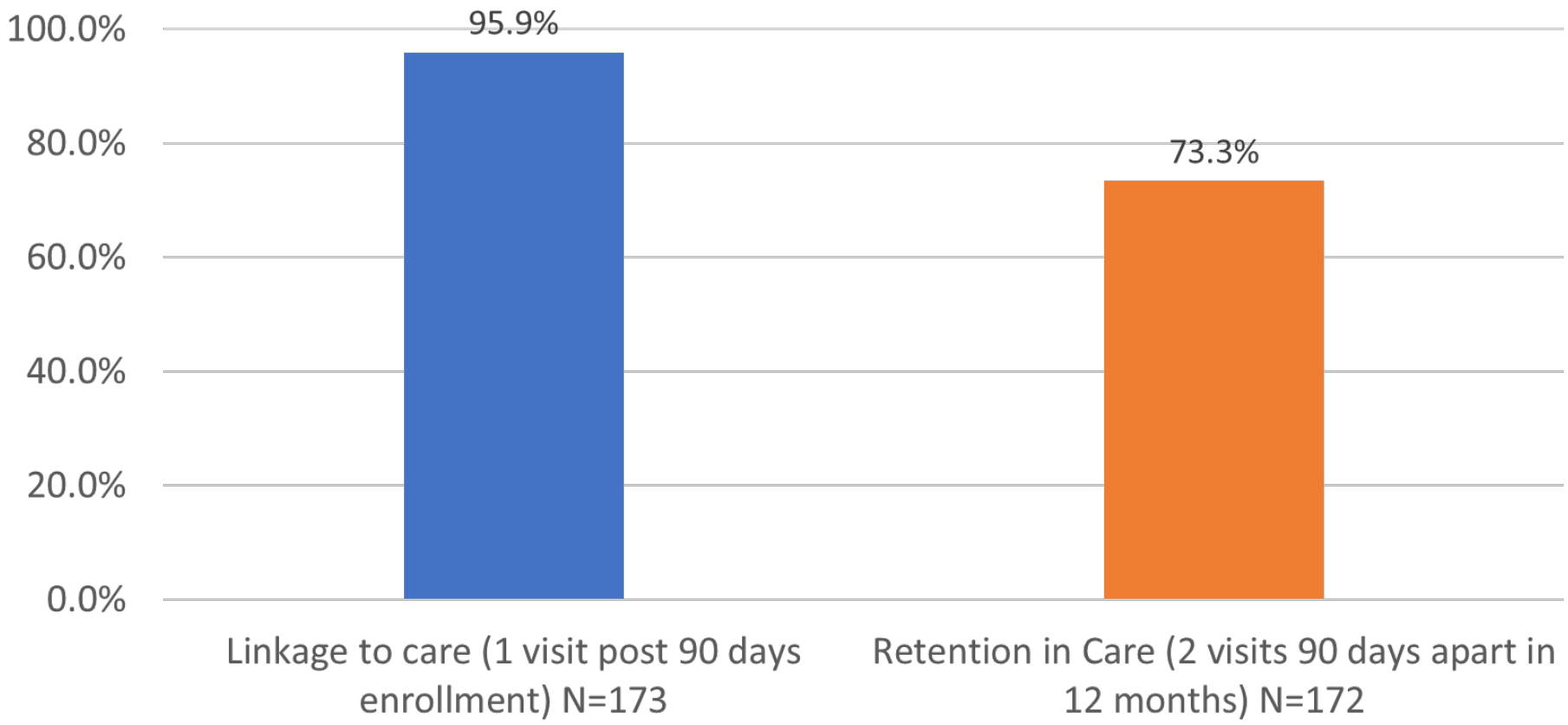
Transitional Care Coordination: Linkage to and Retention in Care



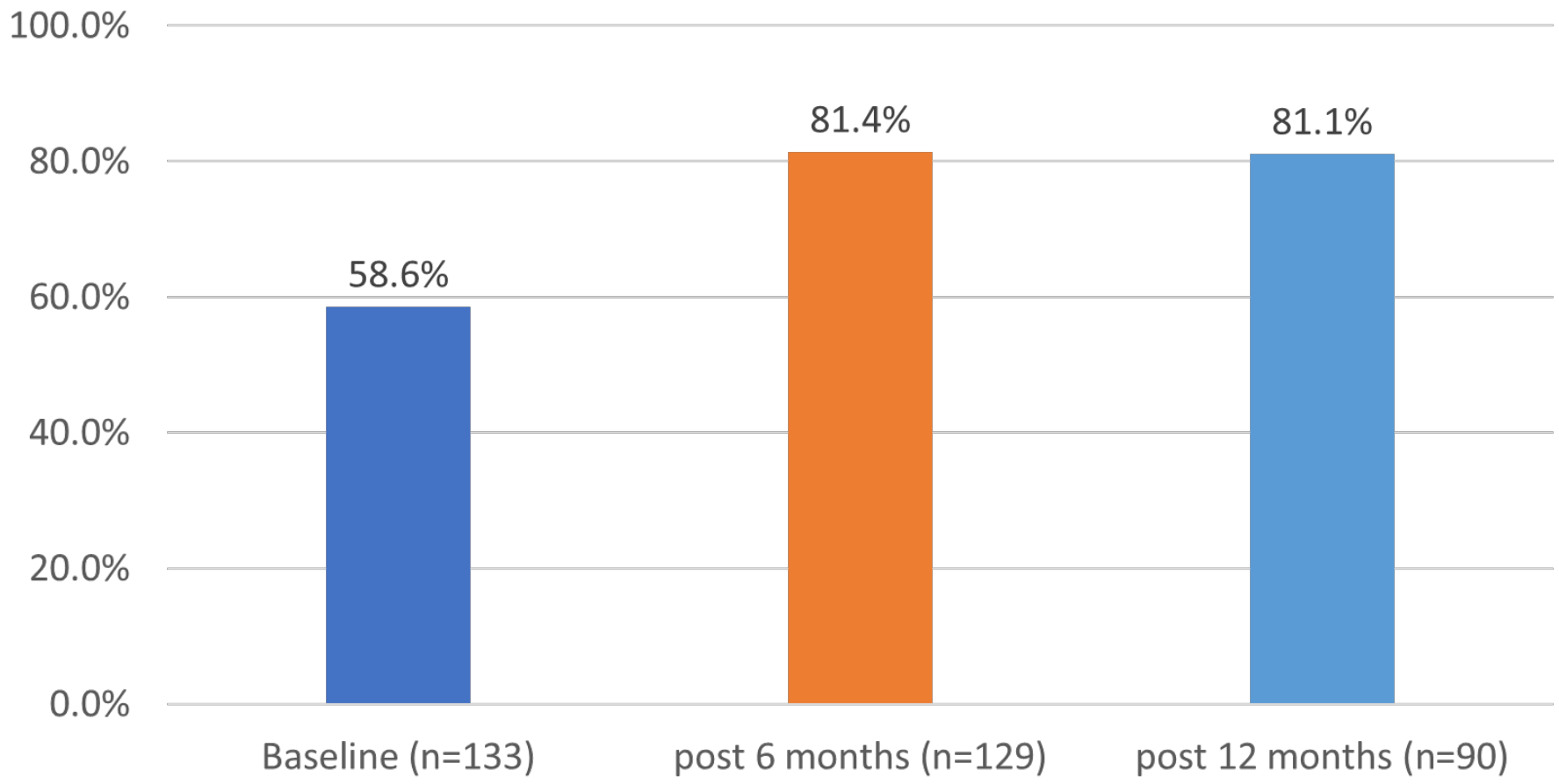
Transitional Care Coordination: Viral Suppression



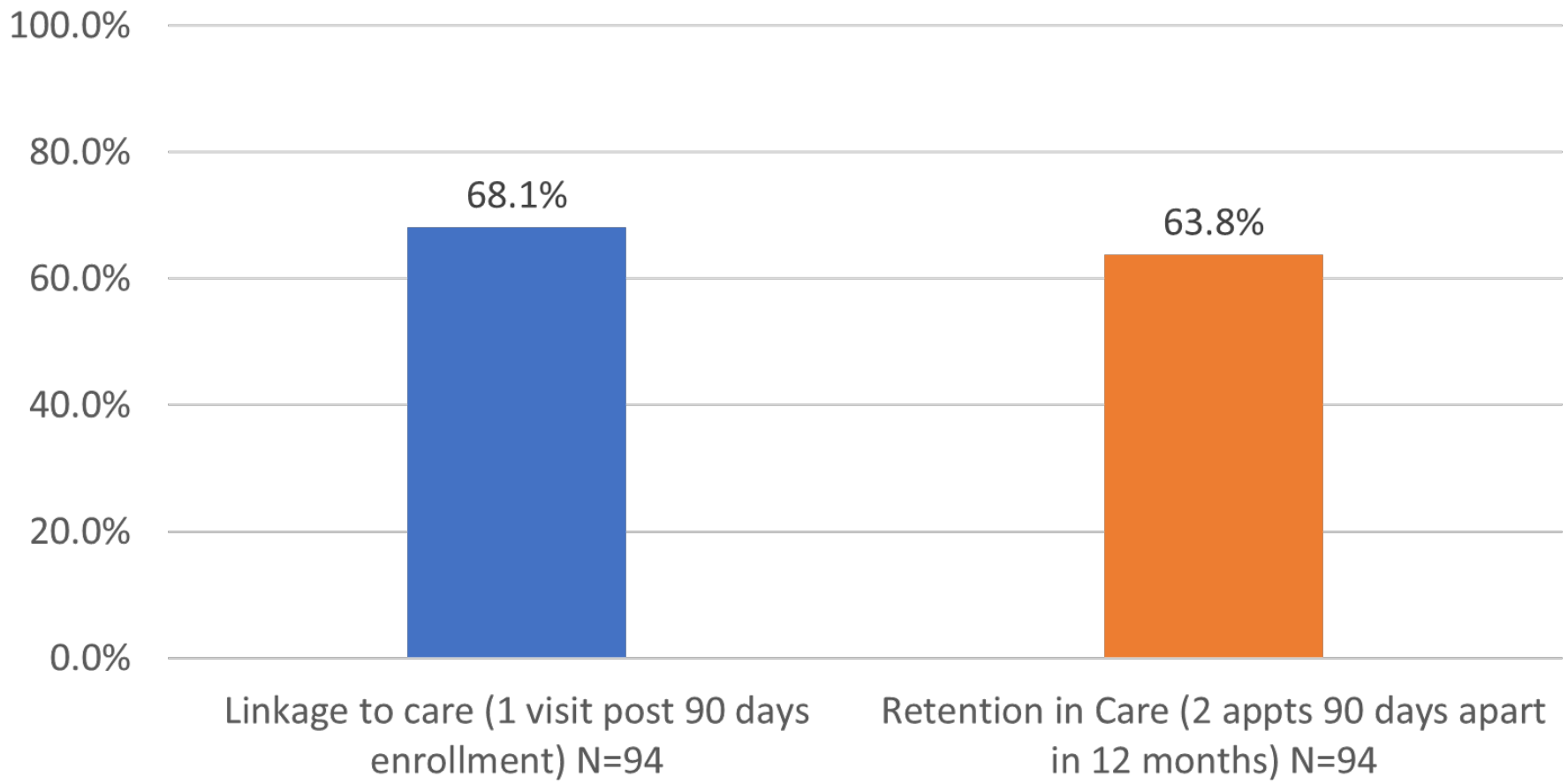
Peer: Linkage to and Retention in Care



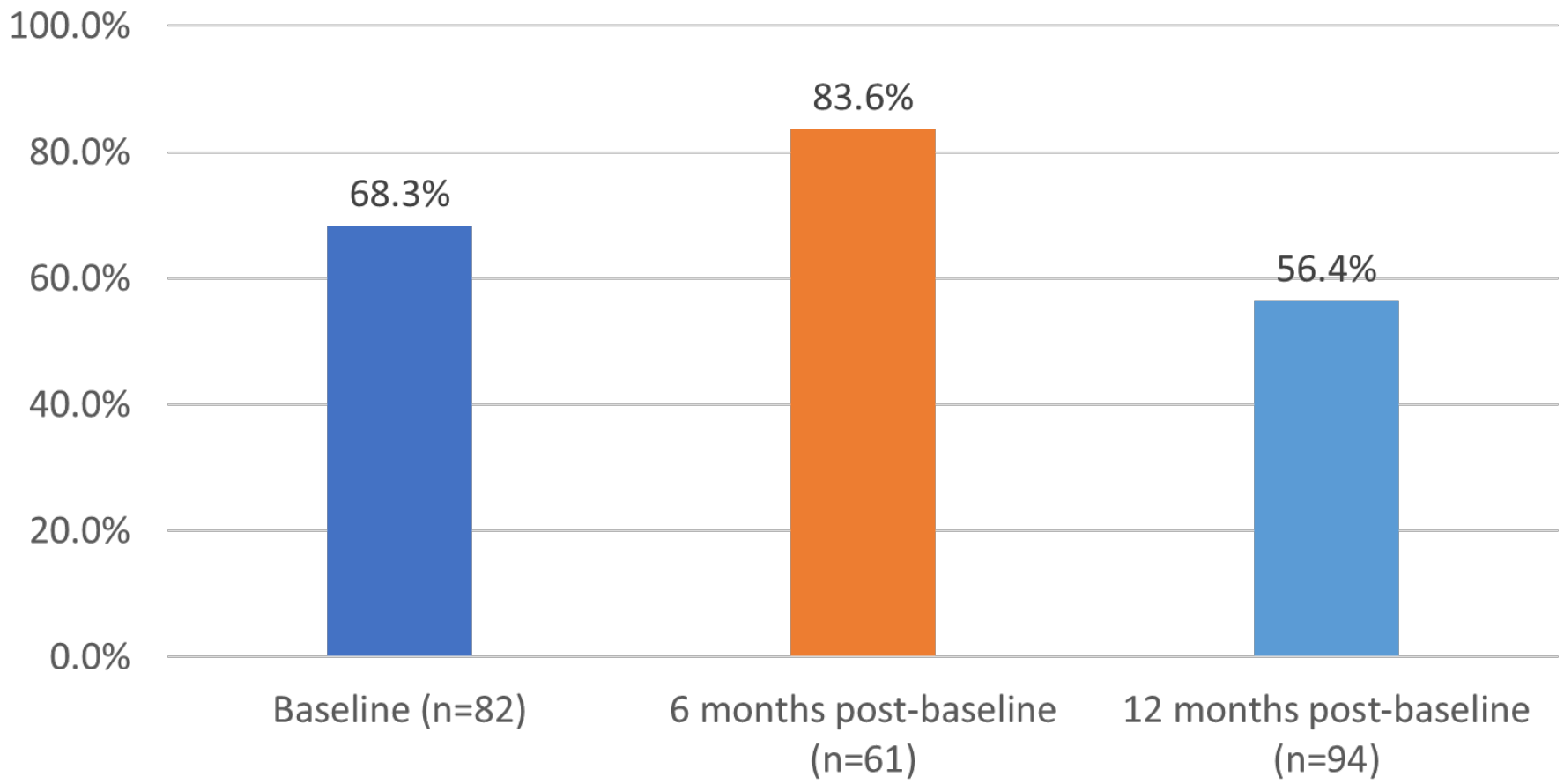
Peer: Viral Suppression



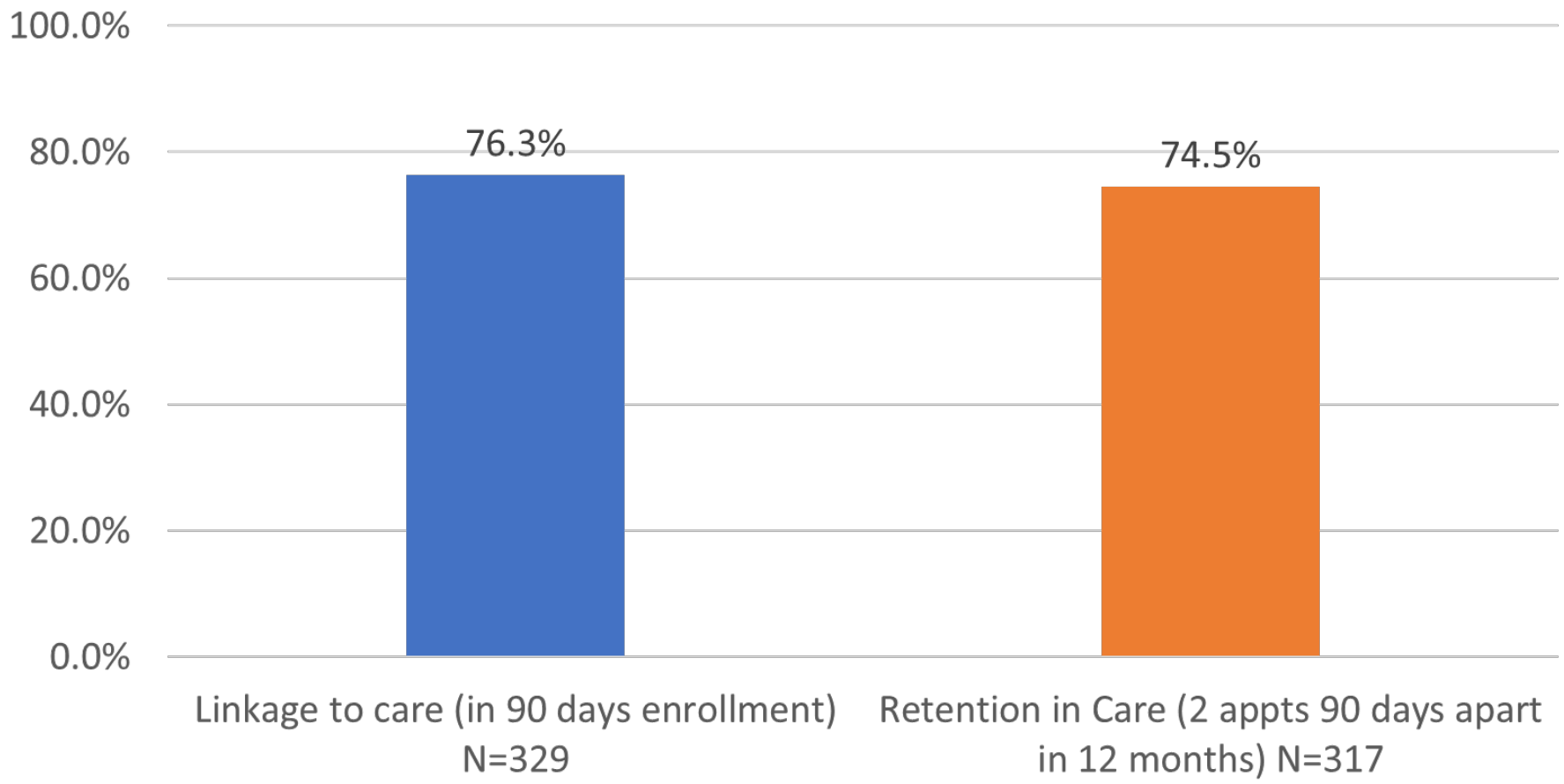
Buprenorphine: Linkage to and Retention in Care



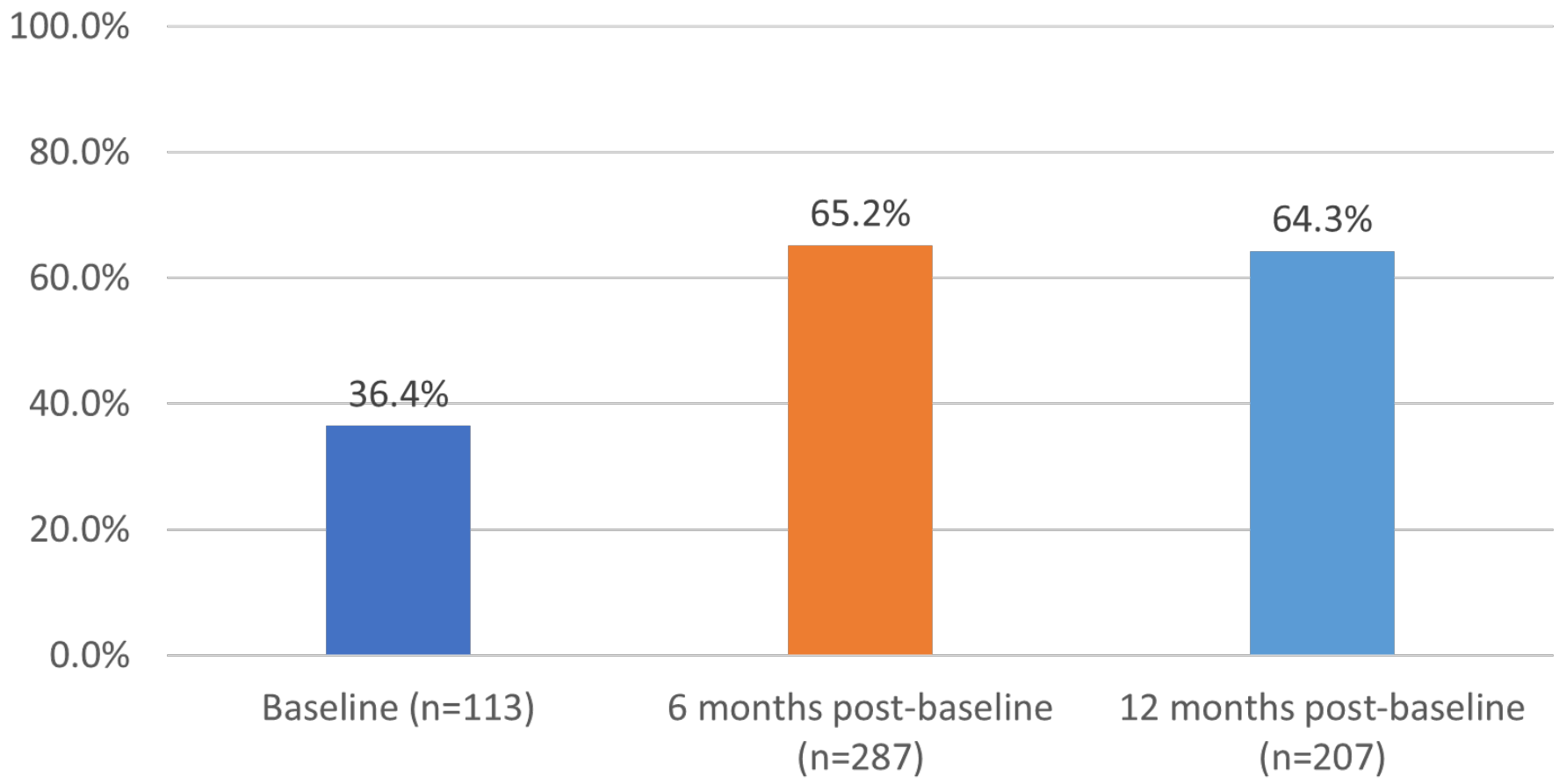
Buprenorphine: Viral Suppression



Patient Navigation: Linkage to and Retention in Care



Patient Navigation: Viral Suppression



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Intervention-Specific Lessons Learned

Lessons Learned: Transitional Care Coordination

Barriers

- Lack of leadership
- Jail specific policies (i.e. release times)
- Changes in policy or programming (i.e. bail reform)

Facilitators

- Strong leadership from clinic administration and supervisors
- Collaborative relationships with the jails from the top down
- Proactive/engaged staff with existing relationships in the jails

Innovative idea: client backpacks

- Backpack is placed into property client is given upon release. Strong relationships are needed with jails in order to get permission to access discharge process and client property.
- We put a pill case in there, like a Monday through Friday, or Monday through Sunday pill case. We put a calendar in there, and we usually write their first appointment in there. We'll put some bus passes, some T-shirts, socks. If we have the hygiene kits available, we will put all of that in there as well. We'll put a discharge plan. And then, now that we have the non-perishables, we'll put whatever we have available. Like we had some shakes, we've had like some chips and crackers and cookies that we've thrown in there.

Lessons Learned: Bup

Barriers

- High-quality intensive behavioral health services are not always available
- Limited physical space
- Co-occurring substance use
- Patient readiness for treatment
- Prior authorizations

Facilitators

- Team communication
- Investment from leadership
- Clinical coordinator moved to a full-time position
- Non-punitive, non-judgmental environments
- Integration within clinic, alleviates burden of other staff

Innovative idea: team approach

- The University of Kentucky Bluegrass Care Clinic used a team approach when meeting with patients.
- Clinical coordinators and prescribing providers met with clients at the same time to streamline communication and care.

Lessons Learned: Peer

Barriers

- Client level
  - Poverty
  - Family matters
  - Immigration related legal matters
  - Transportation assistance
  - Multiple medical needs
- Stigma
- Staff turnover
  - Supervisor and peer level
- Challenges with transition
  - Complex medical and social needs
  - No medical case manager in place especially if services are provided by an outside agency

Relationship building takes times- 4 months was too short!

Facilitators

- Offer and connect to other health care needs
  - Dental care
  - Mammograms
  - Diabetes
- Social support/ education groups
  - Phenomenal Women's group
- Multi-modal recruitment strategies
- Partnerships
  - School programs
  - Linkage with EIS workers
  - MOU with recovery centers for women
  - Correctional facilities
- Self care & professional development

Innovative idea: Phenomenal Women support group

- Support group for women
- Discuss health and factors that impact their quality of live

- " We had a lot of women that came to the group that had been positive for a while and had not disclosed…We talked about their status, we talked about them disclosing to family, to their children. I had a couple of young ladies that hadn't disclosed to family members…we talked about what was best for them, depending on the relationship with them and their family. I have had a couple of clients now that was in the program that went back to school, have jobs.

Lessons Learned: Patient Navigation

Barriers

- Clients are experiencing many challenges
- Transitioning to the SOC is difficult for some clients
- Interest in attending education sessions declines over time

Facilitators

- Engaged and motivated navigators
- Transportation and outreach support
- Clinics with wrap-around services to support clients

Innovative idea: home visits

- Given the large geography of LA County, and the difficulty with getting transportation support, the USC Keck Team took advantage of home visits
- Home visits included conducting education and follow-up support visits with existing clients, and leaving letters from medical providers for clients they were recruiting

DEII Resources

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30 YEARS

[Target HIV Website https://www.targethiv.org/deii](https://www.targethiv.org/deii)

- Intervention Summary
- Implementation Manual
- Training Manual
- Technical Assistance Agenda
- Site Spotlights

Tools for HRSA's Ryan White HIV/AIDS Program

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Dissemination of Evidence-Informed Interventions

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Project Goals and Resources

The end goal of the initiative is to produce and evaluate four evidence-informed Care And Treatment Interventions (CATIs) that are replicable; cost-effective; capable of producing optimal HIV care continuum outcomes; and easily adaptable to the changing health care environment. The multisite evaluation of this initiative will take a rigorous Implementation Science (IS) approach, which places greater emphasis on evaluation of the implementation process and cost analyses of the interventions, while seeking to improve the HIV care continuum outcomes of linkage, retention, re-engagement, and viral suppression among client participants.
Read the HRSA HAB Overview.

The four interventions are:

- Transitional Care Coordination: From Jail Intake to Community HIV Primary Care
- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care
- Peer Linkage and Re-Engagement of HIV-Positive Women of Color
- Enhanced Patient Navigation for HIV-Positive Women of Color

Contact Information

Project Contacts:

Alexis Marbach
Senior Program Manager, Dissemination and Evaluation Center
Boston University School of Social Work, Center for Innovation in Social Work & Health / Abt Associates
Alexis_marbach@abtassoc.com
617-520-3909

Hannah Bryant
Program Associate, Implementation Technical Assistance Center
AIDS United
hbryant@aidsunited.org
202-408-4848 ext. 261

HRSA Contacts:

Corliss D. Heath
Corliss.Heath@hrsa.hhs.gov

Funding:

Funding Mechanism: Cooperative Agreement

Part 2 DEII Institute

- **Wednesday August 12, 2:30-4:00pm**

How to strengthen RWHAP-funded programs and staff to implement and adapt an evidence-informed intervention: Introducing the HRSA/SPNS/DEII Care and Treatment Intervention Training and Implementation Manuals

- Erin Nortrup, LCSW AIDS United
- Alicia Downes, LMSW AIDS United
- Hannah Bryant, MPH AIDS United

Other DEII Presentations

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Site	Title	Type	Time/date	Presenters
Centro	Continuum of Care in the Wake of a Natural Disaster: The Role of Emergency Planning for Effective Opioid Treatment and HIV Care	Poster	August 12, 4:00 -4:25 pm ET	Hannah Bryant, Romano Baroni
Bup-Cohort	Clinical Coordinators: The Key to Your Medication-Assisted Therapy (MAT) Team in HIV Primary Care Settings	Presentation	August 13, 12:45-2:15 pm ET (first 30 minutes of grouped workshop)	Hannah Bryant, Alexis Marbach, Diana Ball, Jason McMinn, Delgia Cruz Torres, Ann E. Gonzalez, Kristen Meyers, Corliss Heath
Peer-Cohort	Implementing an Interdisciplinary Team Approach to Engage Women of Color in HIV Care and Treatment	Presentation	August 14, 12:45-2:15 pm ET	Serena Rajabiun, Alicia Downes, Allison Byrd, Lasheena Miller, LeSherri James, Tamiko Grimes
TCC-cohort	Outcomes of a Transitional Care Coordination Intervention Linking PWH in Jails to Community HIV Care and Services	Presentation	August 13, 9-10 am ET	Jane Fox, Hannah Bryant
TCC-cohort	Replication of the Transitional Care Coordination (TCC) Intervention to Improve Outcomes Across the HIV Care Continuum	Presentation	August 12, 12:45-2:15 pm ET *this is a grouped session; TCC will have 45 minutes of the time slot*	Jane Fox, Hannah Bryant, Claire Farel, Cheryl Betteridge

Contact Information

Presenters:

DEC PI:

- Serena Rajabiun, Rajabiun@bu.edu

DEC Co-PI:

- Jane Fox, jane_fox@abtassoc.com

DEC Team Members

Core Team Members:

- Serena Rajabiun, PI
- Jane Fox, Project Director and Site Liaison
- Alexis Marbach, Project Manager and Site Liaison
- Ellen Childs, Site Liaison
- Marena Sullivan, Project Coordinator
- Howard Cabral, Biostatistician
- Clara Chen, Data Management
- Karen Fortu, Data Management

Intervention-Specific Consultants:

- Transitional Care Coordination:
  - Alison Jordan
  - Jackie Cruzado
- Buprenorphine
  - Chinazo Cunningham
  - Paula Lum
- Patient Navigation and Peer Linkage
  - Janet Myers
  - Janet Goldberg
- Communications
  - Sarah Cook-Raymond and Impact Marketing + Communications

References

- Breitenstein, S. M., Gross, D., Garvey, C. A., Hill, C., Fogg, L., & Resnick, B. (2010). Implementation fidelity in community-based interventions. *Research in Nursing and Health, 33*, 164-173.

- Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science, 2*(40). doi: 10.1186/1748-5908-2-40

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- Wojewodka, G., Hurley, S., Taylor, S. J. C., Noble, T. J., Ridsdale, L., & Goldstein, L. H. (2017). Implementation fidelity of a self-management course for epilepsy: Method and assessment. *BMC Medical Research Methodology, 17*, 1-10. doi: 10.1186/s12874-017-0373-x

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