2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Applying Implementation Science to a Multi-Intervention, Multi-Site Study Linking and Retaining People Living With HIV in Care

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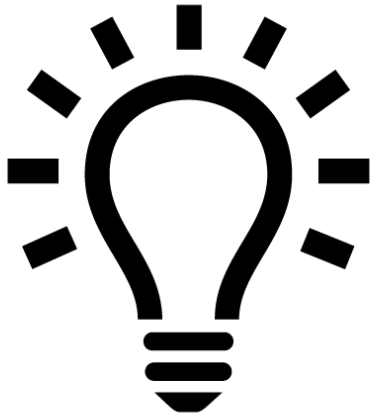
Supported by grant #U90HA29236, "Dissemination of Evidence Informed Interventions", though the U.S. Department of Health and Human Services Administration's HIV/AIDS Bureau

Project Background

- Five-year Cooperative Agreement to Boston University with HRSA's Special Projects of National Significance (SPNS)
- Replicates best practices identified in four previously implemented SPNS initiatives

AIDS United: Implementation and Technical Assistance Center (ITAC)

Select & Fund 12 Sites

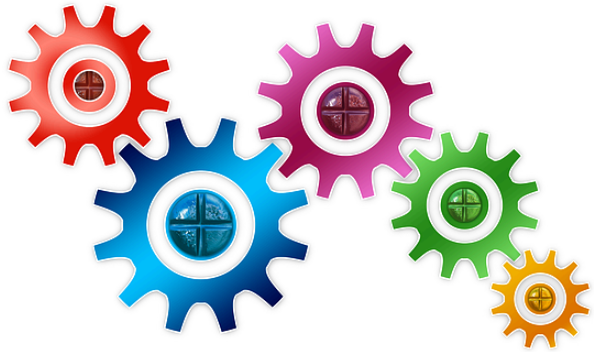


Provide TA

Coordinate Experts

Boston University: Dissemination and Evaluation Center (DEC)

- Adapt and design 4 intervention models for replication.
- Design and implement multi-site evaluation
- Studying both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publish and disseminate final adapted interventions and study findings



DEC Team Members

Current Team Members:

- Serena Rajabiun, PI and Site Liaison
- Jane Fox, Co-PI and Site Liaison
- Alexis Marbach, Project Manager and Site Liaison
- Ellen Childs, Site Liaison
- Howard Cabral, Biostatistician
- Clara Chen, Data Management
- Marena Sullivan, Research Assistant

Past Team Members

- Brena Sena, Research Assistant
- Sally Bachman, Evaluation Advisor
- Mari-Lynn Drainoni, Implementation Science Advisor

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 (Communications)

DEC Project Timeline

- Year 1: Design of implementation manuals and evaluation materials for the adapted interventions (data collection tools and evaluation plan), site selection, pre-implementation at the site level

- Years 2-4: Site-level implementation of adapted intervention and evaluation activities, ITAC implementation of training and technical assistance activities, DEC implementation of implementation science activities

- Year 5: DEC data analysis, publication and dissemination, producing revised implementation manuals (CATIs: **C**are **a**nd **T**reatment **Interventions**)

Timeline of Year 1

Grant awarded

Kick off meeting with Boston University (DEC) and AIDS United (ITAC) held at HRSA

Oct. 2015

Adapted intervention summaries produced

DEC team works with consultants to produce and finalize summaries for each intervention

Nov. - Dec. 2015

Implementation plans produced

DEC team works with consultants to produce and finalize implementation plans (including staffing plan, logic model, and workplan) for each intervention

Jan. - Feb. 2016

Implementation manuals produced

DEC team works with consultants to produce implementation manuals for each intervention

Feb. - March 2016

Evaluation tools and plan produced

DEC and consultant team develop evaluation tools and plan (using an IS approach)

Jan. – July 2016

Site selection

ITAC, DEC, and HRSA meet to select Peer, PN, and TCC sites in April, and Buprenorphine sites in May

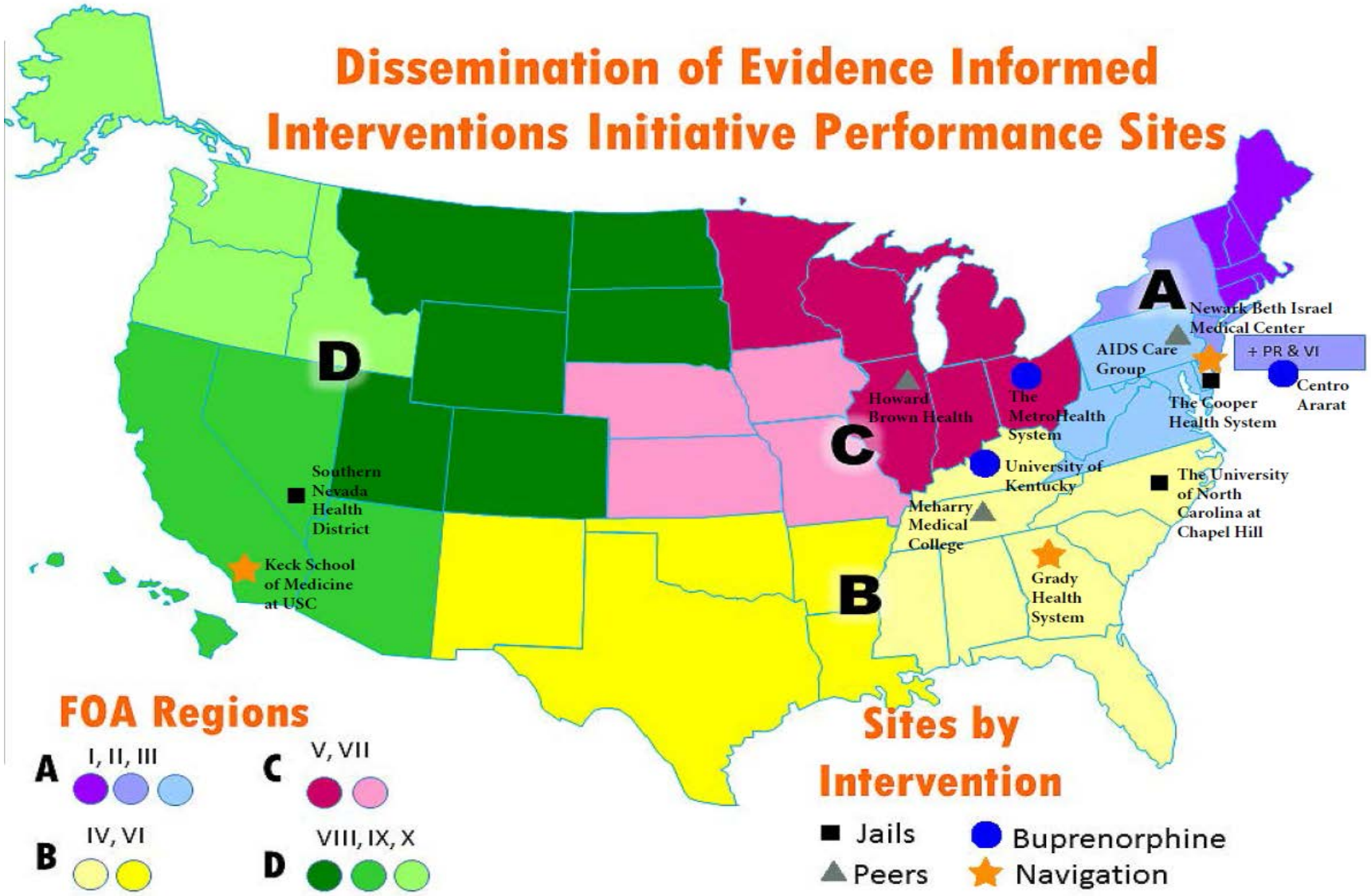
April – May 2016

Sites awarded pre-implementation funding

Sites funded for a three- month formative phase to complete hiring, training, and systems readiness activities

June 2016

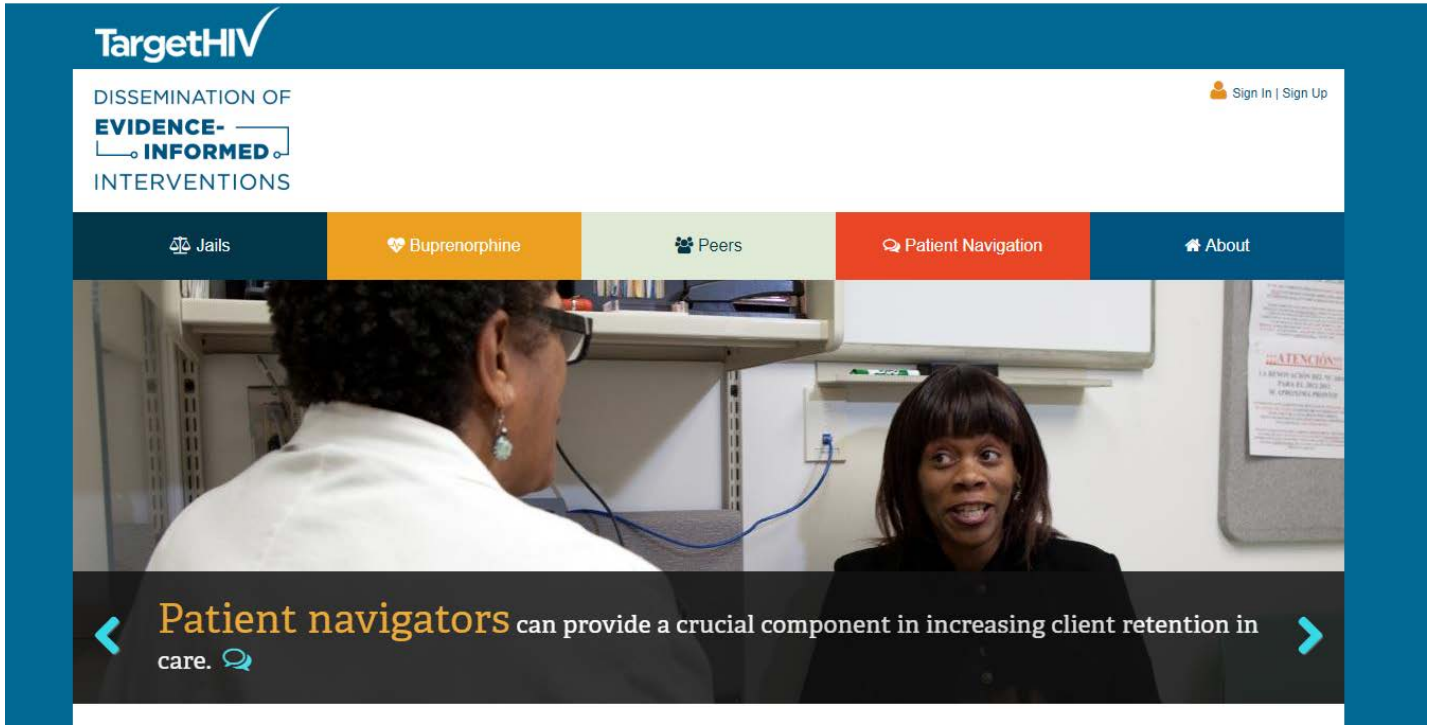
Interventions


Dissemination of Evidence Informed Interventions Initiative Performance Sites
A
B
C
D
Newark Beth Israel Medical Center
AIDS Care Group
+ PR & VI
Centro Ararat
The Cooper Health System
Howard Brown Health
The MetroHealth System
University of Kentucky
Meharry Medical College
The University of North Carolina at Chapel Hill
Grady Health System
Southern Nevada Health District
Keck School of Medicine at USC
FOA Regions
A I, II, III
B IV, VI
C V, VII
D VIII, IX, X
Sites by Intervention
Jails
Peers
Buprenorphine
Navigation

Materials Available at TargetHIV.org

Adapted intervention summaries and draft implementation manuals are available at:

https://nextlevel.targethiv.org/



What are your evaluation priorities?

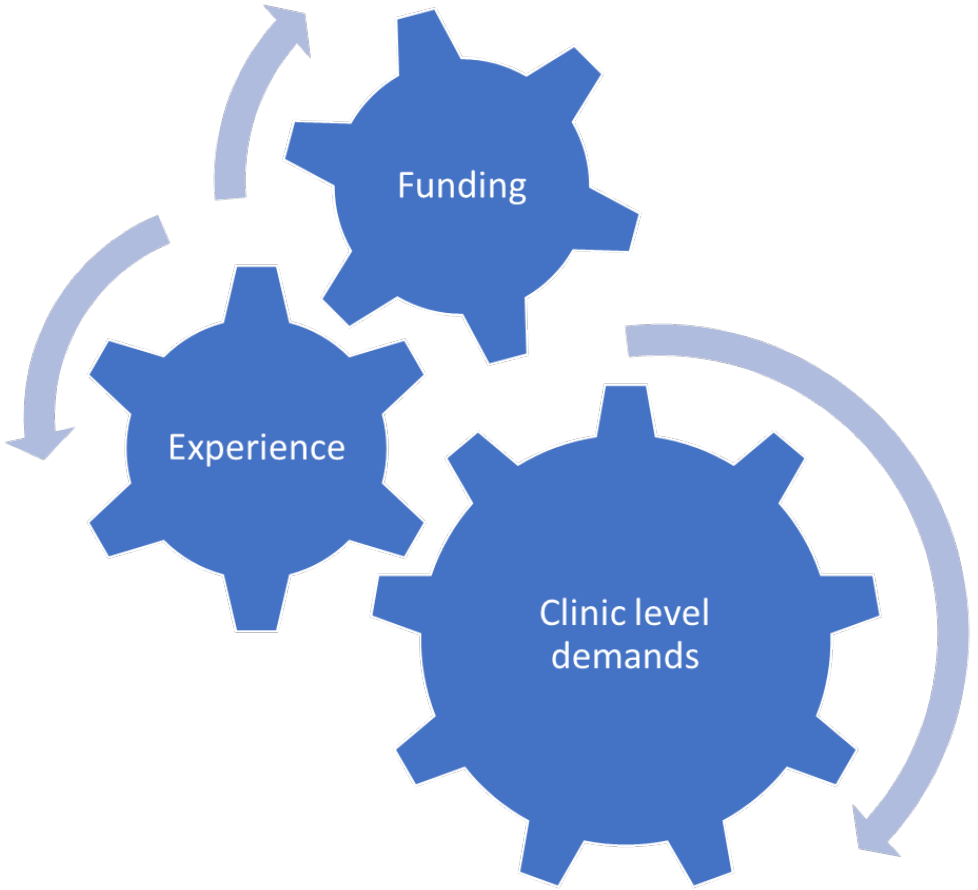
Implementation

- Process of implementation

Outcomes

- Patient-level Outcomes
- Viral Load
- CD4

What are the drivers of your evaluation work?



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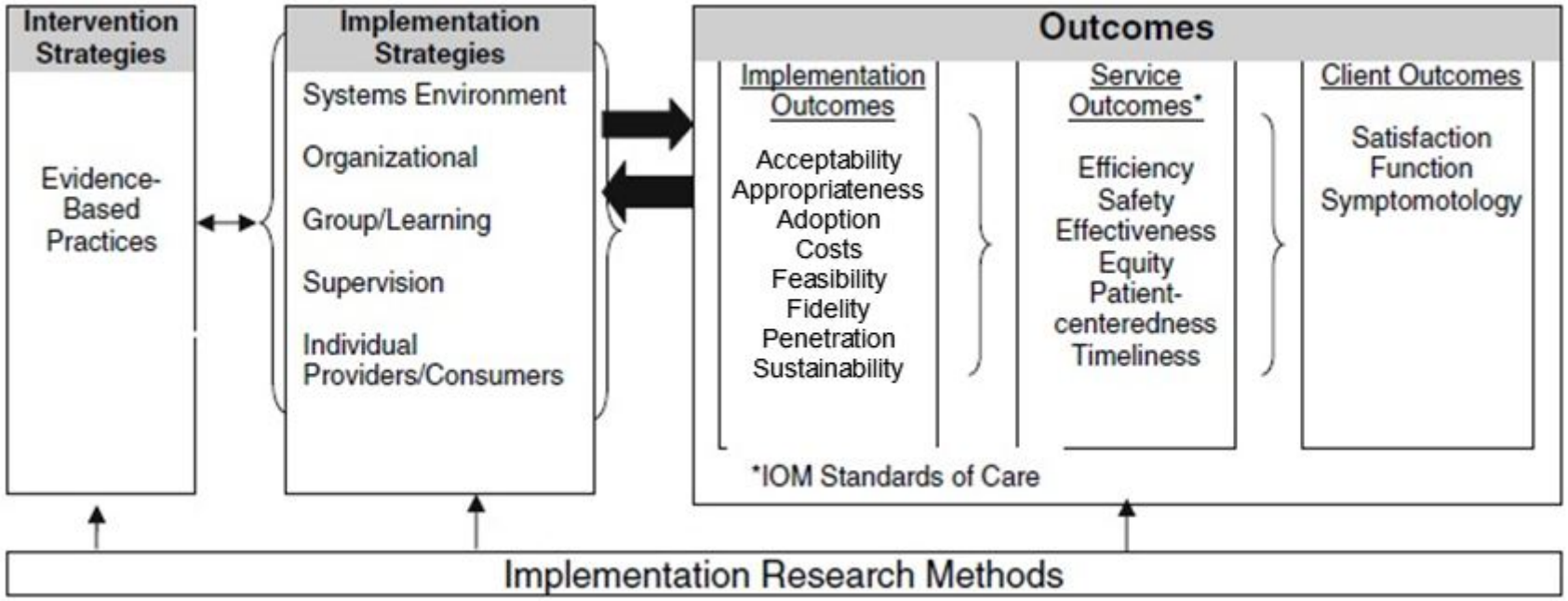
Implementation Science: A shift in perspective

Implementation Science Approach: Proctor Model



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? (*note – this is a merger of penetration and sustainability

Proctor Model in Action

Imagine this scenario: Alexis is making a new year's resolution to go to bed earlier.

Her plan is to:

- Shut off all devices by 8 pm
- Have a cup of sleepytime tea between 8 and 9 pm
- Be in bed at 9 pm with the lights off by 9:30

She plans on following this exact plan EVERY NIGHT for 30 days.

Assessing Implementation in Your Setting

- Break into pairs

- Take turns assessing a project you are implementing at your organization through the Proctor Model lens

How the DEC team implemented this approach

Implementation Data Collection Sources

Organizational Readiness to Change Assessment (ORCA)

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…

- Better sense of players within the clinic
- All intervention staff hired
- Conduct follow-up

Encounter Forms

- Filled out by the interventionists

Knowing what we know now…

- Pre-test with intervention staff or engage intervention staff in design
- Bin “other” category on a routine basis

Locations of encounter(s): Check all that apply.

- [x] Client residence (permanent or non-permanent residence)
- [ ] Intervention clinic
- [ ] Medical, social service, or community based organization setting (external to intervention site). If yes, name:
- [ ] Correctional setting
- [ ] Other (specify):
- [ ] N/A (not face-to-face)

Type of Contact

Face-to-face (Individual)	1
Electronic (email, text, phone, fax)	2
Collateral (client not present)	3
EMR	4
Other	5

Encounter content:

For each encounter that you had with a client in the course of one day, use the columns to the right to enter the type and duration of each type of encounter using the codes above. For example if you took a client to a medical appointment that lasted 1 hour-enter "1" in the "Type" column and "60" in the "duration" column next to the content. Please mark all types of encounters and duration of each type of encounter for the entire day.

Completed?	Encounter Activity	Type	Duration (minutes)
[x]	1. Find client/conduct outreach	1. Face-to-face (Indi	10
[ ]	2. Conduct client intake and/or needs assessment	Please select	0
[ ]	3. Develop a patient care plan	Please select	0
[ ]	4. Conduct acuity assessment	Please select	0

Top Reported Encounters

Transitional Care Coordination

- Relationship building
- Conducting client intake or needs assessment
- Discussing medical appointments with clients
- Arranging HIV primary care appointments
- Finding clients and conducting outreach

Peer Linkage and Re-Engagement

- Relationship building
- Providing coaching on living skills
- Providing appointment reminders
- Discussing medical appointments with clients
- Providing HIV treatment education and support

Top Reported Encounters

Enhanced Patient Navigation

- Relationship building
- Providing appointment reminders
- Conducting client intake and/or needs assessment
- Patient Education Session 1: HIV, the Viral Life Cycle, and Understanding ART
- Patient Education Session 2: Communicating with Providers, Adherence, and Managing Side Effects

Integration of Buprenorphine

- Relationship building
- Conducting monitoring appointment
- Developing a patient care plan
- Conducting client intake and/or needs assessment
- Follow up with provider to discuss client

Monthly Site Forms and Site Visit Reports

Monthly site forms:

- Sites complete a form each month to collect data on implementation, staffing changes, local dissemination, de-identified case studies, and dissemination and sustainability efforts. As of December 5, we've collected **299** monthly forms.

Site Visit Reports

- Completed by the sites prior to each site visit to frame the conversation. Finalized by the ITAC and DEC post site visit

Knowing what we know now…

- Create an online form (vs. using a word document)

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…

- We’re still learning! We are currently in the process of collecting these interviews.

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

1. 30% of clients who have consented to being recorded are randomly selected to be recorded
2. Interventionists record every interaction they have with selected clients
3. Interventionists have 72 hours to upload recordings to the data system
4. 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 the quality of the client-interventionist interaction
- Measuring fidelity in a non-scripted intervention

Facilitators:

- Maintaining detailed notes of the interaction to measure quality
- Training audio recording reviewers

Cost study

Payer perspective: Does not include societal costs for client time and preferences

Start-up & Recurrent annual costs: Program only, excludes Study evaluation costs

Standardized spreadsheet with cost elements

- Personnel
  - Includes data management time for out of care list
  - Medical personnel as relevant for intervention
- Overhead rates
- Direct costs (transportation, staff-client communication expenses, tangible reinforcements, printing for materials)
- Facilities/space as necessary

Cost study

Intervention encounter forms

- Document the number of contacts
- Direct staff and collateral contacts

Cost per contact

Cost per outcomes linked to HIV care continuum

- Cost per linkage to care
- Cost per retention in care
- Cost per viral suppression

Lessons Learned: Collecting Implementation Science Data

- Important to have a firm evaluation plan and a shared-knowledge with all team members to execute the various tasks
- Team needs training on the implementation science approach to know what to look and listen for on calls, in email exchanges, and during site visits, and what kind of follow-up questions should be asked back to the sites
- Strong relationships with sites facilitates data collection
    - Sites will only share their barriers and facilitators to implementation if they trust that they will be supported regardless of the information they share

Pre-implementation Data

Pre-implementation data:

- Organizational Readiness to Change Assessment (ORCA)
- Monthly monitoring call forms
- Site visit reports

Pre-implementation Lessons Learned

- Staff turnover is challenging for the sites and for the individual interventionists. Once the in-person training opportunity has passed (convening), onboarding new staff is labor and resource intensive.
- In future iterations of the manuals, include more customizable tools such as clinic assessments, workflow diagrams.
- Training topics that should be addressed in future iterations of the interventions prior to implementation: boundary setting, confidentiality, trauma informed care, vicarious trauma, harm reduction, motivational interviewing

Pre-implementation Lessons Learned: Transitional Care Coordination

Facilitators of successful implementation:

- Strong leadership from clinic administration and supervisors
- Existing collaborative relationships with the jails
- Proactive and engaged staff that have existing relationships with the jails

Barriers to implementation:

- Lack of leadership
- Policies specific to each jail setting (for example, people being released from the jail in the middle of the night)

Pre-implementation Lessons Learned: Integration of Buprenorphine

Facilitators of successful implementation:

- Overwhelming need for this service due to the epidemic
- Commitment and engagement from all intervention team members and clinic leadership

Barriers to implementation:

- Issues with prior authorizations persist
- Barriers to creating collaborative relationships (historical RW funding cuts)
- Stigma of accessing substance abuse treatment in smaller communities, geographic barriers (urban clinic treating patients from rural areas)

Pre-implementation Lessons Learned: Patient Navigation

Facilitators of successful implementation:

- By being part of larger clinic settings, the PNs have large out of care lists to draw from

Barriers to implementation:

- PNs are serving clients with high acuity and are having to address basic needs as priority and patient education sessions having to wait until these needs are addressed. If the level of acuity of clients seen continues to be relatively high, we'll want to monitor for when the patient education sessions are being completed.
- EMR and technology access
- Transitioning to SOC (Roles of the PN)

Pre-implementation Lessons Learned: Peers

Facilitators of successful implementation:

- Clinical supervisor role/ provision of clinical supervision

Barriers to implementation:

- Administrative (HR policies related to job description; peer readiness; compensation and balancing issues around disability benefits and disclosure; difficult to fill the peer positions)
- Dedicated space
- Variation among the experiences/professional backgrounds of the peers
- Comfort with documentation
- Challenges with patient recruitment –out of care list

Implementation Lessons Learned

Implementation Lessons Learned: Transitional Care Coordination

- Sites with strong implementation teams and strong leadership have been able to smoothly weather staff turnover/transitions.

- The intervention requires constant tending to the relationship with the jail (admin, medical, and officers). Staff turnover within the jail setting can impact intervention staff.

- Adaptations have been necessary to “fit” the model into each setting.

- Post release challenges are many and addressing them is key to retaining clients in HIV care. Challenges include: homelessness/unstable housing, mental health disorders, substance use disorders, transportation, and ongoing engagement with the criminal justice system.

Implementation Lessons Learned: Integration of Buprenorphine

- Enrollment is dependent on provider and clinical coordinator capacity.

- The landscape of MAT is constantly changing, and it is important for sites to have a champion/advocate to make sure they are “at the table” for conversations about expanding MAT within their clinic/local area.
    - State and local regulations will be important to factor in to future implementation efforts.
    - Access to multiple forms of MAT, as opposed to focusing on buprenorphine, may be necessary as providers assess which treatment options may best facilitate their patients’ success.
    - Access to MAT for people not living with HIV is a concern, as partners or family members’ opiate use can impact patients’ success.

Implementation Lessons Learned: Integration of Buprenorphine

- The role of the clinical coordinator needs to have its own implementation materials/manual.
    - Clinical coordinators have coordinated group therapy sessions, in addition to individual counseling, which can support patients in establishing sober support systems.

- Barriers to implementation include stigma of accessing substance use treatment in smaller communities, geographic barriers (urban clinic treating patients from rural areas), and prior authorization challenges.

Implementation Lessons Learned: Patient Navigation

- Co-located services improve service delivery and client retention (comparison between USC Keck and Grady).
- Onboarding and hiring of the patient navigators is key to success.
    - Access to EMRs makes PNs more efficient and effective, and elevates their role on the clinical team.
    - Includes tending to professional development of the PNs throughout the initiative.
- It takes time to build relationships and to build trust.
- Patients with high acuity need to have basic needs addressed prior to initiating the patient education session. PNs need to be flexible with their timelines and need to establish healthy boundaries while engaging with patients and then when transitioning patients to the standard of care.

Implementation Lessons Learned: Peers

- Strong clinic leadership and an internal champion are necessary for initial launch as well as navigating potential challenges in implementation.

- Hiring and onboarding of peers is key to success.
  - Including supporting staff transition from state and federal benefits to full-time employment.
  - Peer teams need continuous support and training to engage hard to reach women.

- Case management needs to be in place prior to implementation.

Implementation Lessons Learned: Peers

- Clear, strong, and consistent communication between team members and the larger clinic team is crucial to working with women who are at risk for falling out of care or have struggled to link.

- Mobility outside of the clinic is an effective strategy for finding and engaging with clients.

- Transportation assistance is crucial to help clients get to appointments and meetings with Peers.

Next Steps for DEII

Nov 1, 2018	Last day to enroll clients in the multi-site evaluation
April 30, 2018	Data collection ends
Starting February 2019	Analysis of patient outcomes
Starting Fall 2018	Analysis of implementation findings
Starting Fall 2018	Adaptation of the implementation manuals for the four intervention models
Starting Summer 2020	Dissemination of the revised implementation models

Questions?

Questions to the group

What makes you excited about using this approach?

What are your reservations about using this approach?

Contact Information

Presenters:

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