Dissemination of Evidence-Informed Interventions

August 27, 2018
Welcome from the HRSA HIV/AIDS Bureau
HIV/AIDS Bureau Vision and Mission

**Vision**
Optimal HIV/AIDS care and treatment for all

**Mission**
Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV and their families
HRSA Welcome and Overview

• Funded in 2015 by the Health Resources and Services Administration, Special Projects of National Significance.

• Studies the implementation of four previously evidence-informed SPNS/Secretary’s Minority AIDS Initiative Fund (SMAIF) funded interventions.

• Follows a rigorous implementation science approach.

• Places emphasis on evaluation of the implementation process and cost analyses of the interventions.

• Seeks to improve the HIV Care Continuum outcomes of linkage, retention, re-engagement, and viral suppression among client populations.

• Aligns with this administration and HRSA HAB priorities of:
  • Increasing Collaboration;
  • Promoting Innovations;
  • Increasing Efficiencies; and
  • Strengthening Well-being Across the Life-Span
Office of HIV/AIDS Training & Capacity Development (OTCD)

- Harold Phillips, Director, Office of Training and Capacity Development, HPhillips@hrsa.gov

- April Stubbs-Smith, Director of the Division of Domestic Programs, Astubbs-smith@hrsa.gov

- Adan Cajina, SPNS Branch Chief, ACajina@hrsa.gov

- Corliss D. Heath, Health Scientist/ DEll Project Officer, CHeath@hrsa.gov
Welcome from the Dissemination of Evidence-Informed Intervention Initiative Dissemination and Evaluation Center
Dissemination and Evaluation (DEC) Team

**Site specific contacts:**
- Transitional Care Coordination:
  Jane Fox, jane_fox@abtassoc.com
- Peer Linkage and Re-engagement:
  Serena Rajabiun, rajabiun@bu.edu
- Enhanced Patient Navigation:
  Ellen Childs, echilds@bu.edu
- Integration of Buprenorphine:
  Alexis Marbach, alexis_marbach@abtassoc.com

**Team members:**
- Sally Bachman, PI, sbachman@bu.edu
- Howard Cabral, Biostatistician, hjcab@bu.edu
- Clara Chen, Biostatistics and Epidemiology Data Analytics Center, cachen@bu.edu
- Marena Sullivan, Research Assistant, marenas@bu.edu
DEC Intervention-Specific Experts

Transitional Care Coordination: Alison Jordan and Jacqueline Cruzado-Quiñones

Peer Linkage and Re-engagement, Enhanced Patient Navigation: Janet Myers and Janet Goldberg

Integration of Buprenorphine: Chinazo Cunningham and Paula Lum
DEII Initiative Overview

• Replicates 4 previously-implemented SPNS initiatives with the goal of creating Care and Treatment Interventions (CATIs).
  – CATIs will be able to be implemented in HIV care settings across the country without the support of an implementation and evaluation training and technical assistance team.

• This multi-year initiative, led by AIDS United and Boston University, represents the first attempt to bring innovative SPNS-supported interventions to scale across the field.
Interventions Being Replicated

1. **Transitional Care Coordination**
   - From Jail Intake to Community HIV Primary Care

2. **Peer Linkage and Re-Engagement of HIV-Positive Women of Color**

3. **Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care**

AIDS United

Implementation and Technical Assistance Center (ITAC)

Select & Fund 12 Sites

Provide TA

Coordinate Experts
Implementation Technical Assistance Center (ITAC) Team

- Alicia Downes, Senior Program Manager, AIDS United
- Hannah Bryant, Program Manager, AIDS United
- Joseph Sewell, Program Associate, AIDS United

ITAC Intervention-Specific Experts

Transitional Care Coordination: Alison Jordan and Jacqueline Cruzado-Quiñones

Peer Linkage and Re-engagement: Simone Philips and LaTrischa Miles

Patient Navigation: Linda Scruggs and Vanessa Johnson

Integration of Buprenorphine: Mike MacVeigh and Kristen Meyers
Dissemination and Evaluation Center (DEC) Team

• 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
Building Towards Implementation

• **Adapted Intervention Summaries:** Intervention Summary, Literature Review, Theoretical Basis, Intervention Components, Programmatic Requirements, Staffing Plan, Costs, Resources

• **Implementation Plan:** Logic Model, 3-year Work Plan, Staffing Plan, Job Descriptions, Budget

• **Implementation Manual:** Step-by-step Implementation Guide
Intended for organizations and agencies considering strengthening connections between community and jail health care systems to improve continuity of care for HIV-positive individuals recently released from jails.

Designed to implement a new linkage program to support their care retention and engagement post-incarceration and as they re-enter the community.
TCC Intervention Overview

• **Target population:** HIV-positive individuals who are incarcerated.

• **Time frame of the intervention:** From when a client completes an intake and assessment in the jail to 90 days post-release.

• **Enrollment numbers:** at least 50 participants enrolled in the first 12 months of implementation and at least an additional 20 enrolled in the following six months of implementation.
TCC Sites

University of North Carolina-Chapel Hill (Chapel Hill, NC)
• Subcontracts with Wake County Human Services for Care Coordinator staff
• High degree of support and buy-in from local jail system and Jail Health Administrator

Southern Nevada Health District (Las Vegas, NV)
• Long-standing relationship with the county correctional system, as SNHD provides epi surveillance within the jail. High degree of support for integration of the intervention into the jail system post-DEII funding

Cooper Health System (Camden, NJ)
• Existing relationship with local jail system via Cooper physician who provides medical care within the jail
• Majority of clients receive medical care and support services through Cooper, which enhances the site’s ability to facilitate connection to services and tracking
PEER LINKAGE AND RE-ENGAGEMENT
For Women of Color

Intended for organizations and clinics considering a short-term intensive peer-focused model to increase linkage of newly diagnosed and re-engagement of out of care HIV-positive women of color.
Peer Intervention Overview

- **Target population:** HIV-positive women of color who are newly diagnosed with HIV or who have fallen out of care (have not attended an HIV primary medical appointment in the last 6 months).

- **Time frame of the intervention:** 4 months

- **Enrollment numbers:** at least 70 participants enrolled in the first 12 months of implementation and at least an additional 30 enrolled in the following six months of implementation.
Peer Sites

Meharry Medical College (Nashville, TN)
- One of the nation's oldest and largest historically African-American/Black academic health science centers
- Peer services delivered from the Wellness Center, a hospital based outpatient clinic and affiliated clinic sites
- Wraparound services are provided to women through Meharry’s Hospital System

AIDS Care Group (Chester, PA)
- Largest FQHC in Southeastern PA with the majority of HIV cases
- Third poorest city of its size in the nation; focus on working with African immigrant community and women coming out of the criminal justice system
- By providing Saturday clinic peers and staff are able to re-engage women of color and provide meals

Howard Brown Health (Chicago, IL)
- Newly opened clinic in the Englewood Community, with high rates of HIV
- Intentionally enrolling both cis and transgender women
- Peers have led the creation of support groups and are conducting community outreach to increase enrollment
Utilizes patient navigators to retain HIV positive women of color (WoC) in HIV primary care experiencing at least one of the following:

- they have fallen out of care for 6 months or more,
- are loosely engaged in care (have cancelled or missed appointments),
- are not virally suppressed,
- and/or have multiple co-morbidities.
Patient Navigation Overview

- **Target population:** HIV-positive WoC 18 years and older who meet the following criteria: have not been seen at the clinic in the prior 6 months; have missed 2 or more appointments in the prior 6 months; are loosely engaged in care (have cancelled or missed appointments in the prior 12 months); are not virally suppressed; and/or have multiple co-morbidities.

- **Time frame of the intervention:** Patient navigators will work with patients for a minimum of 6 months and a suggested maximum of 12 months. After 6 months, patients will be reassessed every 3 months using an acuity based system to determine if they still need the support of the navigator.

- **Enrollment numbers:** at least 70 participants enrolled in the first 12 months of implementation and at least an additional 30 enrolled in the following six months of implementation.
Patient Navigation Sites

Newark Beth Israel (Newark, NJ)
- Family Treatment Center is located within the larger medical facility and serves 700 people living with HIV
- Challenge related to clients’ changing contact information but are able to text clients to remind them of appointments

Grady Health System (Atlanta, GA)
- Strong supervision and leadership support
- Navigators report working with clients with multiple comorbidities
- Team works to coordinate enrollment with other appointments to increase client follow through

Keck School of Medicine at USC (Los Angeles, CA)
- Clinic is the largest family-centered, comprehensive HIV program in California
- Particular challenge in their location is transportation, as women may travel up to two hours to reach the clinic
INTEGRATING BUPRENORPHINE TREATMENT

For Opioid Use Disorder in HIV Primary Care Settings

This intervention is intended for implementation in HIV primary care settings that do not already provide on-site buprenorphine treatment services.

Follows principles of harm reduction, enabling providers to treat addiction along with other chronic medical conditions experienced by their patients.
Buprenorphine Overview

- **Target population**: HIV-positive individuals who are addicted to opioids.

- **Time frame of the intervention**: No predetermined time frame – the time from induction to stabilization to maintenance will vary for each patient.

- **Enrollment numbers**: at least 25 participants enrolled in the first 12 months of implementation and at least an additional 25 enrolled in the following six months of implementation.
Buprenorphine Sites

University of Kentucky/Bluegrass Cares Clinic (Lexington, KY)
- Many patients live in rural areas and drive for a number of hours to reach clinic
- Staff report consistent success building trusting, honest relationships with clients

MetroHealth (Cleveland, OH)
- The rate of opioid-related, specifically fentanyl-related, overdoses in Cuyahoga County has drawn attention to the opioid epidemic and medication-assisted treatment (MAT). Leadership within the health system is already discussing MAT integration on a larger scale

Centro Ararat-FAITH clinic (Juana Diaz, Puerto Rico)
- The primary modes of HIV transmission for patients who inject drugs is injection drug use and sex with partners who are living with HIV.
- Organizational leadership is supportive; close-knit clinic environment supports coordination
Current Enrollment Numbers by Site

Subject Enrollment (Starting November 7, 2016) as of August 14, 2018
Total Subjects based on completed baseline interview: 815

*Enrollment as of 8.14.18
Using an Implementation Science Framework
Proctor Model

- **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?
<table>
<thead>
<tr>
<th>Implementation Outcome</th>
<th>Outcome</th>
<th>Data Collection Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptability</strong></td>
<td>Level of acceptability of the intervention among providers, staff, and leadership</td>
<td>Organizational Readiness to Change Assessment Pre-implementation qualitative interviews</td>
</tr>
<tr>
<td>(Pre-implementation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appropriateness</strong></td>
<td>Level of agreement among providers, staff, and leadership regarding the fit between the intervention and the needs of the clinic, clients, and community</td>
<td>ORCA Pre-implementation qualitative interviews</td>
</tr>
<tr>
<td>(Pre-implementation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adoption</strong></td>
<td>Ability of site staff to articulate intended plan to implement the protocol as outlined in the implementation plan and adapted intervention summary</td>
<td>Pre-implementation qualitative interviews Initial site visit report</td>
</tr>
<tr>
<td>(Pre-implementation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>Labor Costs Cost of supplies and materials</td>
<td>Cost analysis worksheet</td>
</tr>
<tr>
<td>(Start-up, implementation, and maintenance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feasibility</strong></td>
<td>Feasibility of implementing the intervention components as outlined in the adapted interventions and implementation plan Training and preparation necessary to implement the interventions as prescribed</td>
<td>Site visit report form Monthly site calls form Key informant qualitative interviews TA tracking form</td>
</tr>
<tr>
<td>(Start-up, implementation, and maintenance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fidelity</strong></td>
<td>Amount or number of intended units of each intervention or component delivered or provided by interventionists Extent to which the intended, methods, strategies, and/or activities were used by providers and intervention staff</td>
<td>Site visit report form Monthly site call form Key informant qualitative interviews Audio Recording Patient Care Plan review</td>
</tr>
<tr>
<td>(Implementation and maintenance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>Level of incorporation into the clinical setting as part of the standard of care</td>
<td>Site visit report form Monthly site call form Key informant qualitative interview</td>
</tr>
<tr>
<td>(Maintenance and integration)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Using the Implementation Science Lens: Lessons Learned
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 (administration, medical, and officers).
- Staff turnover within the jail setting can impact intervention staff.

Adaptations have been necessary to “fit” the model into each setting.
- For example, sites have varied in how they have partnered with jail staff to find meeting space and time for working with clients.

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.
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.
- Develop plan to help Peers adapt to benefit changes that result from full-time employment.
- Peer teams need continuous support and training to support their efforts in engaging women that are hard to reach.

Case management needs to be in place prior to implementation.

Peers (and data managers!) need space to have private, confidential conversations with clients.
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.
Enhanced Patient Navigation
Implementation Lessons Learned

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.
- Trust needs to be established between the PNs and the client and between the PNs and the providers.

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.
Integration of Buprenorphine
Implementation Lessons Learned

Enrollment is dependent on provider and clinical coordinator capacity.
- Patients with high acuity and substance use disorder need more time and engagement with the clinic staff and often do not have a linear path to recovery (i.e. need more time intensive services), making it hard to take on additional clients and offer high quality care.

The landscape of MAT is evolving, 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.
Providers and clinical coordinators are addressing patients with high acuity, co-occurring substance use disorders, mental health concerns, and high levels of experienced stigma, impacting the level of care they need to receive.

Develop implementation materials and manuals for the clinical coordinator.
- Clinical coordinators have coordinated group therapy sessions in addition to individual counseling, both of 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.
## Encounter Data

<table>
<thead>
<tr>
<th>Site</th>
<th>Encounter Forms for an attempted encounter</th>
<th>Encounter Forms for an encounter with a client or on behalf of a client</th>
<th>Total Number of Encounter Forms</th>
</tr>
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<tbody>
<tr>
<td>Cooper</td>
<td>239</td>
<td>965</td>
<td>1204</td>
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<tr>
<td>UNC at Chapel Hill</td>
<td>116</td>
<td>503</td>
<td>619</td>
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<td>SNHD</td>
<td>261</td>
<td>472</td>
<td>733</td>
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<tr>
<td>AIDS Care Group</td>
<td>8</td>
<td>869</td>
<td>877</td>
</tr>
<tr>
<td>Meharry</td>
<td>102</td>
<td>351</td>
<td>453</td>
</tr>
<tr>
<td>Howard Brown</td>
<td>299</td>
<td>481</td>
<td>780</td>
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<tr>
<td>Newark Beth Israel</td>
<td>134</td>
<td>2168</td>
<td>2302</td>
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<tr>
<td>Grady Health System</td>
<td>244</td>
<td>2508</td>
<td>2752</td>
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<tr>
<td>USC Keck</td>
<td>418</td>
<td>1423</td>
<td>1841</td>
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<tr>
<td>University of Kentucky</td>
<td>69</td>
<td>1011</td>
<td>1080</td>
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<tr>
<td>CENTRO ARARAT</td>
<td>21</td>
<td>440</td>
<td>461</td>
</tr>
<tr>
<td>MetroHealth</td>
<td>19</td>
<td>378</td>
<td>397</td>
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<tr>
<td><strong>All Sites</strong></td>
<td><strong>1930</strong></td>
<td><strong>11569</strong></td>
<td><strong>13499</strong></td>
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</tbody>
</table>

*Encounters as of 8.14.18*
Top Reported Encounters

Transitional Care Coordination

- Relationship building
- Discussing medical appointments with clients
- Providing appointment reminders
- Finding clients and conducting outreach
- Following up with provider to discuss client

Peer Linkage and Re-Engagement

- Relationship building
- Discussing medical appointments with clients
- Providing appointment reminders
- Finding clients and conducting outreach
- Following up with provider to discuss client
Top Reported Encounters

Enhanced Patient Navigation
- Relationship building
- Providing appointment reminders
- Following up with provider to discuss client
- Finding clients and conducting outreach
- Discussing medical appointments with client

Integration of Buprenorphine
- Conducting monitoring appointment
- Providing client support during maintenance or stabilization
- Relationship building
- Assist with obtaining transportation services
- Provide coaching on living skills
Patient Outcomes
Beyond Viral Suppression

- Patient satisfaction
- Changes in patient experience and clinical outcomes
- Factors that support patient success
- Helps us to understand replication efforts (on our path to creating the Care and Treatment Interventions)
## Patient Outcomes

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Time Points to administer patient outcome surveys and tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>When client is enrolled</td>
<td>3 months post enrollment</td>
</tr>
<tr>
<td></td>
<td>6 months post enrollment</td>
</tr>
<tr>
<td></td>
<td>12 months post enrollment</td>
</tr>
<tr>
<td></td>
<td>18 months post enrollment</td>
</tr>
<tr>
<td>Peer Linkage and Re-engagement</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Medical chart abstraction</td>
</tr>
<tr>
<td></td>
<td>Medical chart abstraction</td>
</tr>
<tr>
<td>Enhanced Patient Navigation</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Medical chart abstraction</td>
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<tr>
<td></td>
<td>Medical chart abstraction</td>
</tr>
<tr>
<td>Integrating Buprenorphine Treatment into HIV primary care</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Medical chart abstraction</td>
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<td></td>
<td>Medical chart abstraction</td>
</tr>
<tr>
<td></td>
<td>Medical chart abstraction</td>
</tr>
<tr>
<td>Transitional Care Coordination</td>
<td>When client is enrolled</td>
</tr>
<tr>
<td></td>
<td>30 days post-release</td>
</tr>
<tr>
<td></td>
<td>4 months post release</td>
</tr>
<tr>
<td></td>
<td>6 months post release</td>
</tr>
<tr>
<td></td>
<td>12 months post release</td>
</tr>
<tr>
<td></td>
<td>18 months post release</td>
</tr>
<tr>
<td>Baseline</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
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<td></td>
<td>Medical chart abstraction</td>
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<td></td>
<td>Medical chart abstraction</td>
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</tbody>
</table>
Client Baseline Survey Data: Preliminary Findings

*As of August 14, 2018*
How old are you?
Mean (± Standard Deviation)

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean (± Standard Deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCC (N=255)</td>
<td>39.7 ± 10.7</td>
</tr>
<tr>
<td>Peers (N=167)</td>
<td>42.1 ± 12.3</td>
</tr>
<tr>
<td>PN (N=304)</td>
<td>40.1 ± 12.2</td>
</tr>
<tr>
<td>Bup (N=90)</td>
<td>44.0 ± 10.7</td>
</tr>
</tbody>
</table>

*Baseline Data as of 8.14.18
Gender Identity

Currently, which do you consider yourself to be?
Actual Value (percentage of total)

<table>
<thead>
<tr>
<th></th>
<th>TCC (N=255)</th>
<th>Peers (N=167)</th>
<th>PN (N=304)</th>
<th>Bup (N=90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>218 (85.5)</td>
<td></td>
<td></td>
<td>69 (76.7)</td>
</tr>
<tr>
<td>Female</td>
<td>30 (11.8)</td>
<td>146 (87.4)</td>
<td>301 (99.0)</td>
<td>21 (23.3)</td>
</tr>
<tr>
<td>Transgender</td>
<td>7 (2.7)</td>
<td>15 (9.0)</td>
<td>3 (1.0)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6 (3.6)</td>
<td></td>
<td></td>
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*Baseline Data as of 8.14.18
### Race (derived)**

<table>
<thead>
<tr>
<th>Race Type</th>
<th>TCC (N=255)</th>
<th>Peers (N=167)</th>
<th>PN (N=304)</th>
<th>Bup (N=90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>132 (51.8)</td>
<td>160 (95.8)</td>
<td>228 (75.0)</td>
<td>20 (22.2)</td>
</tr>
<tr>
<td>White</td>
<td>72 (28.2)</td>
<td></td>
<td>55 (18.1)</td>
<td>47 (52.2)</td>
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<tr>
<td>Multiracial</td>
<td>36 (14.1)</td>
<td>6 (3.6)</td>
<td>14 (4.6)</td>
<td>14 (15.6)</td>
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<tr>
<td>American Indian/Alaskan Native</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>1 (0.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown/Refused</td>
<td>12 (4.7)</td>
<td>1 (0.6)</td>
<td>7 (2.3)</td>
<td>9 (10)</td>
</tr>
</tbody>
</table>

*Baseline Data as of 8.14.18
** Participants were asked about each category separately*
## Hispanic, Latino/a, Spanish Origin

Are you of Hispanic, Latino/a, or Spanish origin?
Actual Value (percentage of total)

<table>
<thead>
<tr>
<th></th>
<th>TCC (N=255)</th>
<th>Peers (N=167)</th>
<th>PN (N=304)</th>
<th>Bup (N=90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>226 (88.6)</td>
<td>160 (95.8)</td>
<td>237 (78.0)</td>
<td>46 (51.1)</td>
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<tr>
<td>Yes</td>
<td>28 (11.0)</td>
<td>7 (4.2)</td>
<td>67 (22.0)</td>
<td>43 (47.8)</td>
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<tr>
<td>Refused</td>
<td>1 (0.4)</td>
<td></td>
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<td>1 (1.1)</td>
</tr>
</tbody>
</table>

*Baseline Data as of 8.14.18*
## Language

What language do you speak most of the time, with friends and family?

<table>
<thead>
<tr>
<th></th>
<th>TCC (N=255)</th>
<th>Peers (N=167)</th>
<th>PN (N=304)</th>
<th>Bup (N=90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>245 (96.1%)</td>
<td>156 (93.4%)</td>
<td>239 (78.6%)</td>
<td>53 (58.9%)</td>
</tr>
<tr>
<td>Spanish</td>
<td>7 (2.7%)</td>
<td>2 (1.2%)</td>
<td>43 (14.1%)</td>
<td>33 (36.7%)</td>
</tr>
<tr>
<td>Haitian Creole</td>
<td></td>
<td></td>
<td>8 (2.6%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3 (1.2%)</td>
<td>9 (5.4%)</td>
<td>13 (4.3%)</td>
<td>4 (4.4%)</td>
</tr>
<tr>
<td>Refused</td>
<td></td>
<td></td>
<td>1 (0.3%)</td>
<td></td>
</tr>
</tbody>
</table>

*Baseline Data as of 8.14.18
Was your highest education greater than HS/GED?
Actual value (percentage of total)

<table>
<thead>
<tr>
<th></th>
<th>TCC (N=255)</th>
<th>Peers (N=167)</th>
<th>PN (N=304)</th>
<th>Bup (N=90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>190 (74.5%)</td>
<td>103 (70.1%)</td>
<td>192 (63.2%)</td>
<td>60 (66.7%)</td>
</tr>
<tr>
<td>Yes</td>
<td>64 (25.1%)</td>
<td>48 (28.7%)</td>
<td>112 (36.8%)</td>
<td>30 (33.3%)</td>
</tr>
<tr>
<td>Refused</td>
<td>1 (0.4%)</td>
<td>2 (1.2%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Baseline Data as of 8.14.18
During the last 12 months, how many times did you run out of money for basic necessities like housing or food?

*Baseline Data as of 8.14.18
What kind of health insurance do you have?

*Baseline Data as of 8.14.18*
Where do you live now?

*Baseline Data as of 8.14.18*
Are you currently taking HIV medication?

*Baseline Data as of 8.14.18*
In the past three months, have you participated in substance use treatment?

*Baseline Data as of 8.14.18*
# Top Reported Needs

**Transitional Care Coordination**
- Transportation assistance
- Housing assistance
- Assistance in applying for benefits
- Medication assistance
- Assistance getting substance use treatment and/or mental health treatment/counseling

**Peer Linkage and Re-Engagement**
- Transportation assistance
- Housing assistance
- Assistance in applying for benefits
- Assistance getting substance use treatment and/or mental health treatment/counseling
- Other assistance

*Baseline Data as of 8.14.18*
**Top Reported Needs**

**Enhanced Patient Navigation**
- Transportation assistance
- Housing assistance
- Assistance applying for benefits
- Medication assistance
- Assistance getting substance use treatment and/or mental health treatment/counseling

**Integration of Buprenorphine**
- Transportation assistance
- Assistance getting substance use treatment and/or mental health treatment/counseling
- Housing assistance
- Medication assistance
- Assistance getting medical care

*Baseline Data as of 8.14.18*
Next Steps
## Important Dates

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Event Description</th>
</tr>
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<tbody>
<tr>
<td>June – Sept.</td>
<td>DEC Team will conduct key informant interviews</td>
</tr>
<tr>
<td>Nov 1, 2018</td>
<td>LAST DAY TO ENROLL!</td>
</tr>
<tr>
<td>Dec 2018</td>
<td>Project updates provided at the 2018 Ryan White Conference</td>
</tr>
<tr>
<td>April 30, 2019</td>
<td>LAST DAY TO ENTER DATA!</td>
</tr>
<tr>
<td>April – June 2019</td>
<td>Final site visits and data closeout</td>
</tr>
<tr>
<td>June 2019 – August 2020</td>
<td>DEC Team will create final versions of the Care and Treatment Interventions!</td>
</tr>
</tbody>
</table>
https://nextlevel.targethiv.org/
Questions? Please reach out to us!

**Site specific contacts:**
- Transitional Care Coordination: Jane Fox, jane_fox@abtassoc.com
- Peer Linkage and Re-engagement: Serena Rajabiun, rajabiun@bu.edu
- Enhanced Patient Navigation: Ellen Childs, echilds@bu.edu
- Integration of Buprenorphine: Alexis Marbach, alexis_marbach@abtassoc.com

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- Clara Chen, Biostatistics and Epidemiology Data Analytics Center, cachen@bu.edu
- Marena Sullivan, Research Assistant, marenas@bu.edu