PROTOCOL TITLE:
Feasibility of Brief Intervention for HIV+ Adults 50+ in Primary Care Settings

PRINCIPAL INVESTIGATOR:
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REVISION HISTORY

Revision #	Version Date	Summary of Changes	Consent Change?
1	9-26-19	Transfer to RAMP, add a site	No

Table of Contents

1.0 Study Summary

Study Title	Feasibility of Screening, Brief Intervention for HIV+ Adults 50+ in Primary Care Settings
Study Design	We will use a repeated measures randomized control trial design to compare patient outcomes at baseline as well as 3 and 6 months post-intervention.
Primary Objective	Feasibility and Acceptability of intervention
Secondary Objective(s)	Substance misuse
Research Intervention(s)	Screening, Brief Intervention, Referral to Treatment with Peer Navigator (SBIRT-PN)
Study Population	HIV+
Sample Size	90
Study Duration for individual participants	6 months
Study Specific Abbreviations/ Definitions	SBIRT-PN = Screening, Brief Intervention, Referral to Treatment with Peer Navigator

2.0 Objectives*

In order to develop effective substance use intervention models for HIV care settings the specific aims of the current project are:

Aim1: Examine the feasibility of implementing the SBIRT-PN model in Infectious Disease-Medical Specialties Clinics in the state of Florida.

H1: We hypothesize that the SBIRT-PN model will demonstrate high feasibility as evidenced by at least 80 % of the total N having screenings.

Aim2a: Assess the acceptability of SBIRT-PN.

H2a: We hypothesize that SBIRT-PN will demonstrate high acceptability among patients
enrolled in this condition.

Aim2b: Assess the acceptability of SBIRT-PN among HIV-positive individuals by age cohort (younger vs older).

H2b: We hypothesize that SBIRT-PN will demonstrate higher acceptability among older HIV-positive patients enrolled in this condition.

Aim3: Assess influence of SBIRT-PN model on treatment engagement and substance use compared to enhanced treatment as usual (TAU).

H3: We hypothesize that those in the SBIRT-PN condition will evidence greater treatment engagement and a reduction in substance use.

3.0 Background*

Substance use science-to-service gap needs to close for the underserved aging with HIV. Many effective interventions do not translate into meaningful outcomes that improve patient care. Therefore, NIDA and the Office of AIDS Research have prioritized research that promotes the uptake of evidence-based interventions into real-world settings. In order to provide effective patient-centered care, effective interventions need to reach those in need. In particular, substance use interventions have lagged in moving from the bench (research labs) to the community (real-world settings). Extant literature suggests that peer navigators may improve treatment engagement among substance users and thereby has the potential to improve the effectiveness of SBIRT in this population in particular.

Florida provides the opportunity to implement substance use interventions among older HIV-positive adults. In Florida 42% of people living with HIV are aged 50 years and older compared to 31% in the rest of the United States. While cART has transformed HIV into a manageable chronic condition, leading to a large population aging with the disease, people aging with HIV continue to engage in high risk behaviors. At this stage in the HIV epidemic, we must use available evidence-based tools to meet the needs of those aging with HIV. Older adults living with HIV misuse alcohol and illicit drugs at rates higher than the general population. In addition, HIV+ adults aged 50 years and older are likely to be frailer than their chronological age indicates due to their

disease status, which makes them more vulnerable to the consequences of substance misuse (i.e., greater intoxication even with lower levels of consumption). Further, substance misuse is associated with decreased medication adherence, decreased engagement in HIV care, more medical co-morbidities, higher rates of depression, and poorer quality of life. Extant research suggests depression and pain are considered motivators of misuse and may make patients less responsive to interventions. Importantly, depressive symptoms among older, chronically ill populations are associated with transition from informal community-based care by family and friends to institutionalization. Therefore, studies located in Florida provide an opportunity to examine how primary care health systems can adopt interventions to reach this population and remain effective.

Determine best methods for improving uptake of substance use interventions in real-world settings While the primary care setting presents an opportunity to address substance misuse among older HIV-positive adults, barriers exist at multiple levels in the public health sector. Extant literature indicates that underserved adults aging with HIV need substance use intervention on a broad scale. However, to be effective we need to improve our understanding of the mediators and moderators of effective delivery of substance use interventions in this population. A study that implements SBIRT-PN and then examines the barriers to uptake will provide data needed to implement evidence-based substance use interventions in public health settings while creating sustainable interventions that the community can maintain

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4.0 Study Endpoints*

Primary Outcome

Feasibility Calculation. Feasibility is defined as the extent to which the intervention can be successfully used or carried out within the UF Health Infectious Disease-Medical Specialties Clinic. Therefore, we will calculate feasibility using the following steps (see link to method for calculation below):

- **Step 1:** Enumerating all potential participants in target population. The target population will be defined as all patients seen by Dr. Janelle seen during study period.
- **Step 2:** Quantify Exclusions. List reasons for and number of exclusions.
- **Step 3:** Quantify missed cases. List number of lost cases or missed due to lack of staff resources, etc.
- **Step 4:** Quantify Eligible Participants. List number of known eligible participants who were offered participation.
- **Step 5:** Quantify number of Patients Reached. Divide number of participants enrolled to determine percent participation.
- **Step 6:** Report most common reasons for declining participation.

http://re-aim.org/resources-and-tools/calculations/calculating-and-reporting-on-reach/

Acceptability Questionnaire. This 10-item questionnaire (1 = not acceptable to 5 = highly acceptable) queries the participant on the acceptability of the program. Item content includes the following:

1. Program was a good use of my time
2. Program was helpful
3. Program will be useful in my daily
4. Likeability of interventionist
5. Clinical skill of interventionist
6. Likeability of assessor
7. Ease of participation in assessments
8. Ease of participation in intervention
9. Interactions with program staff
10. Overall rating.

To examine ratings of acceptability, we will use the overall acceptability score and percentage of acceptability. Overall acceptability will be assessed by summing ratings from the 10-item questionnaire to provide a total intervention acceptability score for the intervention, such that acceptability scores for the intervention could range from 10 (low acceptability) to 50 (high acceptability). The intervention will be considered to have acceptability if 80% of the participants rank the intervention as acceptable (i.e., 4 or higher) on 80% or more of the scale items. We will then examine each question of the Acceptability Questionnaire separately to determine strengths and weaknesses of the intervention.

Secondary Outcomes

Substance Use Treatment Engagement: Participants will self-report if they obtained formal substance use treatment (i.e., any services sought to address substance use from individual therapy to 12 step fellowships). We will request treatment facility information and permission to verify treatment. Once treatment has been verified, treatment engagement will be coded as 0= no formal treatment 1= formal treatment engagement

Substance use NIDA STTR Drug and Alcohol Use Measure: A standard measure from the NIDA STTR Vulnerable Populations Data Harmonization tool kit will be used. It will assess quantity and frequency of types of substances used in the prior 30 days.

Biologically Confirmed Drug Use: A CLIA 12-Panel Instant Drug Test Cup (CLIAwaived™, San Diego, CA), which tests for the presence of 12 common substances in the urine will be used.

5.0 Study Intervention

Intervention Procedures: The 30 minute intervention session will cover the following content: 1) Psycho-educational content (5 minutes): The interventionist will discuss substance use and misuse, HIV, and the interaction of aging and substance use (e.g. greater intoxication effects with lower amounts). 2) Readiness Assessment (10 minutes): The interventionist will give the patient feedback on their NM-ASSIST score and assess the patient's readiness to change based on Prochaska's stages of change. 3) Goal-Setting (5 minutes): The interventionist will use motivational interviewing techniques to identify the patients' most salient reasons for addressing substance use issues. 4) Identifying and prioritizing needs (5 minutes): The interventionist will use problem-solving techniques to help patients identify which services may best help them work

towards their goals. Services will include (but are not limited to) emergency crisis services, counseling to deal with substance use, referral to local self-help groups (Alcoholics Anonymous, Narcotics Anonymous, etc.), legal assistance, faith-based counseling, or mental health counseling. 5) Assignment of Peer Navigator and Session wrap (5 minutes): The interventionist will use a referral resource guide to provide the contact information of agency representatives and help the patient formulate a plan for follow-up.

6.0 Procedures Involved*

Recruitment/Sampling: Patients will be recruited using convenience sampling technique from HIV primary care clinics with whom the PI works regularly: the Columbia County Department of Health (Lake City, FL) and the CAN Community Health Clinic (Jacksonville, FL)

Preliminary Screen: Patients will be prescreened for eligibility using a computerized screening tool, NIDA Modified Alcohol, Smoking, Substance Involvement Screening Test [NM-ASSIST], to assess substance misuse risk level. All clinic patients will have the opportunity to complete the substance use screening assessment after checking in for their appointment. All who score moderate and above on the alcohol or illicit substance portion of the NM-ASSIST and meet eligibility criteria will be referred to the study. We will train all recruiters (clinic staff) to provide an extensive explanation of why we are offering these services, as the patients may not perceive themselves as having a substance misuse issue.

Baseline Assessment Procedures: Following a successful initial screen, study staff will explain the procedures of the study and obtain informed consent. All study activities will be conducted in a private room in the clinic. The research assistant (RA) performing the assessment will verify the patient's complete understanding of the informed consent form and all study procedures. Following informed consent, patients will complete the baseline assessment. The baseline assessment will consist of urine drug screen and a series of research questionnaires delivered on a mobile device. The research questionnaires include information on: substance use, substance use treatment, HIV treatment engagement, depression, and pain. The assessment is relatively brief in order to maximize willingness to participate and decrease patient burden. The assessment will take approximately 30 minutes to complete. The questionnaires will be given in a computerized. The iPad/tablet will use REDCap survey software, which provides direct, encrypted transfer of information via internet to a secure study server.

Three and Six Month Follow-Up Assessment: *Participants will be contacted three and six months post-intervention to schedule an in-person follow-up assessment. We will evaluate substance use treatment engagement post intervention and substance use (self-report and urine toxicology analysis). Participants will be compensated $30 for each*

Randomization: We will use Block random assignment (blocks of 4 by each recruitment site) to ensure equal numbers are assigned to each condition by site. Randomization should create groups with equal characteristics with respect to disease related and medical variables. However, we will assess for baseline differences prior to conducting any analyses and control as necessary.

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7.0 Data and Specimen Banking*

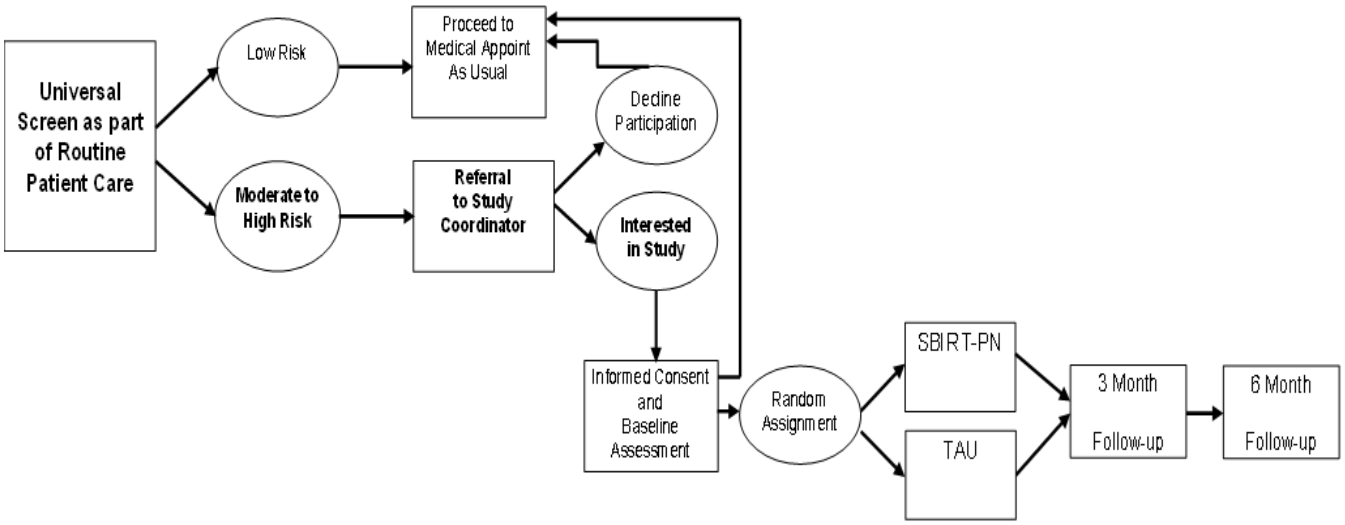
N/A.

8.0 Sharing of Results with Subjects*

N/A.

9.0 Study Timelines*

Figure 2: Schematic Overview of Study Procedures



10.0 Subject Population*

Participants will be 90 patients recruited through DOH Columbia County and CAN Community Health.

Study inclusion criteria includes that patients must be:
1. HIV-positive (seropositive confirmed by medical records).
2. Arrive for a clinic visit with an HIV physician.
3. Have a substance misuse screening score indicating moderate or high risk.

Persons will be ineligible if they:
1. are unable to interview and consent in English
2. unwilling or unable to participate in follow up
3. currently in addiction treatment
4. have a medical marijuana prescription

11.0 Vulnerable Populations*

N/A.

12.0 Local Number of Subjects

N= 90

13.0 Recruitment Methods

We will recruit participants from patients attending the primary care clinic for routine medical appointments. Patients will be prescreened for eligibility using a computerized screening tool, NIDA Modified Alcohol, Smoking, Substance Involvement Screening Test [NM-ASSIST], to assess substance misuse risk level. All clinic patients will have the opportunity to complete the substance use screening assessment after checking in for their appointment. All who score moderate and above on the alcohol or illicit substance portion of the NM-ASSIST and meet eligibility criteria will be referred to the study. We will train all recruiters (clinic staff) to provide an extensive explanation of why we are offering these services, as the patients may not perceive themselves as having a substance misuse issue)

Participants will be compensated $30 for each assessment which includes the baseline visit and two follow up visits for a total of $90 of compensation throughout the entire six month study period

14.0 Withdrawal of Subjects*

Participants may be withdrawn from the study without consent for the following reasons:

- Participants who tell us that they are going to hurt him or herself or someone else will be withdrawn from the study. These participants will be referred to community based agencies that provide counseling and treatment services.
- The Principal Investigator can withdraw participants from this study for unanticipated reasons.

15.0 Risks to Subjects*

Possible Discomforts and Risks: Questions may be unpleasant or difficult for participants to answer. Additionally, despite taking appropriate steps to safeguard collected information, there is a slight risk that participant information could be revealed accidentally or inappropriately. This release of information may upset a participant or even affect their insurability or employability. A Certificate of Confidentiality will be obtained from the National Institute of Drug Abuse to assist us in protecting participant information.

16.0 Potential Benefits to Subjects*

Participants may benefit from information about substance misuse and how it could negatively affect their mental and physical health.

Participants may also benefit from tips and strategies that decrease substance misuse

17.0 Data Management* and Confidentiality

Analysis Plan

Aim 1: Feasibility will be calculated as described above. The model will be considered feasible if 80% of the target population has been reached.

Aim 2: Acceptability scores will be calculated for all participants as listed above to determine overall acceptability of the SBIRT model. Sub analyses will be conducted for disease type and HIV x age using calculations listed above. Acceptability will be examined by disease type HIV vs. non-HIV. Acceptability will also be examined for HIV only by younger (<49) versus older >50).

Aim 3: This pilot is a randomized two groups (SBIRT-PN vs. TAU) with repeated measures (baseline and 3 and 6-month follow-ups) design. We will clean the data, examine variable distributions, compute descriptive statistics, examine outliers, and examine the effectiveness of randomization prior to analyses of specific aims to ensure the underlying assumptions of normality and equal variance have not been violated. Before testing each secondary outcome, we will examine whether intervention and control group participants differ on potential confounding variables at study entry. We will control for a variable if it differs by condition on the outcome variable being tested in that analysis at $p < .05$. Using chi-square (or t-test for continuous variables) we will examine the associations between the dependent variables and relevant demographic variables. All analyses will employ an intent-to-treat approach.

Our first step will be to see if the intervention influenced formal engagement in substance use treatment. Using chi-square analyses we will examine group difference on engagement in formal treatment (0=no treatment/1=treatment confirmed). To test the remainder of the hypothesis, analyses will rely on mixed model repeated measures ANOVA since the relatively small sample size is likely to prohibit more sophisticated statistical modeling. Hypotheses testing rely on inspection of F values and associated p values. A mixed model ANOVA is used to test for differences between two or more independent groups while subjecting participants to repeated measures. In the current analyses the fixed effect will be group condition (SBIRT-PN or TAU) and the random effect will be number of drug use days in the past 3 and 6 months.

Missing Data. We will handle missing data values with a 3-step process. First, the dropout rates will be compared across the groups with chi-square analyses to assess systematic differences due to condition. Second, demographic and dependent variables will be examined for their relationship to dropout. Those variables related to dropout status will be used to impute missing values for use in the analyses described (via SPSS Missing Items Analysis). Finally, comparison of the completers vs. imputation analyses will yield an additional estimate of the effect of dropouts on hypothesis tests.

Confidentiality Safeguards

To ensure confidentiality, all information will be coded so that it cannot be associated with any individual. A master sheet, with individual names and their respective code numbers will be kept in a locked file that can be accessed only under supervision of the PI. All data entered into the computerized database will be identifiable by subject code number only. No one outside of the lead research team will have access to records identifying participants' names at any time. The information gathered will be used only for scientific, educational, or instructional purposes.

Data Safeguards
Any computer files with identifying data, such as subject logs needed to match data to names over time, will be protected by multiple passwords. During the analysis of the data, all identifying information with the exception of the subject identification number is removed from the data.

18.0 Provisions to Monitor the Data to Ensure the Safety of Subjects*

N/A

19.0 Provisions to Protect the Privacy Interests of Subjects

To ensure confidentiality, all information will be coded so that it cannot be associated with any individual. A master sheet, with individual names and their respective code numbers will be kept in a locked file that can be accessed only under supervision of the PI. All data entered into the computerized database will be identifiable by subject code number only. No one outside of the lead research team will have access to records identifying participants' names at any time. The information gathered will be used only for scientific, educational, or instructional purposes.

Any computer files with identifying data, such as subject logs needed to match data to names over time, will be protected by multiple passwords. During the analysis of the data, all identifying information with the exception of the subject identification number is removed from the data.

Discomfort with Procedures or Disclosure Safeguards
During the course of participation in the research, a participant may have questions about the assessment procedure. A project staff member or interventionist will be available to answer questions. To prevent discomfort or embarrassment, staff are trained in building rapport and skillful interviewing. Participants are informed prior to the assessment that they may choose to skip any questions or procedures they find uncomfortable. If any individual becomes overly distressed or distraught, the assessment will be stopped immediately and a staff clinician will talk privately with the affected individual(s) and appropriate referrals will be made, as needed.

20.0 Compensation for Research-Related Injury

N/A

21.0 Economic Burden to Subjects

N/A

22.0 Consent Process

All participants will be required to read detailed consent forms prior to participation. Then the Research Assistant who will be consenting the participant will address all of the major details of the study. Before signing, participants will be given the opportunity to ask any questions they may have about the study. Participants are advised of the voluntary nature of participation and of their right to withdraw from the project at any time and their right to require that information about themselves be removed from data analysis. Each study participant receives a verbal and written description of the study.

Non-English Speaking Subjects

- *N/A*

Waiver or Alteration of Consent Process (consent will not be obtained, required information will not be disclosed, or the research involves deception)

- *N/A*

Subjects who are not yet adults (infants, children, teenagers)

- *N/A*

Cognitively Impaired Adults

- *N/A*

Adults Unable to Consent

  - *N/A*

23.0 Process to Document Consent in Writing

Participants will sign an IRB approved informed consent document. Before signing, participants will be given the opportunity to ask any questions they may have about the study. Participants are advised of the voluntary nature of participation and of their right to withdraw from the project at any time.

24.0 Setting

Recruitment/Sampling: Patients will be recruited using convenience sampling technique from HIV primary care clinics with whom the PI works regularly: the Columbia County Department of Health (Lake City, FL) and the CAN Community Health Clinic

(Jacksonville, FL). The PI has dedicated space in these locations to conduct all study activities.

25.0 Resources Available

Since SBIRT is intended to be a universal intervention within a targeted setting, all adults (18+) who are being seen in clinic will be screened using validated screening instruments as part of routine care. Scores and the nature of the follow up (i.e., referred to brief intervention or no intervention needed) will be documented in the electronic medical record. We will train all recruiters and clinic staff to provide an extensive explanation of why we are offering these services, as the patients may not perceive themselves as having a substance misuse issue.

Universal Screening Procedures
Screening is intended to identify individuals at varying levels of risk associated with the use of alcohol and/or drugs. It is not intended to provide a formal diagnosis (which is the function of clinical assessment), but rather to provide guidance for deciding which level of intervention may be needed to address the identified level of risk. The ASSIST is an eight-item instrument developed by the World Health Organization (WHO) to screen for hazardous, harmful, and dependent use of alcohol, tobacco, and drugs. The ASSIST typically takes about 5-10 minutes to administer, although it can take longer depending on the number of drugs used over the lifetime. For each drug endorsed, questions are asked about frequency of use, problems related to use, dependence indicators, and injection drug use in the three months prior to the current administration of the instrument. Following ASSIST administration, separate risk scores are calculated, with scores falling within a low-, moderate-, or high-risk range. Table 1 shows the risk-level scores for alcohol and drugs and the indicated intervention for each risk level, as specified in the WHO brief intervention manual. We will use a computer based version of the ASSIST to make the screening faster to administer and score (see link below).

https://www.drugabuse.gov/nmassist/

Table 1 ASSIST risk scores and level of intervention

	ASSIST Alcohol Score	Assist Drug Score	Intervention
Low Risk	0 – 10	0 – 3	Feedback on ASSIST score, literature
Moderate Risk	11 – 26	4 – 26	Feedback on ASSIST score, literature, brief intervention
High Risk	27+	27+	Feedback on ASSIST score, literature, brief intervention, referral to treatment

Retention

Attrition is a significant concern in an implementation trial. First, we will develop a strong collaborative relationship between participants and members of the research team. This is a critical component of our retention strategy, beginning at the moment of first contact between the recruiter and potential participant. Second, we will ensure that participants understand that they are making a contribution and that their efforts have the potential to improve other people's experiences. Participants will receive study newsletters and flyers containing useful and pertinent information on wellness management and other related resources and local events. Finally, we will obtain secondary contact information and will use multiple communication channels (email, phone, text messaging, social media) to maintain contact with study participants. We have budgeted research staff time for tracking and follow-up of participants. One RA will dedicate 20% time to patient tracking during recruitment and follow up phase. Based on our prior work using these strategies with this patient population, we anticipate a 10% dropout rate with a maximum dropout rate of 20% by time 3.

Follow-up visits will be scheduled 4-6 weeks in advance of the next study appointment. Participants will then be contacted with assessment visit reminders within the week before their 3-month and 6-month visits. If participants cannot be reached by phone, a voicemail will be left listing the day and time of the scheduled visit along with instructions to call and reschedule if the participant is no longer available at the scheduled day and time. Participants who do not attend their assessment visit will be called 15 minutes after the anticipated start time of the visit and asked to reschedule. If the participant does not answer the phone, a voicemail will be left and an email sent asking the participant to call our study staff to reschedule their visit. Participants will be contacted up to 5 times to reschedule. Participants who cannot be reached will be sent a registered letter through the USPS reminding them of the final assessment visit and asking them to contact study staff to schedule. We will also use clinical schedules from our research partner clinics to monitor for participant return visits to clinic and use these visits as an opportunity to reengage with study participants. We will continuously review and examine our retention strategies to ensure that they meet participant approval and are maximally effective.

26.0 Multi-Site Research*

+++Per NIH policy research funded via Career Development Awards, such as the current study are NOT subject to the NIH single IRB policy due to the scope of the research award. The current research is funded via a career development award from NIDA under grant 1K23DA039769-04.

See section C item 6 in the link below.

https://grants.nih.gov/grants/policy/faq_single_IRB_policy_research.htm#5180