Cooperative Re-Engagement Controlled Trial (CoRECT)

OMB No. 0920-New

Supporting Statement A

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- Scope/Goals of the study: Establish a data-sharing partnership between health departments and HIV care clinical providers designed to identify HIV-infected persons who are out-of-care. Implement an engagement in care intervention to increase the number of HIV-infected out-of-care individuals who: (a) link to an HIV clinic; (b) remain in HIV medical care; (c) achieve HIV viral load suppression within 12 months; and (d) achieve durable HIV viral load suppression over 18 months.

- The subpopulation to be studied: HIV-infected persons who are considered out of care.

- Methods to be used: The CoRECT study is a randomized controlled trial that seeks to establish a data-sharing partnership between health departments and HIV care clinical providers to identify HIV-infected persons who are out of care and evaluate and intervention that aims to link and retain them in HIV care.

- How data will be analyzed: Baseline characteristics will be compared between the intervention arm and SOC arm to determine the success of randomization. An exploratory analysis of all variables collected will be conducted using the appropriate statistical test. Associations between variables of interest will also be tested to inform any potential issues with co-linearity during multivariate analysis.

- Benefit to federal government: Determine the feasibility of a joint health department – clinic intervention to identify recently out-of-care individuals and the efficacy of an active health department intervention to (re)-engage these individuals in HIV medical care. Describe the key successful components to identifying HIV-infected individuals out-of-care by a health department – clinic collaboration, and their feasibility.

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Division of HIV/AIDS Prevention (DHAP) requests a 3-year OMB approval for a new information collection for a new research study entitled "The Cooperative Re-engagement Controlled Trial (CoRECT)". The purpose of the study is to evaluate a combined health department and clinic intervention to improve engagement in human immunodeficiency virus (HIV) care. The data collection is authorized under the Section 301 of the Public Health Service Act (42 U.S.C. 241) **(Attachment 1).**

BACKGROUND

HIV antiretroviral therapy (ART) can durably suppress the plasma HIV viral load, which improves individual survival and dramatically reduces further HIV transmission. Increasing the number of people living with HIV who access HIV care and achieve viral load suppression is a priority of the National HIV/AIDS Strategy. Within the continuum of HIV care in the United States, improvements in linkage to and retention in effective care provide the greatest opportunity to improve rates of HIV viral suppression. It is estimated that of the 1.2 million persons living with HIV in 2011, only 40% were engaged in HIV medical care and only 30% achieved viral suppression. Moreover, persons not retained in medical care are estimated to account for 60% of HIV transmissions in the United States.

HIV clinical trials with enhanced case management have demonstrated that interventions provided by the health department can improve linkage to HIV care and interventions provided by the clinic can improve retention in HIV care. Although linkage to care has improved in many health department jurisdictions, being linked to care is not enough. There is a need to ensure that: (i) people diagnosed with HIV and linked to care are engaging medical care (i.e., attending their enrollment appointment and returning for follow-up medical appointments); and (ii) people who have disengaged from HIV care (i.e., have missed medical appointments and have not been seen in clinic for more than 6 months) are able to efficiently re-engage in care.

Linkage and re-engagement programs have demonstrated that strong partnerships and information exchange between health departments and HIV treatment clinics can improve HIV care outcomes. People can be identified as disengaged from care based on both laboratory data that is reported to the health department for HIV surveillance (i.e., the absence of reported CD4 or viral load data for more than 6 months—use

of laboratory data to identify persons as out of care is known as a Data-to-Care approach to linking or re-engaging persons in HIV care) and from clinic data (i.e., not attending clinic for more than 6 months). Observation studies have provided evidence that health department or clinic-based re-engagement in care projects utilizing surveillance data can identify people as out of care and facilitate re-entry into care. However, there have been no randomized controlled studies using a Data-to-Care approach to identify and re-engage out of care persons. Controlled studies are critical to determine the effectiveness of HIV prevention interventions; trials often provide generalizable information that cannot be obtained with observational studies.

2. Purpose and Use of the Information Collected

The respondent population will be individuals who have failed to link to care after initial diagnosis and individuals who haven't received care within 6 months of their last documented HIV indicative lab. Three participating departments of health (DPH), Connecticut, Massachusetts, and Philadelphia, will aim to enroll 600 participants each over the 2 year enrollment period, for a total of 1,800 persons. These participants will be randomized into either an intervention arm, or a standard of care arm. Each site will contribute 300 participants into the intervention arm and 300 from each site into the standard of care arm, for a total of approximately 900 participants in each arm. The main outcome measures will be analyzed using an "intent-to-treat" approach.

CDC will use the information collected for the following purposes:

1. To identify HIV-infected persons in three jurisdictions who are out-of-care.
2. To implement an active re-engagement in care field services intervention using the "Out of Care" lists
3. To determine if the active intervention improves a) linkage to an HIV clinic b) retention in HIV care c) achievement of viral load suppression within 12 months and d) achievement of durable viral load suppression over 18 months

The scientific knowledge collected will assist in:

1. Determining the extent to which a health department intervention can successfully engage out-of-care persons in HIV medical care;

2. Describing the key successful components to identify HIV-infected persons out-of-care by a health department – clinic collaboration

3. Findings from this study will be presented at national scientific conferences and published in HIV/AIDS specialty journals

3. Use of Improved Information Technology and Burden Reduction

The grantees will submit the data to CDC in an Excel, Access, or SAS databases, or by using another similar data software package. Surveillance and clinic data will be abstracted from existing eHARS (electronic surveillance system) and electronic medical records.

4. Efforts to Identify Duplication and Use of Similar Information

DHAP research group routinely conducts searches to identify current and past HIV/AIDS research efforts. Prior to the development of the CoRECT study, research of the compendium of care-reengagement research was reviewed. There are approximately five evidenced based interventions on HIV care reengagement and six evidence informed interventions. There was no reengagement trial identified by previous research efforts. In addition to reviewing the compendium of research on HIV care reengagement further review was conducted on HIV care engagement trial using Data to Care to inform surveillance programs of individuals who are Out-of-Care. There is no other HIV care reengagement trial that has utilized data to care. Listed below is the DHAP compendium website for previous research: http://www.cdc.gov/hiv/prevention/research/compendium/lrc/index.html

5. Impact on Small Businesses or Other Small Entities

There will be 8-26 project clinics, which may vary in size, at each of the three study sites (Philadelphia, Massachusetts, Connecticut health departments). The data collection will be the same for all facilities within each of the three study sites. Project clinic participation is voluntary. Routine assessments will be conducted to determine the impact on the study clinics' standard of care practices and operating procedures for patients seeking HIV/AIDS care at these clinics. If the burden is found to be too burdensome, the monthly case conference sessions will be reduced and if allowed additional health department staff will be deployed to assist the providers. To reduce the burden of collecting data, each of the three project sites will be limited to enrolling 600 clients (divided between the total number of project clinics within each project site) over the 2 year enrollment period (for a total of 1800 study clients). Project clinics will phase enrollments to prevent a vast quantity of study participants enrolling all at once.

6. Consequences of Collecting the Information Less Frequently

The Barriers to Care survey is a one-time data collection. The Standard of Care survey is being conducted twice yearly in order to document changes in standard practices at the study clinics that may influence study participants' re-engagement in care; if this information was collected less frequently we would not be able to determine if differences in participants' re-engagement were contributable to the study intervention or to changes in the standard of care. Health Department Surveillance data and data from clinic electronic medical records are continuously captured and maintained as part of these agencies daily operations. These data will be sent to CDC quarterly in order to monitor study outcomes (e.g. viral load suppression, re-engagement). The purpose of the Case Conference forms is to identify out of care persons in real time. Thus, the case conference forms will be completed on a monthly basis. Completing the case conference forms on a less frequent basis will disallow expedient identification of persons who are out of care and will delay interventions to re-engage these persons.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with regulation 5 CRF 1320.5.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A 60-day federal register notice to solicit public comments was published on 11/10/2015, Volume 80, Number 217, Pages 69683-4 (**Attachment 2**). No comments have been received.

The development of the data collection variables and instruments, has been a collaborative effort between CDC, Connecticut State Department of Public Health, the Massachusetts State Department of Public Health, and the Philadelphia Department of Public Health. The following persons have reviewed the data collection variables and instruments for content, clarity, frequency of collection and necessity. Each individual has been consulted in 2013 and each is either an expert on DIS investigations or HIV care reengagement. These individuals are listed below in exhibit 2.

Exhibit 2. External Project Review Consultants

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Heidi Jenkins: Principal Investigator; Program Director, Connecticut DPH Fax-(860)-509-7853 Cell-(860)-558-9051 heidi.jenkins@ct.gov	Merceditas Villanueva, MD: Co-Investigator; Clinical Services Director; Yale University School of Phone: (203) 688-6959 Fax: (203) 737-4051 merceditas.villanueva@yale.edu
Frederick Altice, MD, MA: Co-Investigator; Research Frederick Altice, MD, MA: Co-Investigator; Research Director; Yale University School of Medicine Director frederick.altice@yale.edu	

9. Explanation of Any Payment or Gift to Respondents

The Massachusetts Department of Public Health will offer a token of appreciation in the amount of a $25 CVS gift card to participants who agree to take the “Barriers to Care Survey” which will be offered in their respective CoRECT clinic. “The Barriers to Care Survey” will be utilized to inform the study on what circumstances are preventing those identified as “out of care” from engaging or beginning treatment/care for his or her HIV diagnosis. The CoRECT trial aims to evaluate an intervention to identify HIV-infected persons who are out-of-care and engage them in HIV care. Health department laboratory surveillance data and clinic appointment data will be shared at monthly case conferences to define recent out-of-care HIV-infected individuals. To improve participation and survey completion for those who have been located or contacted by DIS to re-engage HIV care, tokens of appreciation will be offered to compensate for the participants time and effort. The Barriers to Care survey” compensation is considered to be a standard practice at CoRECT clinical sites so individuals randomized to participate in the trial and other clinic participants will be offered the survey.

Prior research projects have utilized tokens of appreciation for participants who have agreed to participate in a survey. It is also predicted by study coordinators that offering tokens of appreciation will increase survey response. Research projects such as Development of Messages for the Act Against AIDS National Testing Campaign OMB # 0920-0920 and the HIV Prevention among Latino MSM: Evaluation of a locally developed intervention OMB # 0920-0942 both utilized tokens of

appreciation to garner participation and increase survey completion which will ensure valid findings.

10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

Project Overview

The CoRECT study is a randomized controlled trial that seeks to establish a data-sharing partnership between health departments and HIV care clinical providers to identify HIV-infected persons who are out of care and evaluate and intervention that aims to link and retain them in HIV care. The study is funded by CDC through cooperative agreements with the Connecticut State Department of Public Health (in collaboration with Yale University School of Medicine), the Massachusetts State Department of Public Health, and the Philadelphia Department of Public Health (DPH).

The three health departments participating in the CoRECT study will generate an out-of-care list using HIV laboratory surveillance data. Collaborating clinics will concurrently generate out-of-care lists using clinic appointment data. The combined out-of-care list will be reconciled by the health department and clinics, and discussed at monthly case conferences. An out-of-care individual will be defined as: (1) a person who has received HIV medical care at a CoRECT clinic and then disengages from care (no clinic visits or HIV labs (CD4 count or HIV viral load) in six months); or (2) a person with newly diagnosed HIV infection who has an appointment at a CoRECT clinic, but has not linked to medical care within 90 days. Each study site will enroll 600 out-of-care HIV-infected individuals (300 per arm) during a two-year enrollment period. All individuals determined to be out-of-care will be randomized to receive either: (1) usual linkage and engagement in care services (standard of care [SOC]); or (2) an active health department field services intervention in addition to SOC. The active intervention activities will vary among jurisdictions. This is the intervention being evaluated in this study; all individuals receiving active intervention are participants in the study and randomized to the intervention arm. All sites will include field services to locate, contact, and provide assistance, including a same-day appointment, to access HIV medical care. The field services will be conducted by the health departments' Disease Intervention Specialists (DIS) who are trained to conduct voluntary interviews with patients who have been diagnosed with a sexually transmitted disease in order to obtain the names and contact information of their sexual partner(s) and then use that information to contact a patient's sexual partner(s) and inform them of their potential exposure to an STD or HIV. Locating, contacting and providing assistance to individuals who are found to be out of care will enable them to re-engage in HIV care.

In addition to using a Data-to-Care approach to identifying persons who are out of care, the Philadelphia and Connecticut Departments of Health will also conduct the evidence-based Antiretroviral Treatment and Access to Services (ARTAS) intervention.

For the Connecticut Health Department CoRECT intervention, individuals randomized to the intervention arm will receive field services to locate, contact, and provide assistance to access HIV medical care. Dedicated disease intervention specialists (DIS) will be employed by CT DPH for this project.
Core components of the intervention include the following:
1. *Locating patients*: The DIS will spend 30 days with multiple attempts to actively locate the patient randomized to the DIS intervention but will be available 90 days after randomization before the DIS signs off and the case is considered closed for follow-up. DIS will employ all available electronic state information and clinic-based information to find the patient, including searching records for the most accurate locating information, conducting phone calls, field visits to home, work, friends and next of kin.
2. *Contacting patients:* Once the DIS locates the patient, a secure area will be found where a private conversation can take place. After confirmation of identity, the DIS will describe the intervention.
3. *Barriers to Care Assessment:* A barriers to care assessment tool will be administered by the DIS (**Attachment 6**).
4. *Intervention to Address Barriers to Care:* The DIS will also assess the readiness to re-engage into care as well as determine the need for additional interventions prior to the first clinic appointment. DIS will be trained on the ARTAS intervention, which addresses barriers to care. This is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result. To address some of the logistical barriers after locating the client, the DIS will contact the participating clinic to make urgent appointment within 24 hours if possible.
5.*(Re)-engagement and handoff to the clinic:* Once the patient is located, the DIS will work with the patient for up to 6 weeks to assure the first clinic visit occurs. Then the DIS will spend up to an additional 6 weeks with the patient to assure the first medical appointment takes place. If after this time, the patient still is not linked to care, the DIS will sign off with this patient and close the case.

For the Massachusetts Health Department CoRect intervention, individuals randomized to the intervention arm will receive public health field services to locate, contact, and provide assistance to access HIV medical care. Core components of the intervention include the following:

Patient Outreach: Outreach and patient re-engagement efforts will follow the established protocol currently used in conjunction with syphilis and acute HIV infection investigation and follow-up. The reconciled out-of-care line list generated though MDPH-clinic collaboration will include all of the most recent address and contact information for the patient that is available. The field services supervisor will assign cases to field specialists for investigation and follow-up. Field specialists will initiate outreach to locate out-of-care patients within one day after case assignment. Face-to-face initial contact with patients will be prioritized. If locating information obtained from the last known provider is not accurate or is out-of-date, field specialists will conduct public records review (e.g. white pages) to obtain accurate locating information. Absent information necessary to physically locate assigned patients, field specialists will use phone or electronic (e.g. Facebook, email address) to contact patients to arrange a face-to-face meeting.

Barriers to Care Assessment: A one-time survey of persons within both the intervention and control arms of the study. (**Attachment 5**) Survey to be administered by a project clinic provider. Survey focuses on barriers to accessing and remaining in care. All participants will be offered a token of appreciation ($25 CVS gift card) to complete the barriers to care survey.

Efforts to locate and contact out-of-care patients will continue for up to 30 days after case assignment. At least three attempts to locate and contact patients will be made. If within 30 days subsequent to case assignment, a patient cannot be located, is located but contact is not successful or if a patient declines to be interviewed by the field specialist, the case will be closed.

The Philadelphia Department of Public Health CoRECT intervention will be a combination of the traditional public health disease investigation model and the evidence based strengths based case management of the Anti-Retroviral Treatment and Access to Services (ARTAS) approach.

The core components of the PDPH intervention include the following:

1. *Locating patients*: Outreach for the Philadelphia CoRECT program will be conducted by trained DIS who will begin “actively” locating patients randomized to the intervention during the first 30 days after randomization, including contacting individuals via phone calls, letters, or by conducting home visits, and the use of patient locator programs to update contact information. If a patient is not located during this 30-day period, DIS will be available to assist patients for a minimum of 90 days after randomization in response to follow up from the patient.

2. *Contacting patients:* All patients randomized to the intervention arm will be contacted by a DIS, who will confirm the patient's identity, describe the nature and purpose of the contact, and obtain a medical release of information.

3. *Barriers to Care Assessment:* When the DIS engages an OOC patient for the first time, they will inquire about the challenges that have prevented the patient from seeking and/or staying engaged in medical care. DIS are trained to routinely utilize a qualitative interviewing strategy to ascertain very intimate and sensitive information about the nature of a variety of issues that may prevent a patient from obtaining treatment for sexually transmitted. Building on this existing training, DIS will be given a list of domain areas and a list of statements that might indicate a patient is experiencing challenges in the respective area (**Attachment 7**). The DIS will use this information to help gauge future goal setting, strength building and resource referral services that will be offered by the DIS as part of the intervention. Barrier information may also be shared with providers with patient consent to ensure that a continuity of services is maintained. Philadelphia also has a comprehensive HIV Medical Case Management network that is available to provide long term intensive services. All DIS will connect patients to this system when appropriate.

Exhibit 1.Items of information to be collected

Data collection	**Attachment number**
Electronic surveillance and clinic data: Data manager electronically submits clinical and surveillance variables routinely collected by clinics and health departments in de-identified data files. Variables include sex, race/ethnicity, HIV exposure risk category, CD4 and viral load test results, date of first clinic visit, insurance status. Data will be reviewed by project sites monthly and sent to CDC quarterly.	**3**
Electronic clinic data abstraction: Clinic Data manager will electronically submits clinical data to the health department staff to provide a list of potential "Out of Care" for comparison with surveillance "Out of Care" list. Variables include sex, race/ethnicity, CD4 and viral load test results, date of first clinic visit. Data will be reviewed by project sites monthly and sent to CDC quarterly.	**4**
Barriers to Care survey: Massachusetts: One time survey of persons within both the	**5, 6, 7**

intervention and control arms of the study. Survey to be administered by a project clinic provider. Survey focuses on barriers to accessing and remaining in care. Connecticut: One time survey of persons within the intervention arm of the study. Survey to be administered by a Disease Intervention Specialist. Survey focuses on barriers to accessing and remaining in care. Philadelphia: Domain assessment that DIS will use to determine challenges that are preventing the participants from seeking care. The Domain assessment will be a onetime survey the DIS will use to asses barriers to seeking care.	
Standard of Care survey Philadelphia: Self-administered survey of project clinic providers. Two providers from each project clinic will complete the survey at the baseline of the study, every 6 months in the first year of the study and every 3 months thereafter until the end of the study period. Massachusetts and Connecticut: Self-administered survey of project clinic providers. Two providers from each project clinic will complete the survey at the baseline of the study and every 6 months thereafter until the end of the study period. All Standard of Care survey data will be sent to CDC twice yearly.	**8, 9, 10**
Preliminary Case Investigation Form Health Department staff will provide a listing of potential out-of-care patients who will be reviewed to determine those who appear to be out-of-care, as determined by study eligibility criteria, versus those who meet criteria for exclusion. Data will be collected monthly and sent to CDC quarterly.	**11**
Case conference form Health department staff will collect information on final disposition of patients who are in-care versus those who are out-of-care. Data will be collected monthly and sent to CDC quarterly.	**12**
Cost analysis form Health department staff will collect variables for cost	**13**

analysis at baseline and every 6 months during the two year study.	

Overview of the data collection system

The CoRECT Study data collection is comprised of seven core components: 1) electronic clinic data abstraction 2) electronic surveillance data abstraction 3) a "Barriers to Care" survey 4) a "Standard of Care" survey, 5) a Participant Eligibility Disposition form, 6) a Case Conference form and 7) a Cost Analysis form

Electronic clinic data abstraction: Electronic Medical Record (EMR) abstraction will be conducted by project clinic staff at each respective project clinic. These data will be used to develop the "Out of Care" lists to be compared with health department developed out-of-care lists. De-identified client-level data will be collected. Project clinics will send the data to the respective project grantee. Program participant will be assigned a unique program ID. CDC will store and access data by the assigned participant ID. Data from the electronic medical record abstraction will be sent to CDC quarterly. (**Attachment 3**)

Electronic surveillance data abstraction: Electronic surveillance data abstraction will be conducted by project health department staff at each respective project site. These data will be used to develop the "Out of Care" lists. De-identified client-level data will be collected and sent to CDC through SAMS and each program participant will be assigned a unique program ID. CDC will store and access data by the assigned participant ID. Data from the electronic surveillance data abstraction will be sent to CDC quarterly. (**Attachment 3**)

Barriers to Care survey: Each of the three project sites will assess barriers to care. Two of the sites will use a survey (Attachments 4 and 5) to assess barriers to care. In Massachusetts, the survey will be administered once by clinic staff at the participating clinics during the first primary HIV care provider re-engagement clinic visit and will be administered to patients randomized to both arms of the study. In Connecticut, the survey will be given once to the intervention participants. The third site, Philadelphia, will utilize domains (grouping questions by category (ie. housing, time management, challenges with medical providers) to categorize and identify the "Barriers to care" by a trained DIS for the intervention arm (**Attachment 6**). These surveys will provide information regarding barriers to accessing healthcare (e.g., transportation, financial assistance, housing, substance abuse services, etc.)The Barriers to Care survey will be administered once.

Standard of Care survey: As there is likely to be a change in the "standard of care" over the five-year study period, it will be important to understand how the delivery of health services evolves over time at participating CoRECT clinics. Investigators will administer a provider "Standard of Care" survey at baseline and at least every six months during the study period (Attachments 7, 8, 9). One to two providers from each project clinic will complete the survey. The survey is meant to provide a general sense of current linkage/ re-engagement processes.

Participant Eligibility Disposition form: a listing of potential out-of-care patients will be reviewed to determine those who appear to be out-of-care, as determined by study eligibility, versus those who meet criteria for exclusion (such as: deceased; incarcerated; moved; changed providers/clinic; etc.)(**Attachment 12 a, b**)

Case conference form: During the case conference, project health department staff will determine if potentially eligible patients, identified from the eligibility screening, should be included in the study, and if so, to which arm of the study they will be placed. Data will be collected monthly and sent to CDC quarterly. (**Attachment 11 a, b**)

Cost analysis form: At baseline and every 6 months (when standard of care survey is administered), a cost analysis form will be administered by the health department at a small group of clinic sites. This form is meant to provide a general sense of the cost of the intervention to perform a cost-analysis.

None of the data received by CDC will be identifiable, and no information will be used for any purpose other than the purpose for which it was supplied. None of the data received by CDC will include patient names, addresses, phone numbers, social security numbers, medical record numbers, or full birthdates (just month and year). In the data sent to CDC, program participants will be identified only by a unique participant ID number. The unique ID number will be assigned and maintained by the three health departments. CDC will have access to the participant ID key. Once at CDC, the data will be stored in a secure CDC server. All CDC project desktop computers and laptops will be password protected. Further, CDC employees will not be intervening or interacting with program participants.

Privacy Impact Assessment

The NCHHSTP Information Systems Security Officer determined that the Privacy Act does apply to the information collection. This collection is covered under the Privacy Act System Notice 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems. HHS/CDC", which enables the Centers for Disease Control and Prevention (CDC) officials to collect information to better understand disease patterns

in the United States, develop programs for prevention and control of health problems, and communicate new knowledge to the health community. Personally identifiable information (PII) is being collected on the instruments (**Attachment 3, 4**). However, CDC is not receiving any identifiable information.

The following procedures will be used to protect participant records:

- CDC will not receive patient names, initials, medical record numbers, social security numbers, locator or other personally identifiable information.
- Data records received by CDC will only be identified by a unique participant ID number. CDC will not be able to link that participant ID number to any personal identifier.
- All data from the project will be encrypted and stored on a secure CDC server.
- Only authorized and authenticated CDC-based project staff (e.g. project officer, project coordinator, data manager) will have access to the data at CDC.
- CDC project staff will complete the Information Security Awareness Training annually.
- Papers and presentations, on project results, will report aggregated information and will not contain any identifying information that can be traced back to a program participant. The ultimate purpose of these data are to provide information to be used by health care providers to improve re-engagement and retention in care efforts, and to assist patients in achieving and maintaining an undetectable viral load. These goals will allow for persons infected with HIV to live longer, healthier lives and can lead to decreased transmission of the virus.

Waiver of Informed Consent for Enrollment in the Research Trial

Program participants will be informed that participation is voluntary. Patients who do not wish to participate in the study will continue to receive their usual care at the medical clinics. Program participants give consent to medical clinics for receipt of medical care, collection of personally identifying information and for sharing of information for the improvement of medical care.

To summarize, the research components of this study include:

(a) Establishing a data-sharing partnership between health departments and HIV care clinical providers to identify HIV-infected persons who are out-of-care

(b) Evaluate a public health intervention to increase the number of HIV-infected individuals out-of-care who (i) link to an HIV clinic; (ii) remain in HIV medical care; (iii) achieve HIV viral load suppression; (iv) achieve durable HIV viral load suppression.

This waiver is requested because individuals in both study arms will be receiving routine public health services. The following four requirements of 45 CFR 46.116(d) are met:

1. The research involves no more than minimal risk to the participants:

• Patient privacy: the risk of access to protected health information (PHI) is minimal as all data will be maintained on password-protected files and transmitted via a FIPS 140-2 certified encryption algorithm. Data sharing will only occur between designated CoRECT study team participants at the clinics, health departments, and CDC. Any data in paper form will be maintained in a secure location and access will be restricted to CoRECT study investigators. All CoRECT staff will comply with local requirements for training with regards to human subjects research and HIPAA requirements. In addition all data will be de-identified (i.e., removal of name, birth date other than year of birth) prior to analysis and before transfer to CDC.

• Patient privacy: Patients randomized to the intervention arm may become upset when they are contacted by the health department to (re)-engage them in care. However, in all three health jurisdictions, contacting individuals with a reportable infectious disease is a routine public health activity conducted by epidemiologists and DIS. This risk can be minimized by ensuring that staff members comply with all protocols.

The minimal risk criterion, therefore, are met in that the probability and magnitude of harm or discomfort anticipated from enrolling into this study are not greater than those ordinarily encountered in daily life or during the performance of routine public health activities.

2. The waiver or alteration will not adversely affect the rights and welfare of the participants.

• Surveillance data has long been used to inform and initiate public health intervention for infectious disease. With respect to HIV/AIDS, however, use of disease surveillance data to drive public health intervention and to monitor engagement in care is novel. Given the efficacy of antiretroviral therapy in facilitating sustained viral suppression, a public health intervention to facilitate re-engagement in HIV medical care represents an important opportunity to maximize “treatment as prevention” in order to substantially decrease incident

infections, to improve health outcomes for people living with HIV/AIDS, and to promote health equity.

- All 3 jurisdictions have the legal and regulatory authority to collect information necessary to investigate, prevent, and control diseases of public health significance. DIS already receive training to find, counsel, and elicit sexual contacts of persons with priority STIs. In some jurisdictions, DIS also perform outreach and engagement in care work for individuals with acute HIV infection identified through laboratory surveillance data. Thus, the proposed project is an expansion of existing roles for health department personnel.

- The welfare of some individuals randomized to the intervention arm may be enhanced if DIS are successful at facilitating (re)-engagement in HIV care. Patients in the SOC arm may also benefit by having their out-of-care status brought to the attention of their clinicians, who may also offer reengagement services through their existing clinic protocols.

3. The research could not be carried out without the waiver or alteration.

The goal of the trial is to evaluate an intervention to actively engage out-of-care persons compared to standard of care. Informed consent prior to randomization would not be possible because out-of-care persons are often difficult to locate (an expected outcome in both study arms); requiring informed consent for enrollment creates logistical complications that could impact the health department's ability to carry out the intervention. Moreover, if patients are contacted to obtain informed consent before randomization, this would function to some degree as an intervention, which could compromise the findings of the study.

4. Whenever appropriate, the participants will be provided with additional pertinent information after participation.

As part of the health department's routine services and activities, all participants randomized to the intervention arm will be provided with information about HIV clinical care and community resources to address barriers to care. Patients in the SOC arm who (re)-engage in clinical care will also have access to this information.

11. Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB Approval

Based on 45 CFR 46.116(d), the IRB is requested to waive specific informed consent for enrollment into CoRECT study. All three local sites have received IRB approval (**Attachment 14, 15, 15**). CDC will

receive a project determination for each site as CDC involvement does not constitute engagement in human subjects research.

Sensitive Questions

Information on alcohol and drug use, incarceration, housing and employment, financial concerns, and mental and emotional health will be collected as part of the Barriers to Care survey. Collection of this sensitive data will allow clinicians and health care providers to identify barriers to retaining patients in care, and can provide information that will assist them in achieving successful linkage to care for individuals who are newly diagnosed. Drug and alcohol use, mental and emotional issues, incarceration, homelessness and unemployment can all affect both retention and adherence to therapy, collection of this information is necessary for determining factors associated with the stated linkage and viral load suppression outcomes.

In addition, the project will collect information on race and ethnicity that is routinely collected by clinical providers as part of routine care for HIV-infected persons, and will be obtained from eHARS and electronic medical record abstraction.

The context in which questions will be asked helps to overcome potential sensitivity and to emphasize to the respondent the legitimate need for the information:

a. Nearly all questions allow for responses of “don’t know” or “refuse to answer.” In addition to the refusal option the DIS will conduct the surveys using qualitative collection strategies which will give the participants the opportunity to answer questions comfortably.
b. The surveys will be administered by local Health Department DIS who have been previously trained in collecting sensitive information, and will be used for to enhance public health.
c. Massachusetts surveys will be self-administered and Philadelphia and Connecticut’s surveys will be administered by the DIS trained to collect sensitive information.

12. Estimates of Annualized Burden Hours and Costs

The *Electronic Transmittal of surveillance Variables* (**Attachment 3**) will be conducted by a CoRECT study coordinator staff for a total of 4 burden hours for the Philadelphia site, 4 burden hours for the Massachusetts sites and 4 burden hours for the Connecticut site; the data transmittal will occur on a quarterly basis. The Electronic Transmittal of Clinic Variables (**Attachment 4**) will be performed by the CoRECT clinic data manager for each clinic site. They will provide

an out of care list to the study coordinator and these transmission will occur on a quarterly basis. These activities will occur quarterly and is estimated to take 1 hour for a total of 32 burden hours for the Philadelphia CoRECT site, 48 hours for Massachusetts and 104 hours for Connecticut.

The *barriers to care survey* (**Attachment 5, 6, 7**) will be administered by DIS to 300 individuals (intervention group only) in Connecticut and up to 600 individuals (both arms) by HIV clinical providers in Massachusetts. In Massachusetts, the survey will be administered once by clinic staff at the participating clinics during the first primary HIV care provider re-engagement clinic visit and will be administered to patients randomized to both arms of the study. The survey is estimated to take 30 minutes to complete and the estimated total burden will be 300 hours. In Connecticut, the survey will be given once to the intervention participants. The survey is estimated to take 30 minutes to complete and total burden is estimated to be 150 hours. The third site, Philadelphia, will utilize domains (grouping questions by category [ie. housing, time management, challenges with medical providers]) to categorize and identify the “Barriers to care” by a trained DIS for the intervention arm only (300 individuals). (Connecticut and Philadelphia will only be administering the barriers to care survey to the intervention arm for a total of 1200 participants (CT [300]; PHI[300] and MA[600]). We estimate the interview and domain categorization will take 30 minutes to complete for a total burden of 150 hours.

The *Standard of Care survey* (**Attachment 8, 9, 10**) will be completed by each CoRECT provider. Philadelphia will conduct an initial standard of care survey and follow up with the provider to complete another standard of care survey in six months. In total, Philadelphia will administer 8 standard of care surveys to each clinic nurse coordinator and the survey will take approximately 45 minutes to complete for a total burden of 12 hours. Massachusetts will conduct an initial standard of care survey and follow up with the provider to complete another standard of care survey in six months. Massachusetts will administer 12 standard of care surveys total to each clinic nurse coordinator and the survey will take approximately 30 minutes to complete for a total burden of 12 hours. Connecticut will conduct an initial standard of care survey and follow up with the provider to complete another standard of care survey in six months. Connecticut will administer 26 standard of care surveys to each clinic nurse coordinator and the survey will take approximately 30 minutes to complete for a total of 26 burden hours.

The Clinic data manager and the CoRECT study Coordinator will conduct Case Conference Sessions and the Preliminary Case Investigation forms once a month. The case conference and Preliminary Case investigation

sessions will take one hour and these activities will occur at all three CoRECT sites and all participating CoRECT clinic providers.

The Clinic data managers and CoRECT study coordinators will fill out the cost analysis form (**Attachment 13 a,b**) at baseline and every 6 months through the project period (total 4 times). The cost analysis form will take one hour to complete for a total burden of 196 hours.

Table 12A Estimates of Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per respondent	Average Burden per Response (in hours)	Total Burden Hours
CoRECT Study Coordinator	Electronic transmittal of surveillance variables (att 3)	3	4	1	12
Clinic data manager	Electronic transmittal of clinical variables (att 4)	46	4	1	184
CoRECT study Participants	Barriers to Care Survey (att 5,6,7)	1200	1	30/60	600
Clinical Nurse Coordinator	Standard of Care Survey (att 8,9,10)	46	2	45/60	69
Clinic data manager	Case Conference Session (att 12a)	46	12	1	552
CoRECT study Coordinator (health department)	Case Conference Session (att 12b)	3	12	1	36
CoRECT study Coordinator (health department)	Participant Eligibility Disposition form (att 11)	3	12	1	36
Clinic data manager	Cost analysis form-baseline (att 13a)	46	1	1	46
CoRECT Study Coordinator	Start-up cost analysis form-Health department (att 13b)	3	1	1	3
Clinic data manager	Start-up Cost Analysis form-Clinic (att 13c)	46	1	1	46
CoRECT Study Coordinator	Annual Costs Analysis form-Health department (att 13d)	3	2	1.5	9
Clinic data manager	Annual Costs Analysis form-Clinic (att 13e)	46	2	1.5	138
Total					**1731**

Table 12B Estimates of annualized burden costs

The annualized cost to respondents for the burden hours is estimated to be $64,939.29 and the details are provided in Exhibit A12.1A, A12.2A, and A12.3A. The estimates of hourly wages were obtained from the U.S. Department of labor (Bureau of Labor Statistics Wage Data (http://www.bls.gov/oes/current/oes151141.htm)

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Cost
CoRECT study Coordinator	Electronic transmittal of surveillance variables (att 3)	12	34.66	$415.92
Clinic Data manager	Electronic transmittal of clinical variables (att 4)	184	$39.56	$7,279.04
CoRECT study Participants	Barriers to Care Survey (att 5,6,7)	600	24.95	$14,970.00
Clinical Nurse Coordinator	Standard of Care (att 8,9,10)	69	44.95	$3,101.55
Clinic data manager	Case Conference Session (att 12a)	552	46.37	$25,596.24
CoRECT study Coordinator (health department)	Case Conference Session (att 12b)	36	34.66	$1,247.76
CoRECT study Coordinator (health department)	Participant Eligibility Disposition form (att 11)	36	34.66	$1,247.76
Clinic data manager	Baseline Cost Analysis form (att 13a)	46	46.37	$2,133.02
CoRECT Study Coordinator	Start-up cost analysis form- Health department (att 13b)	3	34.66	103.98
Clinic data manager	Start-up Cost Analysis form- Clinic (att 13c)	46	46.37	2,133.02
CoRECT Study Coordinator	Annual Costs Analysis form- Health department (att 13d)	9	34.66	311.94
Clinic data	Annual Costs	138	46.37	6,399.06

manager	Analysis form-Clinic (att 13e			
Total				$64,939.29

13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

There are no other costs to respondents associated with this proposed collection of information.

14. Annualized Cost to the Federal Government

The annualized cost to the government is $1,557,076.00. The cost of this project for the five years (including protocol development, IRB approval and recruitment of clinic sites (year 1); patient recruitment (year 2-4) and final data collection, analysis (year 5) is estimated to be $7,785,380.

Table 14A: Annualized Cost to the Government

	Federal salary grade	Salary	% effort	Annualized cost
Co-operative agreement grant	----	----	----	$1,380,000
CDC Project Officer	GS 14-10	$131,342	50%	$65,671
CDC Investigator	GS 15-10	$154,501	20%	$30,900
Project Coordinator	Contractor	$58,000	50%	$29,000
CDC Statistician	GS 14-10	$131,342	10%	$13,134
CDC Data manager	GS 12-5	$81,487	20%	$16,297
CDC Economist	GS 12-5	$81,487	5%	$4,074
CDC travel	----	----	----	$18,000
Total				$1,557,076

*Salary estimates were obtained from the US Office of Personnel Management salary scale at

http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/ATL.pdf.

The personnel related to the CoRECT data collection include project officers (Medical Epidemiologists) at the GS-13 and 14 levels.

15. Explanation for Program Changes or Adjustments

This is a new collection of information.

16. Plans for Tabulation and Publication and Project Time Schedule

Data collection for CoRECT is projected to begin after the OMB process has been completed. There are four main outcomes of the trial:

1. *(Re)-engagement in care:*

Calculate the number and proportion of out-of-care HIV-infected individuals who attend one clinic visit within 90 days of receiving the study intervention compared with SOC.

2. *Retention in care:*

Calculate the number and proportion of out-of-care HIV-infected individuals who remain engaged in care (two clinic visits at least three months apart within 12 months) after receiving the study intervention compared with SOC.

3. *Viral suppression:*

Calculate the number and proportion of out-of-care HIV-infected individuals who achieve viral load suppression, defined as viral load <200 copies/mL, within 12 months of the study intervention compared with SOC.

4. *Durable viral load suppression:*

Calculate the number and proportion of out-of-care HIV-infected individuals who achieve durable viral load suppression of the study intervention compared with SOC. To achieve durable viral load suppression, the following must be documented: (1) the most recent viral load in the 18-month follow-up period after randomization is <200 copies/mL; *and* (2) the viral load immediately prior to, but at least three months apart from, the most recent viral load is <200 copies/mL; *and* (3) all viral load results between time (1) and time (2) are <200 copies/mL.

Analysis of Main Outcomes

The main outcome measures will be analyzed using an “intent-to-treat” approach; all participants randomized in the study will be included in the analysis regardless of disposition or acceptance of the intervention. If a CD4 or viral load result is missing, it will not be counted in the numerator (i.e., it will be presumed “failure”). A per protocol analysis may be considered, as a secondary analysis, beyond

the intent-to-treat analysis to determine whether the intervention appears to be more efficacious when participants who were misclassified at randomization are censored.

Regression analysis, using an appropriate model based on the structure of the data, will be used to evaluate multivariate models for all four main outcomes. Any baseline characteristics (e.g., Table 1) that are found to be statistically different between intervention and control group and that are felt to be potentially confounding the association between the intervention and the outcome will be considered in the multivariate model. The most parsimonious model is desired – only those variables that substantially confound the relationship between the intervention and the outcome and remain statistically significant will remain in the final model.
It is expected that the project will take 5 years to complete, and that Data analysis will begin within the first three months after data collection begins. Analyses are planned to be completed within 12 months of final data collection. The following is a brief overview of the CoRECT Timeline.

Table 16A Project Time Schedule
Plans for Tabulation and Publication and Project Time Schedule

Activity	Time Schedule
Conduct Cooperative Reengagement Controlled Trial	1-24 months after OMB approval
Data collection	1-36 months after OMB approval
Data analysis	3-36 months after OMB approval (ongoing for program performance monitoring)
Final data analysis	33-48 months after OMB approval
Publication preparation	36-48 months after OMB approval

17. Reasons(s) Display of OMB Expiration Data is Inappropriate

The OMB expiration date will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

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