Strengthening the Capacity of SSPs to Respond to COVID-19

Periodic Report 1

Evaluation Partner:

Introduction

In 2022, the Centers for Disease Control and Prevention (CDC) provided funding opportunities to harm reduction agencies to promote COVID vaccine uptake to people who use drugs, giving rise to both innovations and challenges. The funding portfolio for two funders, AIDS United (AU) and NASTAD, included 50 **Tier 1** grantees overseen by AU and six **Tier 2** and two **Tier 3** grantees managed by NASTAD. Tier 1 grantees generally had lower capacity to provide services (e.g., more resource-limited or low-staff programs) and received $100,000 in funding to incorporate COVID, hepatitis A or B, and/or influenza vaccination and or vaccination linkage services. Tier 2 grantees received $200,000, and Tier 3 grantees (programs with the most robust infrastructure for service delivery and evaluation) received $650,000 each.

This report characterizes the start-up efforts and lessons learned by the two funders and a subset of grantees from both a qualitative and quantitative perspective. Qualitative evaluation includes data collected during early summer of 2022 through interviews and focus groups, and quantitative data includes data collected during the first months of program implementation.

Evaluation Process

The evaluation feedback questions were developed and tested by Facente and revised in April-May 2022, incorporating feedback from NASTAD and qualitative advisors. Two Facente team members facilitated, recorded and transcribed notes of interviews and focus groups with grantees, NASTAD, and AU in May 2022. Seven staff from NASTAD and AU participated via three group interviews. Six grantees from Tier 2 and 3 (HIPS, Open AID Alliance, West North Carolina AIDS Project, Blue Mountain Heart to Heart, IDEA Exchange) participated in one focus group. Seven grantees from Tier 1 in rural and urban settings (Sidewalk Project, Holler Harm Reduction, NEXT Distro, WV Health Right, Prevention Point Philly, One Voice Recovery, Intercambios) participated in a series of interviews. Grantees' program establishment timeline ranged from 20+ years ago to relatively recently established.

Initial data analysis was conducted by a Facente team member who was not present at the focus groups and interviews. The thematic analysis process was completed in the following steps 1) review transcripts, 2) review notes from each team member from each data collection, 3) listen to and watch (if video available) each recording, 4) organize qualitative data into a series of categories, or "codes" based on similar questions asked, and 5) identify initial themes associated with program start-up within each of the categories. As with most qualitative research, analysis began on early interviews and focus groups while others were still being conducted, allowing for iterative adaptation of the interview or focus group guides to respond to emerging themes. The data analysis was complex because the participants involved represented both the funders' and grantees' opinions and perspectives. Unsurprisingly, many perspectives and concerns aligned, providing important insights about the startup efforts for these programs.

Creation of the RFP and Application Technical Assistance

Strategies to Improve RFP Accessibility and Diversity

Both AU and NASTAD staff described a concerted effort to ensure that the application process was both low-threshold and manageable for prospective grantees. The online application was intentionally brief and designed to align closely with concurrently open applications by the Comer Foundation and the Syringe Access Fund to improve efficiency for programs applying to multiple funders. As one NASTAD provider noted, "we really didn't have much deviation [from the Comer or Syringe Access Fund applications] outside of a few additional...context points that were more COVID specific." Few supplemental components were required beyond the simple grant narrative, and grantees were repeatedly assured that "picture perfect language" wasn't needed, and rather the core of the proposal was all that would matter to their ability to be funded.

One important strategy to encourage lower-infrastructure programs to apply for funding was to offer open office hours, in addition to informational webinars about the application process (see text box to right).

Several grantees noted and appreciated these efforts, and remarked on the relative ease of applying for these funds compared to government application processes.

It was also very important to both NASTAD and AIDS United that there was both racial/ethnic diversity and geographic diversity among the grantees, in addition to a commitment to involving people with lived and current experience of substance use in the design and implementation of the programs. Again, in alignment with the Comer Foundation and Syringe Access Fund processes, applicants for this funding were required to submit diversity tables including the racial/ethnic distribution of the Board, staff, and volunteer base of their program. Reviewers then compared those tables to census data for the target region during the review. Extra points were awarded for having proportionate (or better) representation of minority communities, with the diversity of program staff built into proposal scoring rubrics.

> *I know when I'm writing grants and you go to the webinar, those often feel like they're just reading you the RFP, and I always had this anxiety around reaching out to the grantor director to ask questions, because I'm like, 'I don't want to stick out in their mind as the one who didn't know what was going on or couldn't figure it out.' But when there's open office hours, where it's like, 'No, we want you to ask us those questions,' that felt much easier than reaching out on your own, at least. It feels like, 'No, we're expecting you to have questions that you don't know how to answer!'*
>
> *--Staff member from AIDS United*

Geographic diversity occurred naturally, especially because AU and NASTAD both have national reach and relationships with programs country-wide. "I think that made a really big difference in terms of some of the geographic diversity, like we could fund smaller programs, we could fund fiscally sponsored programs, all-volunteer programs. You know, the infrastructure didn't have to be huge," noted an AU staff member. Both NASTAD and AU staff did recognize the limited funding that went to Midwest organizations, which they attributed largely to an unfavorable political climate that drove most SSPs underground in those regions. The opportunity to have "fixed cost" grants (as opposed to requiring applicants to have the infrastructure necessary to meet reporting duties of reimbursement-based grants) also contributed to the diversity of programs that applied for funds.

Despite these successful and encouraging strategies, staff at NASTAD and AU universally cited the truncated timeline for grant applications as a major challenge for both TA providers and potential grantees. “Looking at our grant portal and how many folks started an application but didn’t finish it – I think that they just didn’t end up having enough time, and had to prioritize their funding streams,” explained one AU staff member. Numerous people described the multiple competing funding processes – all during the holiday period – which made it very burdensome for potential applicants to apply during the short timeframe, even with a brief and simple application process. In the end, the timeline not only increased stress for applicants but also had negative impacts on the overall process. “I would have wanted to have done more of the…preparations of TA delivery before the actual implementation began. We didn't really have the luxury of doing that because of the timeline,” said one NASTAD TA provider. “The short nature of it means that we’re kind of throwing things together. Even when we have the best ingredients, the best people you know, you’re still on an accelerated timeline…[with a timeline like this] there’s always going to be that first few months of growing pains, figuring things out,” said another.

Setup of the Technical Assistance System

AU and NASTAD staff were able to reflect on numerous successes and lessons learned for the setup of TA for the 58 grantees of this project. Sharing of information from TA providers to grantees through both webinars and standing office hours has been a core component of the work. However, “peer-to-peer TA” has been a cornerstone of the successful TA in this program so far (see text box to right).

> *We have really tried to embed a lot of peer-to-peer opportunities within all the TA so that they can really lean on each other, and really start to understand where the strengths and things lie within their cohort and leverage that to navigate their challenges, because we are not sitting in the same seats as them. So often, you know, their peers who are doing the same work in other places are the most uniquely suited to answer their questions. So just really trying to concretize those relationships and help folks lean on each other – [that] is a big way that we’re trying to address the partnership and networking aspect[s of the program].*
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> *--NASTAD TA Provider*

Another noted that their role was often “just kind of providing [grantees] the space to meet and talk, and act ‘facilitator’ for that work. There’s a lot of similarities in some of the work that these projects are doing and how they’re going about doing them. So just opening up a platform for them to continue to share ideas…they can bring up questions, challenges, and hopes, and answer each others’ questions.” Another TA provider elaborated, “There were a lot of points of connection made between the programs. Some on their own, some of us were kind of gently nudged, but you know, [there were] a lot of parallel aspects of their programs that hopefully will turn into connections over the project and maybe going forward.”

In addition to the short timeline for setup of TA systems, there was one additional major challenge in TA provision for these otherwise experienced TA providers: they were new to the immunization landscape.

As one described, "Sometimes, that's a really difficult position to be in…trying to guide other folks and deliver technical assistance when you're like, 'We're still trying to get our arms wrapped around what the landscape on vaccines looks like!'" This challenge – faced by most of the grantees in addition to TA providers – was mitigated by relying on existing connections and potential partnerships. One provider at NASTAD explained, "Some of the projects…one of the challenges at first was accessing vaccines and connecting with their health departments. One of the things that I did to mitigate that was to find…the immunization contact person at the Department of Health and actually connect them. And that seemed to work." Both TA providers and grantees observed that challenges related to the COVID vaccine landscape were only likely to increase, as a lapse in emergency funding for COVID makes vaccination or COVID treatment generally inaccessible for uninsured participants at SSPs.

Complexities of Federal Funding for SSPs

<u>Conceptual and Logistical Challenges</u>

Though much progress has been made in recent years regarding federal recognition of SSPs as a vital, evidence-based intervention, the history of federal involvement in harm reduction services has been storied. This history continues to affect the willingness of lifesaving SSPs to seek and receive federal funding for their work (see text box to right).

NASTAD and AU staff also described repeated instances of having to reassure applicants that awarded funding would not suddenly be pulled, as this was something multiple harm reduction grantees had experienced previously from federal funds, even in the past year. These concerns also stemmed from years of mistreatment in their local settings (see text box below).

> *As more and more federal funding is coming into the harm reduction space, [there are] inherent tensions between federal funding and government…and the principles of harm reduction. Foundationally there's just a lot of misalignment there. So as the TA provider, it's kind of difficult sometimes to be the face of this funding…I am so excited for more money for these programs, but I'm just like, the government is a purveyor of harm. And if they're not acknowledging that, or they're not really thinking about that in the way that they're entering this space, that is going to be so problematic, and just not sustainable in the long term.*
>
> *-- TA Provider*

> *No matter what they're doing, even if they are operating in a state where it's 100% legal to have a syringe program – it's 100% legal to carry syringes for any purpose in any quantity – they're still operating with some illegal facets, right? They're serving people who use drugs, and using drugs is illegal. So no matter how friendly their state is to programs, they still have to deal with that sort of pushback, whether it be from community or law enforcement or local government. That still exists, no matter how friendly their jurisdiction is toward syringe programs.*
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> *-- TA Provider*

Despite efforts to simplify and streamline the funding process, there were a number of logistical challenges to rapidly selecting grantees and disbursing funds. First, there were restrictions in government funding that posed real barriers to success: grantees and NASTAD and AU specifically mentioned restrictions on purchasing vehicles ("You can purchase everything to outfit a mobile unit, but you can't purchase the engine and the tires and axles," noted one TA provider); the need to justify small purchases; and restrictions on the use of incentives ("A $5 incentive is an insult," recounted one grantee, and "Most of them are doing gift cards, even though they don't feel it's the ideal way to compensate someone," explained a NASTAD TA provider). A second barrier was the lack of funding available to pay application reviewers for their time. Reviewers with expertise in SSP service provision from all over the country were asked to dedicate considerable time for application review and scoring, and as one NASTAD provider noted, "when asked if we could pay reviewers [to compensate them for their time and expertise], it was kind of a question mark. The CDC was like, 'Well, we'll have to check. We'll have to check.'" Notably, lack of clarity about how funds could be used was not only true for reviewer compensation (see text box to right).

> *In regulation, we're not technically allowed to do what AIDS United is doing, this low-threshold [funding] in increments – having contracts that are not cost reimbursable is not allowed with federal money. And so they have been…clear verbally [since the beginning] that yes, they're OK with that sort of thing. But they have really dragged their feet and been hesitant to put any of that in writing, even though we have many levels of assurances with OGS, with OMB…we've spoken to all the people we need to speak to. But…[without this in writing] it's been a big challenge to overcome in terms of our finance department, in terms of the CDC.*
>
> *-- NASTAD Director*

Especially given the skepticism many applicants had regarding receiving federal funding, this posed extra challenges to the trust-building that NASTAD and AU were hoping to leverage for this project. "Establishing a relationship with the projects that does not seem to be punitive [is something I would have started earlier]," reflected one TA provider at NASTAD. "There's a difference between the TA provider and the Project Officer or project manager." His colleague added, "Yeah…we're not here to grade their performance, but to help aid their performance. [I wish I had established] that type of thing in terms of my relationship with the projects early."

Finally, splitting the project across two major organizations as pass-through funders and TA providers also posed some challenges. As one of the TA providers recalled, "The CDC requested it, so we did it, but it has been challenging to do this so intensely across two organizations with two different funding platforms, data platforms…we're fine. We're doing it. It all makes sense. But I do think…just all the grants going out through one organization would have been much easier to navigate."

<u>*Strategies to Mitigate Grantee Concerns*</u>

While there were numerous challenges to success in rapidly standing up such a huge funding effort across 58 different grantees, overall the project roll-out has gone incredibly smoothly. NASTAD and AU staff credited two major strategies with that success: trusting relationships, and flexibility.

TA providers at both AU and NASTAD described numerous direct and encouraging conversations with applicants, helping to answer questions, make reassurances, or provide support throughout the application and start-up process. For example, "We needed to broaden our compliance bench, even just for this project," explained one NASTAD provider. "Which is great, because we have a lot of, like, really nerdy compliance people who are excited about the financial health of these tiny organizations! You know, with a real mission-driven [sense of] 'We want to get them to this place.'" Applicants were repeatedly reassured that data collection, finance reporting, and other infrastructure needs would not be above what they could handle, and the funding would be secure through the full term of the grant. Because AU and NASTAD had pre-existing relationships and a strong reputation for advocacy and support for harm reduction organizations, these assurances were believable and comforting to grantees.

One of the biggest contributors to the success of this effort, however, has been the CDC's flexible approach to the project. NASTAD and AU staff universally praised the CDC for their methods and interactions. One described, "CDC was really trusting of our process…They wanted to recuse themselves from review meetings to not influence anything, and so it felt like they were just really genuinely curious about the cohort that we had chosen. And approval [of our choices] was not a big process." Their colleague added, "I agree. It felt like they just fully trusted us to make the decisions and gave us…their basic criteria, then let us choose from there." The good feelings extended beyond the application and selection process, too, such that NASTAD and AU staff felt able to support program implementation in the best possible way.

> *We were able to have grantees that I think the federal government would never reach otherwise. And so I think that flexibility [in data reporting requirements] is really appreciated. Also, I feel like [the CDC was] really willing to work with us around trying to keep it as low threshold as possible as little burden on programs while still trying to get what they needed.*
>
> *-- TA Provider*

SSP COVID Vaccination Programs and Startup

Best Practices and What is Going Well

Grantees identified several aspects of the SSP vaccine integration programming that were going well. Both Tier 1 and Tier 2 grantees identified the value in having an already established, trusting relationship with participants, which made participants more likely to accept the offer of COVID vaccine. As one Tier 1 grantee explained, "The thing that's been successful [is] the relationship that we have with people. If they've already established a relationship with the harm reductionist working, it's a little easier for them to hear the information about COVID and accept that we're offering them our best explanation and we have their best interests in mind." For participants with less well-established relationships with SSP staff, grantees described the trust building process as time-intensive. Some grantees discussed broaching the offer of a vaccine carefully with hesitant participants, and only after a relationship had been better established. "[Having a staff person] from the South is really important, and it's something that I'm hoping will build trust and support over time, and then [we can] start to build in COVID little by little."

Grantees described the delicate trust-building process as something they were well-equipped to take on given their experiences providing low-threshold and client-centered services.

The majority of grantees who participated in focus groups or interviews reported that the grant funding enabled them to hire staff for their programs, and many also discussed the importance of hiring staff with lived experience in alignment with harm reduction values. One such program uses a hire-by-day model in which participants can be hired for a day at a time to support kit-making and other SSP operation functions without the pressures of full-time employment. A Tier 1 grantee described the mutual benefit of being able to use grant funds to hire someone with lived experience, as the program expands capacity and the new staff person grows professionally. "It's exciting to watch her get more…harm reduction training and understanding…[We're]watching her kind of blossom in the process, and, as a result of being able to hire her through this grant, we're really going to want to be able to expand her days and have her grow within our organization. So that's been really, really positive." While the ability to hire staff with lived experience was highlighted as a clear benefit of receiving these grant funds, it also came with its challenges which are described later in this section.

Both Tier 1 and 2 grantees also described the utility of providing SSP participant incentives to encourage vaccine uptake. Oftentimes the incentives are monetary and may help sway waffling participants toward vaccine acceptance. As one Tier 1 program explained, "The first month…one of the external partners had an amazing incentive. So, it was $100 for vaccine…and we blew vaccinations out of the water." Most grantees spoke of more modest monetary incentives, in the realm of twenty dollars per vaccination. Another Tier 2 grantee noted that their program gave incentives for any kind of engagement around vaccination, including smaller, non-monetary incentives for simply having discussions about COVID vaccination. "I'll just have candy and water and you know, Cup-a-Soup and stuff like that at the SSPs for them in general, so that we're always working on that trust relationship with people." Grantees made the distinction between the usefulness of incentives with participants firmly against vaccination, which was largely ineffective, and those who weren't sure. Incentives were effective in reaching those SSP participants who had not yet made up their minds about COVID vaccination.

Not all grantees were able to have onsite vaccine services at their SSPs, but some of the grantees were able to offer vaccines on site as part of their services, and talked about how helpful that was, particularly when coupled with incentives. "We actually had the health department on site where people could get vaccinated, and they'd really just sit down with the health department for 15 minutes or whatever. And they got a $20 incentive. And I mean, it was busy. And we had 10 people and six of them got vaccinated." Other grantee representatives who did not have direct access to onsite vaccination remarked that they knew their efforts would be more fruitful if they did.

Our delivery model for syringe exchanges is…we have a car and we're kind of like the Uber Eats so people can text, and we'll drive around…And then the nurses actually come with us. So, if someone's interested, we can vaccinate them right there. So, we have some participants who are, like, right away they remember, 'I need my fourth [shot]! I'm immunocompromised, I've been waiting for you guys, I only want to see you guys. You're the only ones I trust.' -- Tier 1 Provider

Finally, grantees also touted the crucial nature of various partnerships that supported the success of SSP vaccination programming, including those who worked with their local health departments to secure COVID and or hepatitis A and B vaccine, or others who worked with private medical systems to set up referral systems for their participants. Strikingly, several grantees expressed appreciation for the flexibility of the grant requirements, and their partnerships with AU or NASTAD. Participants praised the ongoing communication and support they have received from their funders' TA providers in the startup months of this program. "I'm still very happy with how AU makes grant applications and how they run that process…How do you do harm reduction grantmaking? I think AU has gotten some piece of it. So still appreciative of that." Grantees also valued the TA opportunities and communication with other grantees, as hosted by NASTAD and AU. "I love that we get to meet with people from all around the country; that is really exciting. We have seen a little bit of being able to support and ask advice of other programs, but it is interesting and different talking to people around the country."

Challenges Identified in the First Months of the Grant

While the SSPs prioritized hiring folks with lived experience, two grantees spoke about the challenges in doing so. One Tier 1 grantee explained the general challenge underlying hiring people with lived and current experience of substance use, as transportation and other logistical challenges create barriers to steady full-time employment. "We prefer people with not only lived experience, but current use experience. We don't have a problem recruiting people who are active users. Having said that, it's not an easy job, right? It's not easy to maneuver." A Tier 2 grantee found utilizing program participants as vaccine ambassadors to be even more challenging, explaining that decisive COVID vaccine support was more of a rarity among participants than previously considered (see text box to left).

We were going to use a peer ambassador model where we were actually hiring folks who were using the SSP to…do some of the education addressing concerns. And we could not find anyone who was supportive of the vaccine and in a good position to actually have those conversations. We finally found one person who was vaccinated and very excited to talk to folks about vaccination, but it gave us insight into just like how challenging and how low the vaccination rates are among our folks. So that was eye opening.

-- Tier 2 Provider

Several grantees identified general medical mistrust and/or COVID vaccine misinformation as significant barriers to their vaccination efforts. "So, you know, we're dealing with folks that are already coming into this with a lot of not just vaccine hesitancy, but a real, like disagreement that COVID is actually a thing." Others noted that even for participants who were not fully against vaccination, obtaining a COVID vaccine was not very high on their priority list. Multiple grantees stated that some participants were so deeply entrenched in anti-COVID vaccination views that they were not sure they could persuade them through education attempts, but kept trying for those participants regardless.

Grantees also noted the challenge of resources or attention shifting away from COVID in the US, irrespective of COVID rates, just as their programming was ramping up (see text box to right).

We're back into an area where vaccination is increasingly important. But we're not seeing any structural push to do it. Here, we're actually seeing liberalization of public areas and no mask wearing now as defined by government, except for clinical spaces. Right. So, everything is easing off… I just kind of see an innate contradiction of what we're trying to do as a program, and then what the government is saying we should do.

-- Tier 2 Provider

Another concrete example of this phenomenon was shared by a Tier 1 grantee who spoke of losing their agency's onsite vaccine provider because that provider no longer had the staff to prioritize COVID vaccination. "We're about to lose our vaccine partner; next week is our last week with them. And, you know, I'm not sure what we're going to do next. We will refer people to clinics and to CVS and stuff like that, but it's not the same as bringing people services directly." For these grantees it is frustrating to see public resources and attention shift away from COVID as their agencies were resourced to provide education and vaccine.

For several of the Tier 1 programs, their small size presented daily operational challenges, in terms of meeting the needs of program participants and running the organization, underscoring the crucial nature of this funding to expand program staffing. It was sometimes challenging for these less resourced programs to participate in all of the grant activities (see text box to left).

My outreach coordinator is only here today, three days out of the week. So two days of the week, I'm in charge of, you know, managing the program while also doing outreach and deliveries, meeting people at the drop in space, if that's what they need. And it's a one man show. So I think on those days it can get very complicated to both, you know, provide for our participants, which is what we're being paid to do, while also being present for these [AU grantee] meetings." -- Tier 1 Provider

Indeed, there were several instances where Tier 1 participants were slated to participate in interviews or focus group for this report, and were unable to do so at the last minute because they were pulled away by program crises.

Quantitative Data Collection Process

For quantitative data collection, Facente Consulting understood the need to balance several priorities: 1) guarantee reporting was manageable for grantees, 2) maintain the ability to demonstrate program effectiveness, and 3) ensure the ability to analyze who is being served, particularly with respect to racial and ethnic disparities. As such, Facente embarked on a journey to find a sensible approach that was responsive to: balancing the benefits and challenges of a rigorous evaluation model while being committed to collecting only necessary data; collecting data that would be useful and informative; and

demonstrating to funders that the work done at SSPs is vital and worthy of additional resources and support. The following narrative describes the participatory process used to determine an evaluation model that would be responsive to the needs of funders, program administrators, evaluators, and the community being served.

Monthly Reporting

AU opted to have the Tier 1 grantees provide aggregate data monthly that includes tallies of activities and narrative responses to a few simple questions including challenges, successes, and a spending update. These data are entered into Qualtrics and managed directly by AU staff who then provide developed reports to Facente for consideration in overall evaluation.

In an effort to be collaborative and for the evaluation to be as accessible as possible, it was decided to work with Tier 2 and 3 programs to develop a process that was both data- and program-forward. Facente, in partnership with NASTAD, considered several formats for monthly data reporting including Google Forms to be completed at the end of each SSP session, reporting into Alchemer at the end of the month, and completing an Excel or Google Sheets template. It was decided that the monthly reporting should be handled through Alchemer, an online data collection system, as NASTAD utilizes this system for other projects. Facente met with grantees to discuss monthly data collection and explained that programs would report monthly process data tallies in Alchemer to include the number of interactions, brief vaccine education conversations, detailed vaccine education (5+ minutes), referral to external vaccine sites, and vaccination that resulted from COVID education provided through this project.

Quarterly Reporting

AU presented Tier 1 grantees with an outline template for quarterly data reporting that will also be submitted via Qualtrics. The first of these data reports is due to AU on September 12, 2022, for the interim reporting period of February 15 through August 15, 2022.

In order to engage Tier 2 and 3 grantees in a participatory decision-making process, NASTAD and Facente decided to delay the official data collection start date from April 1 to May 1, 2022. Facente worked with NASTAD to convene a virtual evaluation meeting with the eight Tier 2 and 3 programs on April 13, 2022. The meeting goals were to familiarize grantees with Alchemer, as well as determine the best path forward for quarterly data collection to ensure a fruitful evaluation model that would also be low barrier for programs to implement. At this meeting, Facente discussed the need to balance ease of data collection and reporting with data that would tell the story of the important work being done. Facente then polled programs using the online interactive platform PollEverywhere to understand program's comfort and capacity for each of four options proposed (see table below). Facente believes a participatory process in determining evaluation design is a best practice that should be implemented whenever possible, especially for low-threshold grants. In engaging grantees in evaluation design, staff have the opportunity for greater buy-in in data collection and reporting and have a greater understanding of the importance of program data. Grantees expressed gratitude for being able to participate in the evaluation design conversation, being asked what was meaningful and possible, and noted this was a unique experience.

Proposed Quarterly Data Granularity Options and Models for Data Reporting	
Option A	**Overview:** All programs provide aggregate-level data only. No client-level data reported in monthly or quarterly reports.
	+ Simple, quick, and not overly burdensome.
	- Encounter data is limited in telling us about program successes. There is no way to attach demographics to outcomes so limited in being able to assess equity.
Option B	**Overview:** All programs provide client-level data for those vaccinated on-site. No client-level data reported in monthly reports, quarterly reports include client-level data only on participants who have been vaccinated with support of the program.
	+ Not overly burdensome as numbers of folks who are vaccinated should be manageable. Helps us better characterize who has benefitted from these efforts.
	- Collecting client level data may be a challenge for some programs. Will not have a complete picture of those that do not vaccinate through the program.
Option C	**Overview:** All programs provide client-level data for any participant in the program. No client-level data reported in monthly reports, quarterly reports include client-level data only on all program participants who have engaged with SSP vaccination efforts, regardless of vaccination outcome.
	+ Will provide the fullest picture in terms of programs outcomes and effectiveness, and who is being served.
	- Collecting client-level data may be a challenge for some programs.
Option D	**Overview:** Each program would decide what level of data reporting they could do. In this hybrid model programs can opt to do process/activity tallies only, or some client-level data reporting as capacity allows.
	+ Meet programs where they currently are and work with them to get to client-level reporting for all participants.
	- Data not consistent across all programs. Trickier for evaluators to piece together the full story.

Through this process, grantees overwhelmingly indicated the ability to collect and report on some client-level data reporting (Option B), and a preference for implementing the hybrid model (Option D), given an understanding that programs would be at different capacity and capability levels.

After the meeting, Facente and NASTAD agreed on the following parameters for Tiers 2 and 3 data reporting:

1. FC will implement a hybrid model to begin and will provide technical assistance to agencies as needed until all programs are able to report client-level data for all participants, ideally by the end of CY 2022. This allows for programs to elect a comfortable level of data reporting that understands current capability while pushing to increase that capability.

2. Programs will report the following on a quarterly basis: race, ethnicity, age, gender, housing status, concern regarding getting COVID on a Likert scale of 1-5, ever had COVID, COVID vaccination outcome, and other vaccination outcome (hepatitis A, hepatitis B, and flu).
3. Narrative will be collected via qualitative efforts, to contextualize input and ensure understanding.

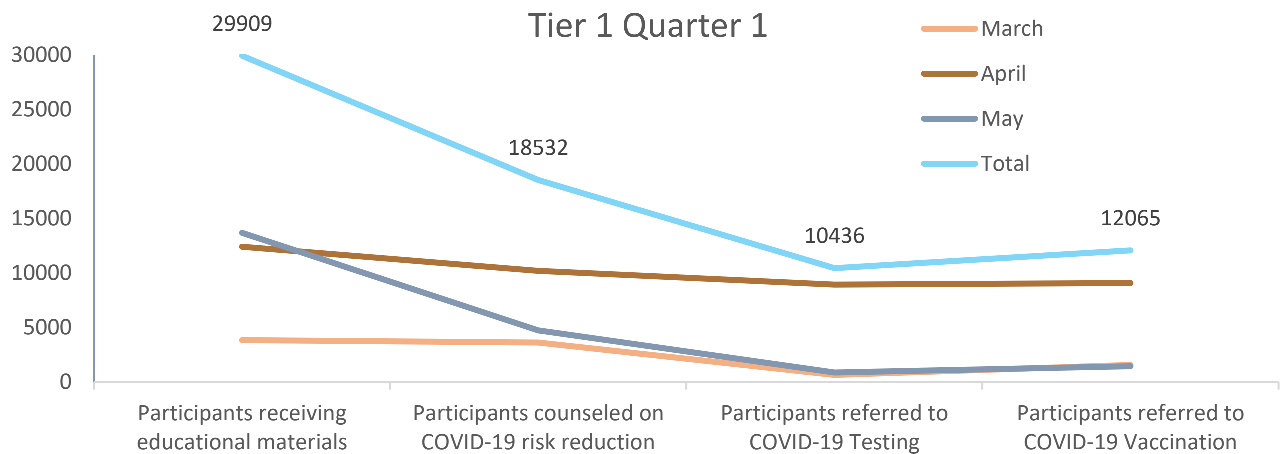
Facente then developed an Excel spreadsheet for quarterly data collection and sent it to Tier 2 and 3 grantees. To determine feasibility and capacity to implement client-level data collection and reporting, Facente then met with each of the Tier 2 and 3 grantees separately to discuss the agreed upon data reporting plan, offer technical assistance, ask about their challenges in meeting data reporting requirements, and answer any questions they may have regarding any aspects of the evaluation. To further support evaluation efforts, Facente created monthly drop-in "office hours" for Tier 2 and 3 programs that have data collection questions or TA requests. The first office hours session was held on May 20th and one of the eight grantees participated. It was a valuable use of time to ensure Facente could clarify data reporting requirements and expectations.

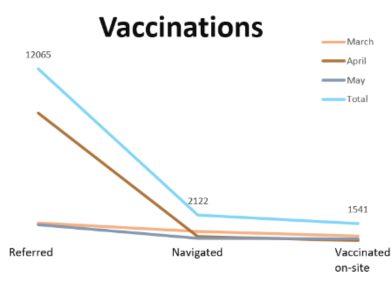
Quantitative Data Analysis

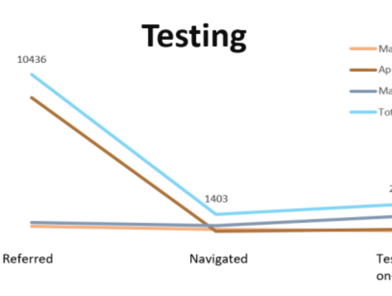
Tier 1 Data

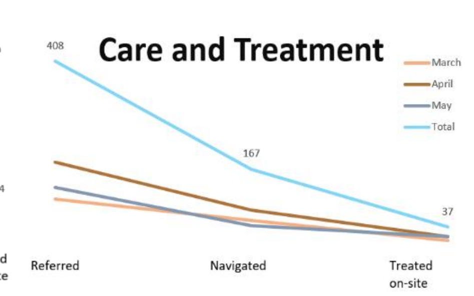
Data for Tier 1 programs were complete, with the participation of all 50 programs. It is likely that this was the result of there being particularly low-threshold data to collect and report. In quarter 1 (March through May 2022), Tier 1 programs created 231 educational materials including informational brochures, pamphlets, slideshows, handouts, and social media graphics on COVID-19 vaccination. Programs distributed these materials to 29,909 SSP participants. A total of 18,532 participants were reached through 6,851 counseling sessions. Most programs conducted individual counseling sessions; however, data indicate that several programs were successful in providing small to large group counseling sessions. 12,065 participants received referrals to COVID-19 vaccinations. Of these, 2,122 received navigation to vaccination and 1,541 were vaccinated on-site. 12% of those that were referred to COVID-19 vaccination were able to receive their vaccination on-site at the SSP.

It was notable that beyond vaccinations, significant work occurred on-site at programs, including testing and care and treatment for COVID-19. In fact, in these three months alone over 2,000 tests were conducted, and 37 participants received treatment for COVID on-site. In addition, staff provided navigation to testing, vaccination, and care and treatment to those who required additional support to receive services.



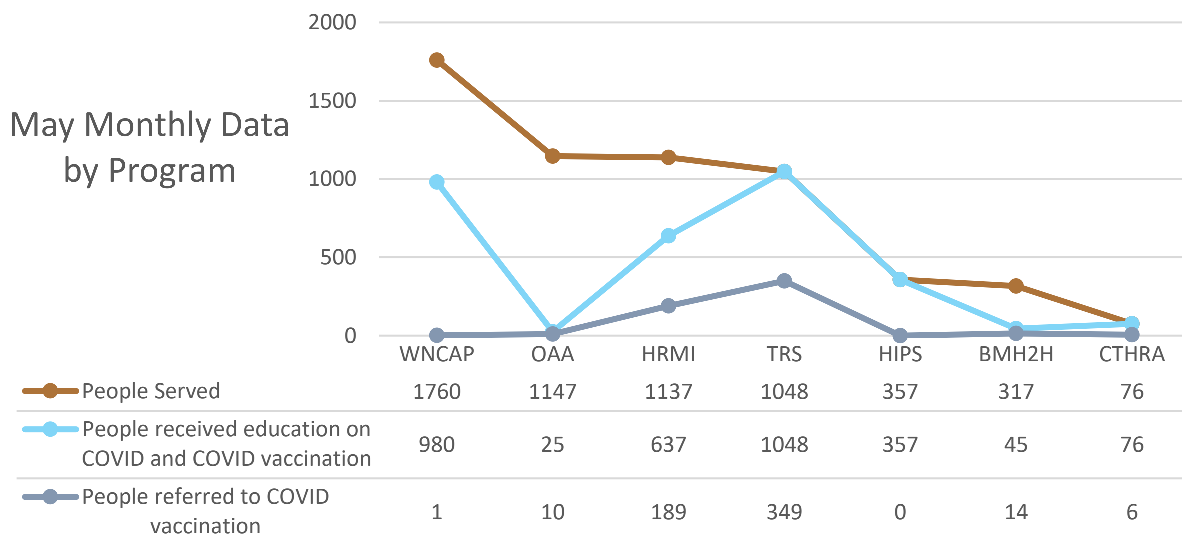






Tiers 2 and 3 Monthly Data

Seven of the eight Tier 2 and 3 programs submitted monthly data for May 2022: Blue Mountain Heart to Heart, Connecticut Harm Reduction Alliance, HIPS, Harm Reduction Michigan, Open Aid Alliance, Transforming Reentry Services, and WNCAP. A total of 5,842 participants were served by these seven programs in the month of May. Of those, 3,168 received education on COVID and COVID vaccination, 569 received referral to COVID vaccination, and 364 participants were vaccinated.

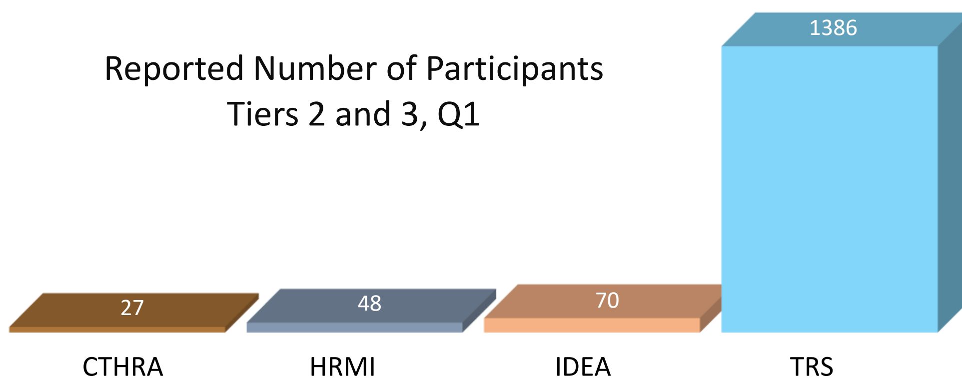


	WNCAP	OAA	HRMI	TRS	HIPS	BMH2H	CTHRA
People Served	1760	1147	1137	1048	357	317	76
People received education on COVID and COVID vaccination	980	25	637	1048	357	45	76
People referred to COVID vaccination	1	10	189	349	0	14	6

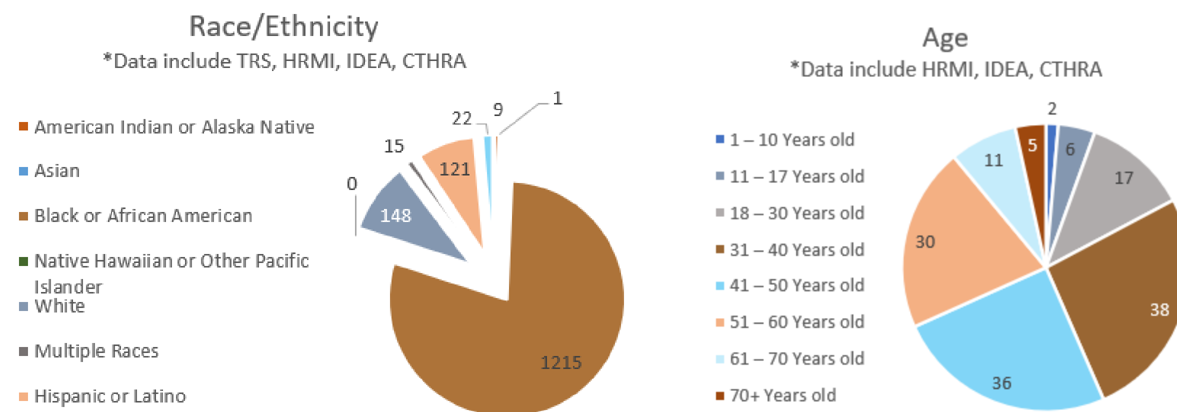
In May, 54% of SSP participants received education on COVID and COVID vaccination. Considering that many programs are in early phases of their COVID programming, it is expected that this percentage will increase over time as capacity for engaging in these conversations increases and program staff are onboarded.

Tiers 2 and 3 Quarterly Data

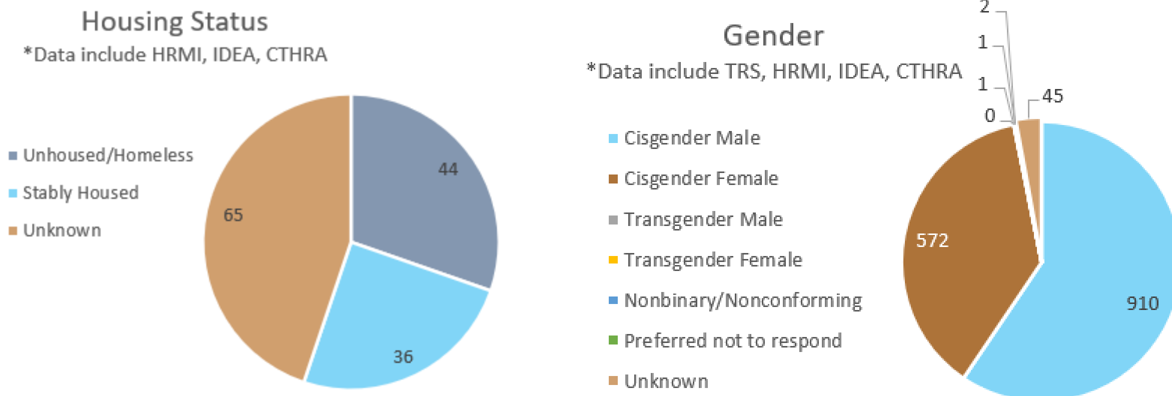
Quarter 1 data for programs in tiers 2 and 3 included only May data due to the later start of data collection. Of the eight programs in these two tiers, only four programs submitted quarterly data: Transforming Reentry Services, Harm Reduction Michigan, IDEA Miami, and Connecticut Harm Reduction Alliance. For those who did submit, some of the data reported were incomplete, missing vital measures or included limited participant data. Although programs initially demonstrated confidence in their ability to produce the requested data, at the time of data submission it was clear that programs required substantial support to complete quarterly data submissions. Facente will provide additional assistance to grantees in subsequent reporting periods.



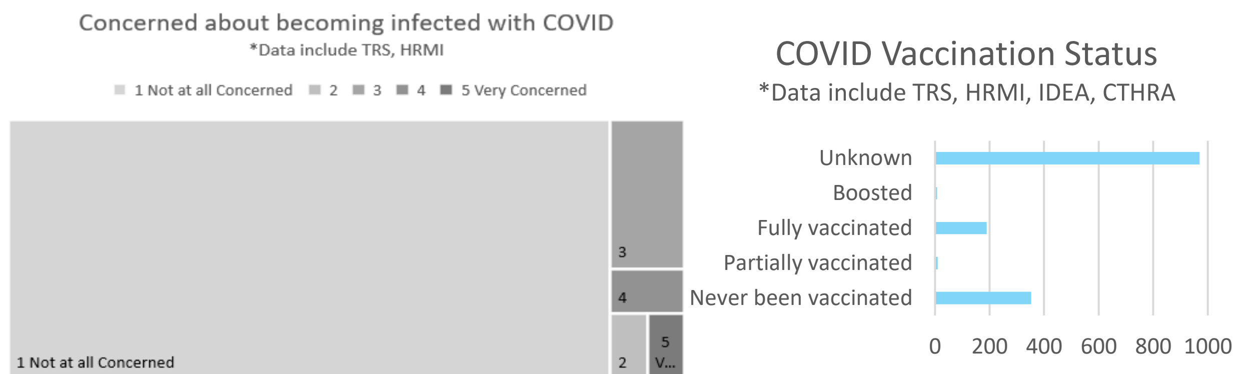
The data submitted indicate that most participants served have been Black or African American. The overwhelming majority of participant data was received from Transforming Reentry Services, which primarily serves people who are Black/African American in Chicago. Age data show that there is a wide range of ages served in participating SSPs, including minors and people over age 60. The majority of people served are between the ages of 31-40, then 41-50, and then 51-60 years old.



To date there is a dearth of information on participants' housing status, indicating this may be a new data collection field for some programs. In addition, gender data are also lacking and may require programs to ask for this information for the first time or ask for this information in a different way than previously asked.



Of the data reported for this May 2022, 7.4% of total participants were vaccinated on site at the SSP. Interestingly, data on participants' concerns regarding becoming infected with COVID showed that most participants were 'not at all concerned' about getting COVID. However, data do not suggest that this is a result of vaccination status; vaccination status is unknown for the majority of participants, but for those for whom this information is known, most have never been vaccinated.



Further Reflection and Conclusion

The theme of trust permeated reflections about the start-up evaluation process, from the trust demonstrated by the CDC to NASTAD and AU and programs through their flexibility, to the deep-built trust between programs and clients. Funders and program providers felt validated and empowered by CDC guidance, despite the truncated timeline. Trust trickled down to the relationships between TA providers and programs, from the application process to delivering TA for program implementation. One of the cornerstones of the start-up process was the peer-to-peer sharing of ideas and challenges. To that end, trust between programs is increasing, and building community is crucial for this work. Although most feedback was positive, the history of the federal government's historical disenfranchisement of

harm reduction programs is a wound that will be slow to heal and should be acknowledged in funding announcements and communication.

Despite Facente collaboratively engaging with programs to determine and support quarterly data processes, issues related to submitting data and data completeness persist. Programs are clearly challenged in providing services to meet the overwhelming community needs while balancing administrative tasks with limited staffing. This is evident in the process to collect and report on quantitative data and was spoken about in qualitative conversations. Facente anticipated challenges for the first month of data collection and reporting, and will continue to work with programs to ensure completeness of data for future reporting periods, providing technical assistance and capacity building to support development of data collection and reporting structures within programs.

The COVID story, as told by programs through qualitative and quantitative data, is that clients are generally unconcerned about COVID and are not particularly inclined to engage with COVID vaccination because they do not feel they are at high risk. However, programs are adapting to and developing solutions to increase vaccination and, improbably, having significant success vaccinating a skeptical population. This start-up evaluation is promising because there is evidence of the trust manifested, flexibility granted, and TA generously provided.