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A Novel Care Navigation Intervention for Patients with Methamphetamine Use Disorder

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Abstract

Patients with methamphetamine use disorder (MaUD) face social, financial, and systemic barriers to accessing evidence-based addiction treatment. We designed a care navigation intervention to better engage patients with MaUD in treatment after an acute care encounter. This intervention was modeled after linkage-to-care strategies for infectious diseases and emphasized rapport building, trauma-informed care, and practical assistance in overcoming barriers to treatment. We also added elements of contingency management given its treatment efficacy with MaUD. We describe the development of the care navigation model, characteristics and care needs of subjects receiving the intervention, and intervention engagement outcomes. Among 94 patients who received this intervention as part of a randomized controlled trial, 64% were considered engaged with at least 2 or more visits with the care navigator. Patients had substantial barriers to care—85% of patients were not stably housed, 83% were unemployed, and 46% lacked access to a phone—and the most common domains of need were accessing addiction treatment, housing resources, or communication needs such as a phone or interpreter services. This intervention poses a model for connecting patients with MaUD to treatment after acute care encounters.

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Keywords

Methamphetamine; Methamphetamine use disorder; Care navigation; Addiction; Case management

Introduction

Methamphetamine is an addictive psychostimulant that is the second most implicated drug in overdose deaths in the United States. Overdose death rates involving methamphetamine have more than tripled in the last ten years (Jones et al., 2022), and methamphetamine use is associated with numerous adverse medical outcomes including cardiovascular disease, bloodborne pathogens, psychosis, and suicidality (Darke et al., 2008). Despite the scope of this epidemic, individuals with methamphetamine use disorder (MaUD) face systemic barriers to treatment including high rates of homelessness, psychosocial barriers, and stigma against disclosing use (Cumming et al., 2016; Kenny et al., 2011; Lappan et al., 2020; Tsui et al., 2020). People who use methamphetamine are often ambivalent regarding use—indeed they may perceive benefits of use—and reluctant to seek treatment (Banta-Green et al., 2020; McMahan et al., 2020). The majority of persons with MaUD report a history of childhood trauma and may therefore experience distrust with treatment settings, which are often perceived as prioritizing opioid use disorder treatment and inexperienced in treating stimulant use disorders (Cumming et al., 2016; Tang et al., 2021).

There are no medications approved or highly effective for treatment of MaUD, and contingency management is the best evidence-based treatment for MaUD (Khalili et al., 2024). Contingency management is a behavioral therapy in which positive behaviors are incentivized through material rewards. For treating MaUD, contingency management programs might entail providing rewards to patients for negative toxicology tests or participation in recovery activities. Contingency management programs often utilize reinforcement schedules in which rewards are provided not every occasion but rather with some unpredictable variation; this intermittent reinforcement pattern is more likely to result in enduring behavioral changes. For example, an addiction counselor using contingency management might have a patient spin a wheel after a negative toxicology test. Despite its benefits, contingency management is often unavailable due to funding and regulatory barriers (Glass et al., 2020; Scott et al., 2021).

Care navigation interventions can help patients overcome barriers to care and successfully engage in treatment. Generally, navigation interventions use dedicated staff who work with patients to facilitate treatment adherence. Navigators may assist with issues related to transportation and insurance; remind patients of appointments; and educate patients on addiction and treatment services. Such linkage-to-care models are considered the standard of care for HIV treatment (Mayer, 2011) and show promise in improving outcomes among patients with substance use disorders, particularly after encounters in emergency settings (Menon et al., 2016; Worthington et al., 2022).

As part of the Beginning Early and Assertive Treatment for Methamphetamine Use Disorder (BEAT Meth) study, we developed a care navigation model to support treatment entry after

methamphetamine-related acute care and hospital encounters. The goal of the current paper is to describe development of the care navigation model, characteristics and care needs of subjects receiving the intervention, and intervention engagement outcomes.

Methods

Setting

This study took place at Denver Health and Hospital Authority (DHHA), a safety-net health system in Denver, Colorado, with an integrated spectrum of hospital and outpatient care for medical and psychiatric care including an opioid treatment program (Gabow et al., 2003). Methamphetamine is the second most commonly implicated drug in overdose deaths in Colorado and has been reported in the deaths of 4,776 Coloradans from 2000 to 2023 (Colorado Department of Public Health & Environment, n.d.).

Development of the Intervention

We designed a care navigation intervention based on previously described linkage-to-care models intended to support patients who enter treatment after diagnosis of HIV or hepatitis C infection (Levinson et al., 2023; Schwarz et al., 2022). Linkage-to-care models comprise an assessment of patient strengths and goals, education on treatment options, assistance in overcoming barriers to care and accessing community supports, and follow-up to address nonadherence. To adapt this model for patients with methamphetamine use disorder, our group conducted qualitative interviews with individuals with MaUD to understand patients' perspectives regarding their methamphetamine use, related emergency department (ED) experiences, and how to improve linkage to substance treatment (Rinehart et al., 2024). Patients shared common experiences including poor communication and stigma during ED visits; unfamiliarity with symptoms of MaUD; the importance of staff demonstrating empathy and a trauma-informed approach; and the importance of being flexible and meeting patients where they are regardless their readiness to seek treatment after an ED visit.

The resulting BEAT Meth intervention utilized a dedicated care navigator to apply a manualized approach to assessment and patient support after acute care. Prior to discharge, the care navigator met with the patient for a warm hand-off in the acute care setting (ED, withdrawal management program, or hospital). During the first visit, the navigator focused on building therapeutic rapport, fostering psychological safety, conducting a preliminary assessment of barriers to care, and providing initial support to help that patient connect with care. The navigator introduced the linkage-to-care model and contingency management. In completing a semi-structured and patient-driven assessment, the navigator assessed the patient's needs across 16 domains as minimal, moderate, or substantial; substantial needs indicated that the domain was regularly interfering in the patient's ability to engage in treatment and recovery. The navigator prioritized the patient's self-identified barriers rather than systematically assessing each domain. A comprehensive list of domains, evaluative questions, and potential intervention strategies are described in the care manual in Online Resource 1. The navigator introduced contingency management as a tool for reinforcing engagement with the care navigator. For participating in this initial session, the patient had an opportunity to "spin" a virtual wheel for a chance to win money on a debit card. Our

institution only allowed patient reimbursement through a debit card (rather than gift card or other mechanisms).

Thereafter, the care navigation intervention lasted up to 90 days. The navigator attempted to have a face-to-face visit with the patient weekly and was available for phone calls and texts at other times. The navigator made two outreaches per week for the first month and at least weekly thereafter, by whatever modality the patient preferred or by contacting the patient during hospital and office encounters. Visits could occur in the treatment setting, in the community, or virtually. Meeting with the navigator either in person or by video visit qualified patients for an opportunity to win from \$5 to \$50 by spinning at the end of the session; spins occurred up to once per week for 12 weeks or up to \$595. The primary goal of the care navigation intervention was to remove barriers and help the patient access addiction treatment services; thus, the contingency management aspect focused on incentivizing engagement in the intervention and did not incentivize urine toxicology results or other activities. We adopted a harm reduction philosophy, and patients could participate in the intervention notwithstanding ongoing use. Care navigators participated in regular group supervision sessions with a psychiatrist and experienced peer counselor. The care manual provides greater detail on the intervention including philosophy of care; timing and content of subsequent visits; supervision structure; crisis response expectations; and contingency management rules.

Study Enrollment and Intervention Delivery

The intervention was developed and delivered as part of a randomized controlled trial ([NCT06033365](#)). The BEAT Meth trial and main outcomes are described elsewhere. For the trial, we recruited patients who had a methamphetamine-related encounter within the health system between April 2023 and September 2024. Potential subjects were identified through clinician referrals or by the presence of an indicator in the electronic medical record, including a diagnosis or screening response suggesting methamphetamine use. Patients were eligible if they were 18 or older, English-speaking, reported not having received substance use treatment in the past 90 days, were not being discharged to or starting treatment, were not on an emergency or involuntary commitment, and did not have any known barriers to participation over the next three months, such as pending incarceration or planned relocation. After consent and baseline data collection, participants were randomized into the care navigation or usual care.

Measurement and Data Sources

The main goal of the current paper is to describe the developed intervention and to assess engagement with the care navigation intervention. Intervention engagement was measured by the number of intervention sessions completed. Patients were considered engaged if they had at least two in-person or virtual face-to-face visits with the care navigator. The first visit was expected to occur prior to discharging from acute care services, and the second visit represented the patient's first care navigation visit outside the acute care setting.

Patient demographics and health utilization were obtained from the electronic medical record and patient self-report. We derived categorical measures for race and gender, as

patients could report multiple or self-define race, ethnicity, and gender. A research associate administered a baseline survey that included the Accountable Health Communities Health-related Social Needs Screening Tool (AHC-HRSC) (Billieux et al., 2017), Drug Abuse Screening Test (DAST-10) (Skinner, 1982), Modified Addiction Severity Index (ASI) scale (McLellan et al., 1992), and the Readiness to Change Questionnaire (Rollnick et al., 1992). We asked about recent alcohol use and prior treatment, overdose, or use of other substances with methamphetamine. Survey data were recorded in REDCap (Harris et al., 2009), and data were subsequently managed in Python (Python v 3.10). The care navigator documented needs across the 16 domains and interventions provided across each of these domain as well as engagement and incentives received in contingency management on a specially built entry form integrated into the electronic medical record. Contingency management data were also captured in a financial record-keeping system used for accounting rewards. Missing data are reported as such where applicable. This study was approved by the local institutional review board (22–0968).

Results

One-hundred and ninety-three participants were recruited into the study. One participant left the study after baseline completion. After excluding two of 96 intervention patients from analyses who had no initial contact with the navigator after randomization, data from 94 participants are analyzed here. The flow diagram in Fig. 1 describes the recruitment process and intervention cohort. Patients were primarily male (80%), unemployed (83%), and unstably housed (85%) (Table 1). Patients commonly reported daily alcohol use (24%) and use of opioids (27%) or other stimulants (31%). Over half (64%) of participants engaged in two or more intervention sessions, and those received a median of 5 (interquartile range, IQR 2–9) sessions.

The domains most commonly endorsed in the initial visit as substantially impacting recovery were a need for substance use treatment (79%), housing (68%), treatment adherence (50%), and communication challenges (25%) such as access to a phone or interpreter services. Table 2 summarizes the proportion of patients with substantial need by each domain, the portion among those with a need that received an intervention for that need, and the proportion with that a substantial need that engaged in the intervention. Domains related to citizenship, disability, and additional psychiatric services were not identified as substantial barriers at the first encounter; these domains and potential interventions are detailed in Online Resource 1.

Navigators documented a median of 17 (IQR 11–30) intervention elements were provided for engaged patients across 352 study visits. The most common interventions across all visits where a substantial need was identified were referring participants to substance use services, educating participants on treatment, and addressing or enhancing participants' motivation for treatment. The care manual in Online Resource 1 provides a list of additional possible interventions. Among the 60 engaged patients, 307 (87%) sessions included a contingency management spin. Over the entire intervention, the average engaged patient spun a median of 4 (IQR 2–8) times and total mean earnings was \$58 (SD ± \$48; median \$45 IQR 20–81; range \$0–205). No adverse events were reported in relation to this intervention. One patient died of an unintentional overdose unrelated to the study intervention.

We conducted exploratory analyses to identify domains of need that might correlate with engagement. There were no demographic differences between the engaged and unengaged groups (Table 1). Because patients who engaged had more opportunities for needs assessment over time, we focused on social needs identified at the first encounter so as to not incur observation bias and underestimate needs among the participants who did not engage. The Table in Online Resource 2 compares domains of substantial needs between cohorts.

Discussion

Despite significant social barriers—including high rates of homelessness, unemployment, and lack of phone access—over half the participants engaged in the care navigation intervention. This paper describes the domains of need, frequency of interventions, and a manualized approach for working with this population who have a high risk of overdose and other adverse psychiatric outcomes. Successful engagement in this care navigation intervention might presage successful clinical outcomes including participation in evidence-based treatment and recovery.

The appeal of this intervention for patients with MaUD reflects our emphasis on therapeutic rapport and delivery of practical, recovery-focused supports. In our preliminary patient interviews, patients often shared how their past experiences of trauma and stigmatization affected their willingness to engage with healthcare and recovery treatment (Rinehart et al., 2024). Accordingly, we designed the initial visit to focus less on logistical assistance and more on understanding patients perceived barriers to care and building trust. This approach also recognized that patients may be experiencing symptoms related to recent substance use, withdrawal, or other medical and psychiatric symptoms during their index encounter in an acute care setting. The navigator then allowed this discussion of patients' needs to drive what services were provided to patients. This patient-guided approach resulted in high rates of engagement with the care navigator. The observed engagement rates are comparable to other linkage-to-care interventions for at-risk patients with substance use disorders (Schwarz et al., 2022; Worthington et al., 2022). Future work will assess whether this intervention and engagement levels result in improved subsequent health outcomes.

Incorporating contingency management into this care navigation intervention is novel. Contingency management is the best evidence-based treatment for MaUD, and we integrated contingency management into the intervention to incentivize connection with the navigator and to also familiarize patients with this treatment modality. The immediate goal of the intervention was to address patient areas of need and to connect patients to ongoing, evidence-based addiction treatment. As our goal was engagement in treatment rather than sobriety, we did not incentivize toxicology screening (which also would have been logistically difficult for patients being seen in community settings). Acute care visits in ED, hospital, and social detoxification programs are opportunities to offer treatment to patients during a period when they are receptive to discussing addiction treatment and recovery (Lindsay et al., 2024; Zhang et al., 2021). While we cannot definitively assess the impact of contingency management as all intervention patients received it, this study suggests promise for including discussion, demonstration, and even enrollment into contingency management

as part of a care navigation intervention. The benefit of contingency management likely encouraged participation across the breadth of the intervention: In addition to contingency management (Brown & DeFulio, 2020), there are additional mechanisms by which this intervention can improve future engagement in care. The care navigator has the opportunity to build rapport with patients who often experience stigma and distrust of healthcare systems. This rapport is founded on an empathetic, trauma-informed relationship as well as a commitment to addressing patient-identified concerns in accessing treatment. Through this relationship, the patient is supported to contemplate treatment and problem-solve barriers to care. The navigator is also able to advocate for patients entering services, as by completing referrals or providing treatment programs with necessary clinical background.

Our description of key areas of social need among patients with problematic methamphetamine use can guide clinicians and policymakers in improving care for this population. The high frequency of needs related to accessing substance use was predictably high and likely reflects our recruiting patients during substance-related healthcare encounters. Navigators also recognized barriers related to housing and shelter in most patients and aiding in treatment adherence through patient education and communication with other providers. Other common issues related to assisting with means of communication (as by providing a cell phone) and transportation needs. Few patients appeared to share significant needs related to certain domains, which may reflect idiosyncrasies of this population or health system and will vary in other locales. (For example, patients did not describe barriers to accessing psychiatric services in the first encounter—likely, patients’ psychiatric care needs were categorized as relating to substance treatment, which is somewhat moot in a system that closely integrates psychiatric and substance treatment care.) Patients who received specific interventions related to these areas of need appeared to engage with the care navigator at high rates. Yet whether these interventions resulted in higher engagement rates is difficult to discern due to observation bias—we were able to report more instances of interventions among patients who were engaged for longer. Sometimes a domain of need was recognized, and a plan made to provide more specific interventions at a subsequent visit. Our results more readily speak to the demand for these specific services among this population rather than their differential impact on outcomes. The most commonly delivered care interventions entailed assisting with referrals for ongoing care, enhancing motivation for and education on treatment, anticipating strategies for adherence, and communicating among providers. It is paramount that navigators be familiar with systems of care and accessible treatment options.

Delivering this intervention highlighted opportunities for improvement. Although our care navigators worked in a large integrated health system, there was a frequent need to partner in patients’ care with outside organizations—as for arranging housing, alternative treatment services, or other needs. Developing these relationships requires significant time, and growing the size of the navigation team would facilitate this work. This model of care is labor intensive and entails frequent patient outreach, including through community meetings and in prioritizing warm hand-offs prior to discharge to begin to establish a relationship. Our navigators’ caseload size was naturally limited by the pace of study recruitment. Implementing this intervention in practice will inform appropriate case load size, which we estimate to be about 10–15 patients depending on level of need. We used up to two care

navigators at one time; larger teams will see greater heterogeneity in styles and effectiveness among providers.

There are limitations to this study. While we manualized the intervention to improve replicability, there is still likely variation in implementation owing to different skills and styles among navigators and supervisors. Similarly, we defined areas and severity of need using a standardized domain assessment structure (Online Resource 1), but this domain structure has not been validated separately. Implementing this intervention in context of a randomized controlled trial will allow us to assess its effectiveness in achieving clinical outcomes beyond the duration of this intervention; however, this approach limits generalizability to a population of patients who are willing and consenting to participate in a scientific study. We had a high proportion of patients contemplating behavioral change—which may reflect that we recruited a population with interest in study participation or observation bias. Participant characteristics suggest that we were indeed successful in recruiting individuals with substantial social and economic barriers to addiction treatment. Future work will extend these findings to understand the impact of care navigation on medical and psychiatric outcomes including treatment entry, overdose rates, service utilization, and recovery. These data support care navigation and contingency management as a promising framework for engaging patients with methamphetamine use disorder, and future replication can further optimize the duration, frequency, or other processes of this intervention.

Conclusion

Patients with MaUD face many recovery challenges individual motivation, the lack of evidence-based treatment in many communities, social and financial barriers, co-occurring medical and mental health conditions, and morbidity and lethality related to ongoing substance use. New approaches for engaging this population and facilitating treatment entry are urgently needed. While many patients and clinicians despair of the difficulty of MaUD treatment, this intervention suggests that most patients can be successfully engaged through an intervention that emphasizes therapeutic rapport, trauma-informed care, contingency management, and practical care navigation support. These solutions cannot come soon enough for patients, families, and communities who are struggling amid our contemporary methamphetamine epidemic.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Data Availability

No publicly available datasets were generated during the current study to protect participant privacy. The authors welcome outreach regarding collaboration on shared data.

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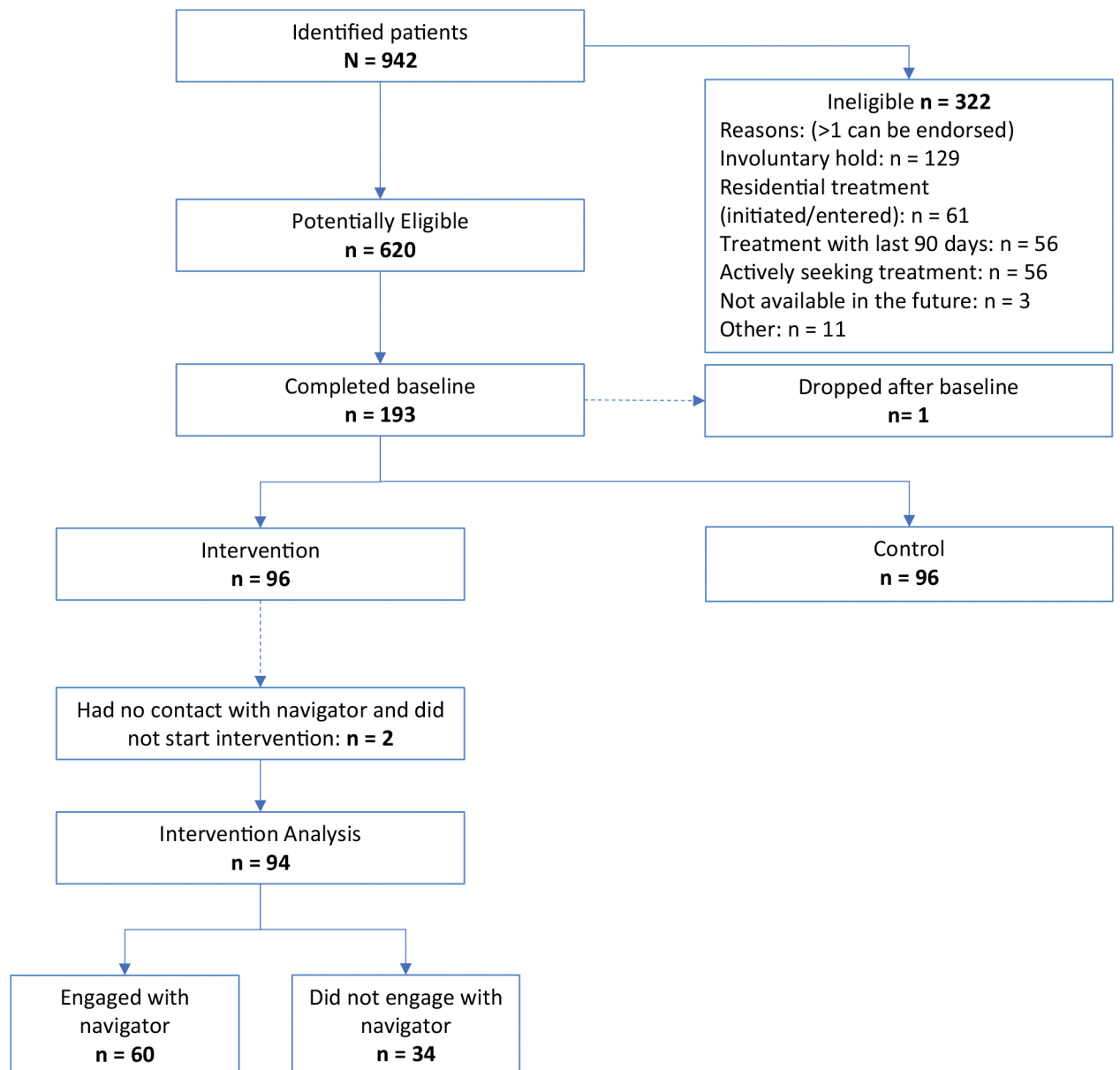


Fig. 1.
Diagram describing recruitment and engagement of a care navigation intervention for patients with methamphetamine use

Table 1

Sociodemographic and clinical characteristics of patients with methamphetamine use in a care navigation intervention ($n = 94$)

	Participants, n (%)		
	Overall ($n = 94$)	Engaged ($n = 60, 64\%$)	Not engaged ($n = 34, 36\%$)
Demographic Characteristics			
Age, median (IQR)	41 (32–51)	41 (32–51)	40 (33–50)
Self-Identified Gender			
Male	75 (80)	47 (78)	28 (82)
Female	17 (18)	12 (20)	5 (15)
Transgender/non-binary	2 (2)	1 (2)	1 (3)
Self-Identified Race/Ethnicity			
White, non-Hispanic	40 (43)	28 (47)	12 (35)
Black, non-Hispanic	11 (12)	6 (10)	5 (15)
Hispanic	27 (29)	15 (25)	12 (35)
Multiple/other	16 (17)	11 (18)	5 (15)
Employment status			
Employed full-time	7 (7)	3 (5)	4 (12)
Employed part-time	9 (10)	5 (8)	4 (12)
Unemployed	78 (83)	52 (87)	26 (77)
Social Determinant Characteristics			
Have unmet health needs ¹	91 (97)	59 (98)	32 (94)
Have no regular access to a working phone	43 (46)	29 (48)	14 (41)
Transportation barriers in the past 30 days	56 (60)	37 (62)	19 (56)
Find it very hard to afford necessities	62 (66)	43 (72)	19 (56)
Currently not stably housed	80 (85)	51 (85)	29 (85)
Currently do not have insurance or health coverage	10 (11)	7 (12)	3 (9)
Substance Use Characteristics			
Drug Abuse Screening Test-10			
Low level (1–2)	3 (3)	1 (2)	2 (6)
Moderate level (3–5)	15 (16)	9 (15)	6 (18)
Substantial level (6–8)	45 (48)	31 (52)	14 (41)
Severe level (9–10)	31 (33)	19 (32)	12 (35)
Modified Addiction Severity Index ²			
None, not at all (0)	13 (14)	4 (7)	9 (27)
Slightly (1)	5 (5)	4 (7)	1 (3)
Moderately (2)	17 (18)	12 (20)	5 (15)
Considerably (3)	30 (32)	20 (33)	10 (29)
Extremely (4)	29 (31)	20 (33)	9 (27)
Readiness for Change ³			
Precontemplation	8 (9)	6 (10)	2 (6)

	Participants, <i>n</i> (%)		
	Overall (<i>n</i> = 94)	Engaged (<i>n</i> = 60, 64%)	Not engaged (<i>n</i> = 34, 36%)
Contemplation	34 (36)	20 (33)	14 (41)
Action	52 (55)	34 (57)	18 (53)
Use of alcohol in prior 3 months			
Never	23 (24)	15 (25)	8 (24)
Monthly or less	29 (31)	19 (32)	10 (29)
Weekly	19 (20)	10 (17)	9 (26)
Daily or almost daily	23 (24)	16 (27)	7 (21)
Use of other substances			
Cannabis	44 (47)	32 (53)	12 (35)
Opioids	25 (27)	15 (25)	10 (29)
Other stimulants	29 (31)	18 (30)	11 (32)
Sedatives/tranquilizers	0 (0)	0 (0)	0 (0)

¹Based on Accountable Health Communities Health-related Social Needs Screening Tool

²Only the following four items from the psychiatric section were included, assessing past 30-day experiences: serious depression, serious anxiety or tension, hallucinations, and trouble understanding, concentrating, or remembering

³The Readiness to Change Questionnaire was modified to refer to methamphetamine use instead of alcohol

Table 2

Domains identified as substantially impairing recovery and related interventions among patients receiving a care navigation intervention for methamphetamine use ($n = 94$)

Domain	Participants with substantial need identified at first encounter ($N=94$), n (%)	Participants who received related intervention across any study encounter, n (%)	Type of intervention provided to address substantial need	Participants with substantial need who received intervention, n (%)	Participants with need identified at first encounter who later engaged (2 + visits), n (%)
Substance Use Treatment	74 (79)	64 (87)	Refer to patient services	59 (80)	49 (66)
			Address/Enhance motivation for treatment	53 (72)	
			Collaborate with treatment provider	37 (50)	
			Schedule appointments	15 (20)	
			Assist with urgent/emergent condition (e.g., intoxication)	11 (15)	
			Follow-up on outcome of referral	11 (15)	
			Accompany to care	1 (1)	
			Assist with obtaining medication	1 (1)	
Housing	64 (68)	29 (45)	Provide short-term shelter options	28 (44)	44 (69)
			Assist with long-term housing	14 (22)	
Treatment Adherence	47 (50)	46 (98)	Education on treatment	46 (98)	32 (68)
			Enhance motivation for adherence	29 (63)	
			Communicate plan to relevant providers	21 (45)	
			Provide strategies to improve adherence	18 (38)	
Communication	23 (25)	21 (91)	Provide cell phone	18 (78)	14 (60)
			Teach on the use of technology	15 (65)	
			Provide additional cell phone minutes	4 (17)	
			Assist with obtaining cell phone	3 (13)	
			Obtain interpreter services	1 (4)	
Transportation	18 (19)	9 (50)	Provide taxi/rideshare	8 (44)	13 (72)
			Provide bus ticket/pass	0	
Employment	10 (11)	10 (100)	Assist with enrollment	8 (80)	7 (70)
			Identify community vocational/employment opportunities	3 (30)	
Domestic Violence and Trauma	4 (4)	2 (50)	Address physical/emotional/social sequelae of DV	2 (50)	2 (50)

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Domain	Participants with substantial need identified at first encounter (N=94), n (%)	Participants who received intervention across any study encounter, n (%)	Type of intervention provided to address substantial need	Participants with substantial need who received intervention, n (%)	Participants with need identified at first encounter who later engaged (2 + visits), n (%)
Medical - Oral/Dental	4 (4)	2 (50)	Connect to domestic violence shelters and/or support organizations	1 (25)	
Legal	3 (3)	1 (33)	Identify dental provider	2 (50)	3 (75)
			Coordination with patient's attorney	1 (33)	3 (100)
			Provide related financial assistance	0	
			Assist with legal resources	0	
Vital Records	3 (3)	0 (0)	Assist with obtaining identification	0	1 (33)
			Provide financial assistance to obtain ID	0	
			Assist with unemployment	0	
Medical - Primary and Specialty Care	3 (3)	3 (100)	Collaborate with provider	2 (67)	3 (100)
			Appointment reminder	2 (67)	
			Manage emergent/urgent condition	1 (33)	
			Schedule appointments	1 (33)	
			Accompany to care	1 (33)	
Food and Clothing	1 (1)	1 (100)	Identify resources for obtaining food or clothing	1 (100)	1 (100)
Medical - Insurance	1 (1)	1 (100)	Assist with enrollment	1 (100)	0 (0)