East Bay Advanced Care:

Eradicating Racism and Striving for Excellence in HIV Care (ERASE)

Implementation Manual

SPNS BMSM Initiative

Authors

East Bay Advanced Care, Sutter Bay Hospitals

Anthony Sillemon, Project Co-Director
Markwell Bahena, Project Coordinator & Data Manager
Damien Sykes, Case Manager
Vernell Shaw, Behavioral Health Case Manager
Sonya Dublin, Project Evaluator
Jeffrey Burack, Project Co-Director
Dandy Meniano, Finance & Grants Coordinator
Julian De la Cruz, Case Manager
Gloria Solorio, Behavioral Health Case Manager

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Background

HRSA's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV who are uninsured and underserved. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV (PWH) to improve health outcomes and reduce HIV transmission among populations considered hard to reach.

The intervention outlined in this Implementation Manual was part of the *Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who have Sex with Men (BMSM)* Initiative (otherwise known as the "BMSM Initiative"). This HRSA Special Projects of National Significance (SPNS) Initiative was funded by the HRSA RWHAP, and the intervention was conducted and evaluated within a RWHAP-funded site. The intervention was implemented by East Bay Advanced Care (EBAC), a subsidiary of Sutter Bay Hospitals (SBH), a RWHAP Parts A, B, and D sub-recipient, and SPNS recipient, based in Oakland, CA. SPNS supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by the RWHAP. SPNS advances knowledge and skills in the delivery of health care and support services to underserved populations with HIV. Through its demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

Specifically, the three-year BMSM Initiative funded eight demonstration sites (or recipients) to implement evidence-informed behavioral health interventions to engage, link, and retain BMSM with HIV in medical care and supportive services. The interventions focused on strategies to integrate behavioral health services with HIV clinical care to specifically address the needs of BMSM with HIV and improve their health outcomes. Each recipient adapted one of four models of care (MOCs) to create an innovative, integrated intervention to serve BMSM with HIV in their respective community.

Introduction

This Implementation Manual provides guidance on how to adapt and implement the Eradicating Racism and Striving for Excellence in HIV Care (ERASE) program, designed and piloted by EBAC, in order to facilitate future replication. Among other things, this Manual describes the selected MOC and adaptations, pre-implementation activities, local evaluation, intervention components and implementation experiences, and intervention outputs and outcomes. This Manual also shares lessons learned and best practices to support successful replication of intervention components.

From September 27th, 2019 to June 30th, 2021, ERASE enrolled 160 clients who completed a total of 2,722 case management visits (17.01 visits on average). Of the 160 enrolled clients, 144 completed the full intervention – defined as immediate linkage to HIV medical care and ongoing case management and service referral/navigation assistance, for 12 or 18 months, depending on the cohort to which they were assigned.

This Manual is designed to provide a broad, concise overview of ERASE to a diverse audience of clinical leadership, HIV service providers, and other stakeholders interested in identifying and implementing new, innovative strategies for improving care for BMSM with HIV and other populations in their communities. More detailed information for future replicators can be found in the Implementation Toolkit, which includes a photo of the dedicated safe space, program flyers, program-specific intake and assessment forms , eligibility screening questionnaire, case management and visit tracking forms, and other protocols that may be helpful for replicators.

Intervention Overview

Demonstration Site Background

East Bay Advanced Care (EBAC), formerly East Bay AIDS Center, at Sutter Bay Hospitals (SBH) in Oakland, California has more than 30 years of experience in providing effective, innovative, culturally-responsive, and accessible HIV services. EBAC primarily serves clients residing in Alameda and Contra Costa Counties, the two easternmost counties of the San Francisco Bay Area, also known as the “East Bay”. EBAC’s jurisdiction is one of the most ethnically diverse in the nation.

Not only is EBAC the largest HIV care provider in the East Bay and one of the largest in Northern California, but EBAC is the only full-time hospital-based HIV primary care center in Alameda County, directly integrating HIV specialty care with primary care by the same provider. As such, EBAC is able to provide some of the most comprehensive services to PWH and those at-risk all under one roof.

EBAC provides a comprehensive continuum of high-quality treatment and support services to all clients regardless of their income status, insurance, or ability to pay. Each year, EBAC provides medical care to over 1,700 PWH, of whom 45 percent are African American, 25 percent are from other ethnic minority groups, 70 percent are men who have sex with men (MSM), and over 50 percent are enrolled in public insurance programs. EBAC also provides robust prevention services, including ongoing PrEP/nPEP services, to 600 HIV-negative individuals, 40 percent of whom are Black and 95 percent of whom are MSM. EBAC’s current clinical staff includes seven physicians, four nurse practitioners, four registered nurses, five medical assistants, and three front desk staff, as well as a fully staffed pharmacy and administrative support personnel.

EBAC's clinic is open from 8:30am to 5:00pm Monday through Friday. Patients are typically scheduled for half hour appointments (longer than the standard visit at most clinics) and same day urgent care visits are always available.

Needs Assessment

EBAC's geographic region is disproportionately impacted by HIV; it has the 17th largest number of cumulative diagnosed AIDS cases of any U.S. metropolitan area, larger than that of 29 US states.[i] Despite being only the seventh most populous county in California, Alameda ranked fourth for cumulative AIDS cases.[ii] From 2006-2016 (most recent available), the total number of PWH in the jurisdiction increased by nearly 40 percent.[iii]

African Americans and MSM in the geographic catchment area are dramatically and disproportionately impacted by HIV. They range from three to six times overrepresented among PWH in EBAC's region[iv,v] and have consistently lower rates of linkage to care, retention in care, and viral suppression than their White counterparts.[vi,vii] These disparities have led to four times higher HIV-related death rates among African Americans in the region.[viii] In 2016, infection rates among African Americans in EBAC's region were over 1 percent; approximately one in every 310 residents was infected with HIV, compared to one in every 93 Black residents.[ix] Thirty-five percent of new MSM infections in the region were among African Americans as of 2016. Among youth ages 13-24, these disparities are even more dramatic: 56 percent of Alameda County and 47 percent of Contra Costa County youth with HIV in 2016 were African American.[x]

The causes of these disparities are complex. Nationally, the literature identifies later HIV diagnosis, fear of stigma and discrimination, and racism in health care settings as major contributors to disparities in HIV outcomes for BMSM.[xi] In the US, BMSM with HIV tend to be younger than their White counterparts, have less formal education, higher unemployment rates, live in neighborhoods with more poverty, and have higher rates of sexually transmitted infections (STIs), specifically rectal chlamydia and gonorrhea.[xii,xiii] In addition, they report higher rates of one-time sexual partners and lower rates of discussing sero-status with partners.[xiv] Young MSM also often report critical needs for housing, mental health, and substance use services—all factors which can dramatically impact linkage, retention, and success in HIV treatment.[xv] Distrust of the medical system and lack of culturally competent care are also long and deep barriers to the provision of effective health care for African Americans in the US. The history of oppression and exploitation, including grievous abuses such as the Tuskegee Study, have left deep rifts in trust which clients and providers must rebuild. The impact of this legacy is seen in HIV care as well, and contributes to disparities in linkage, retention, and effective engagement in care of BMSM. National data also emphasize lack of culturally competent medical services,[xvi] lack of recognition of low health literacy by providers,[xvii] and conspiracy beliefs[xviii] as cultural-medical barriers for BMSM.

Local needs assessment data show unmet mental health, substance use, and housing needs as the primary barriers to care for PWH in Alameda and Contra Costa Counties.[xix] According to local HIV providers, mental health needs are the single greatest barrier for clients with HIV in the region, followed closely by substance use. Approximately 47.8 percent of RWHAP clients in the region reported having been diagnosed with depression, and 42.2 percent with anxiety disorders, as of 2016.[xx] Providers anecdotally report that at least 25 percent of RWHAP clients present with substance use issues. Lack of stable housing (including homelessness) is a third major issue facing PWH in our region. Alameda County and Contra Costa County face severe shortages of affordable housing and both are ranked among the five least affordable counties in the United States.[xxi] The high cost of housing combined with ongoing housing discrimination contribute to dramatic racial disparities in homelessness in the region. In Alameda County, African Americans are 500 percent overrepresented in the homeless population, making up 11.8 percent of the county's population but 54.0 percent of all sheltered and unsheltered homeless persons[xxii]; similarly, they comprise 70 percent of Oakland's unsheltered population.[xxiii] In the East Bay, 18.9 percent of RWHAP clients reported having at least one period of homelessness or unstable housing during the most recent 12-month period (2016).[xxiv]

In the East Bay, there is currently limited culturally competent HIV treatment for BMSM. Most clinics have few staff representing the full range of sexual orientation, age, race, and class of clients, and clients report that clinic spaces and waiting rooms are typically sterile, unwelcoming, and full of stigmatizing stares. EBAC hears anecdotally from BMSM clients that these experiences contribute to their not engaging in care and/or dropping out of care. While 38 RWHAP-funded agencies exist in the East Bay, only five of them provide both medical and mental health services and only two provide both substance use and medical services. While all of the organizations providing medical care also offer medical case management, only two specifically provide treatment adherence support,[xxv] and none provide long-term HIV navigation services for individuals without HIV.

Even with multiple HIV-serving organizations in the region, clients with HIV and at-risk clients do not have access to adequate levels of integrated services. From past experience, even offering medical and behavioral health care in the same agency or at the same site does not ensure effective service integration that can support client retention in care. Disconnected client record systems, HIPAA issues, impersonal referral systems, and long waits for services can result in clients not receiving critical care and being lost to care.

Adapted Model of Care

Original MOC

As noted above, each recipient adapted and implemented one of four evidence-informed MOCs expected to improve linkage to care, engagement in care, retention in care, and HIV health outcomes and address the comprehensive needs of BMSM with HIV. All of the MOCs were

originally developed to improve HIV care and treatment and/or HIV health outcomes for youth and/or adult men of color. EBAC adapted a youth-focused case management intervention.[xxvi] Key components of the original MOC include: two Bachelors-level Case Managers; clinic- and venue-based outreach; a 24-month intervention; and provision of psychosocial case management services. The following table briefly describes the implementation process of the youth-focused case management MOC.

Model at-a-Glance	
Youth-focused case management	
 Step 1	Client referred to **Case Manager**
 Step 2	Case Manager conducts a **comprehensive assessment**
 Step 3	Case Manager develops an **individualized treatment plan**
 Step 4	Case Manager **provides referrals** ● Refer to needed services, including social support and behavioral health
 Step 5	Case Manager meets with client to **assess progress in their treatment plan** ● Scheduled visits are weekly for two months and monthly for 22 additional months. ● Ad hoc communication also includes text messaging, drop-in visits, and phone calls.

Adaptations

ERASE is the first program in the East Bay region to specifically focus on addressing structural barriers BMSM face in accessing care.

In most East Bay clinics, appointments are scheduled weeks in advance, and communicating with clinics requires navigating complex voicemail systems. By contrast, the foundation of EBAC's model is in long-term relationship building with culturally competent staff who invest significantly in building trust and continuously engaging with all clients. EBAC has seen that traditional short-term linkage/navigation models are not typically effective for the high-risk, highly-stigmatized, and hard-to-reach populations that EBAC primarily serves. ERASE used a client-centered intensive case management model adapted from the youth-focused case management model, braided with culturally-responsive approaches to HIV treatment with wraparound supports to provide care for BMSM with HIV ages 18-65. Core MOC adaptations include:

1. Creating a BMSM-specific safe space within EBAC

This was an effective strategy to build trust and reduce stigma and fear by de-medicalizing the physical care space. This strategy was used to transform client relationships with the care system, shift perceived power relationships, decrease social isolation, and decrease barriers to accessing needed services. See the Implementation Toolkit for a photo of ERASE's safe space.

- Complete with a mini-fridge, couches, snacks, music, and decorated with culturally-relevant and affirming items by and for BMSM youth, this space served as a safe space for clients and a waiting room for services.
- Clients could drop in to the space anytime, meet with a peer advocate or Case Manager, walk across the hall to see a medical provider, get labs, pick up prescriptions, see a social worker, or receive services for a wide variety of needs that traditionally create barriers to success in HIV care.

2. Peer staff invest in long-term relationships

- Peer staff with lived experience provided a bridge between the foreign culture of the health care system and clients' own communities. They understood the challenges and motivations clients face and were able to "get the little things right" — for example, asking the extra question in a visit so that medication dosing instructions are clear. Case Managers provided both in-office and home/community visits based on clients' needs.
- Warm handoffs (face-to-face introductions) ensured that the trusting relationship built with ERASE Case Managers could be used to instigate relationships with other care providers.

3. Addressing structural barriers through a "clinic without walls" approach

ERASE implemented policies and practices that reduced barriers to accessing care, including:

- Clients could reach a dedicated peer advocate 24/7 with shared coverage of a staff cell phone.

- Clients could drop in for same-day appointments, including with both medical and behavioral health providers.
- Clients were never penalized for appointment no-shows.
- The program provided transportation, either through public transportation passes, ride shares arranged through the program, or transportation from project staff.

4. Linking to on-site, integrated, wraparound services

For ERASE clients, having access to EBAC's comprehensive services, all under one roof, dramatically reduced the psychological difficulty of going to a new and untrusted environment to receive care. In addition, it reduced the burden of transportation to multiple different sites. Program staff, who all already had established working relationships across the SBH system, provided warm handoffs (often literally walking a client across the hall) to services including:

- Comprehensive primary care and HIV specialty care by the same provider
- Inpatient care by an EBAC physician for clients requiring hospitalization
- A 24-hour on-call physician
- On-site pharmacy with pre-filled pillboxes, delivery services, and automatic notifications to providers regarding missed refills
- Peer navigator program for vulnerable, new to care, and out of care clients
- Shelter Plus Care emergency housing vouchers
- On-site specialty care in psychiatry, psychotherapy, obstetrics and gynecology, colorectal surgery, nutrition, and substance abuse services

Population Served

Initiative Eligibility Criteria

In addition to the eight demonstration sites, NORC at the University of Chicago was funded under the SPNS BMSM Initiative as the Evaluation and Technical Assistance Provider (ETAP). The ETAP designed and implemented a culturally-responsive, mixed methods evaluation to evaluate the impact of the Initiative across recipients. To be eligible to participate in the multisite evaluation (MSE), a client was required to be:

- A person with HIV;
- Aged 13 and older;
- Identify as a BMSM (including cisgender men, transgender men, and gender non-conforming individuals assigned male at birth); and
- Fit into one of the following categories:
    - Newly-diagnosed/new to care;
    - Never entered into care;
    - Fallen out of care;
    - At risk of falling out of care; and/or
    - Not virally suppressed.

For the purposes of this Initiative, risk factors for falling out of care were ongoing behavioral health issues (e.g., mental health and/or substance use disorders), a history of irregular engagement in care, housing and/or employment instability, a history of sexually-transmitted infections, or a history of negative experiences in a health care setting.

Pre-Implementation Activities

Organizational and Community Resources

EBAC is a mature organization, approaching 33 years in 2021, and is positioned within SBH' extensive organizational infrastructure. The clinic bills all major public and private health insurers and benefits programs and receives multiple grants through the RHWAP Parts A, B, and D, and other sources. Maintaining RHWAP service contracts since 1997. EBAC currently manages grants from the Alameda County Office of AIDS, HRSA, and the University of California; subcontracts from UCSF Benioff Children's Hospital Oakland and CalPEP; and participates in various pharmaceutical company-sponsored clinical trials.

SBH is an integrated health care network across Northern California with shared systems that allow for a full continuum of care. EBAC is a subsidiary of SBH, and as such, EBAC staff are able to schedule appointments and support clients in navigating services across the SBH network.

Partnerships

Internal Partnerships

ERASE clients accessed EBAC's full spectrum of partnerships, including other departments within the SBH network. Case Managers referred ERASE clients to services within SBH such as:

Behavioral Health Services

- Inpatient psychiatric services
- Compassionate and experienced outpatient psychiatry and psychotherapy
- Individual and group counseling through a variety of modalities, including Cognitive Behavioral Therapy, mindfulness therapy, occupational therapy, and recreational therapy (e.g., art therapy, etc.)
- Substance use disorder and addiction treatment through the Merritt Peralta Institute for Chemical Dependence Treatment, the oldest hospital-based treatment program in the region. Services include detoxification, inpatient rehabilitation, day treatment, intensive outpatient programs, continuing care services, and an alumni association.
- Behavioral health care specializing in transitional age youth and seniors

- Support groups covering topics such as young adult health, nutrition, mental health, men's health, disease prevention, cancer, caregiving, and end of life. EBAC also held a support group targeted for ERASE participants (see Adaptations section).

Benefits Enrollment and Social Services
An in-house benefits enrollment specialist supports clients presenting without insurance in obtaining MediCal health insurance (California's Medicaid program), as well as enrolling and retaining other public benefits they qualify for (commonly the Supplemental Nutrition Assistance Program (known as CalFresh in California), California Work Opportunity and Responsibility to Kids (CalWORKs), Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)).

In addition, ERASE Benefits Counselors, Case Managers, and Social Workers were all equipped to provide linkage to other community-based resources through longstanding partnerships, including housing, legal services, meal delivery, job preparation and placement, and education services.

Primary, Urgent, and Specialty Health Care

- Full-service pharmacy services were available through EBAC, including specialty services for HIV and hepatitis. The EBAC pharmacy provides an on-call pharmacist, courier delivery of medications, easy medication packaging, refill management, and education and support for medication therapy.
- Urgent care, walk-in care, and emergency departments are all located within the same complex as the EBAC program office.
- SBH includes access to primary care, specialty care, and everyday wellness services, including disease prevention, vision care, sleep diagnoses, urology, allergy consultation, physical therapy, liver care, podiatric services, dermatology, asthma, and dozens more.
- Labs and imaging were available on-site, including for HIV diagnosis confirmation testing.
- Telehealth options were available, including appointments conducted by video or phone, lab and test results available through a mobile application, and direct messages to clients' care team.

Sutter Community Health Programs
In addition to the above services, SBH invests in the community, forming deep partnerships with local organizations addressing the social determinants of health. Through these partnerships, EBAC clients have greater access to a full spectrum of health care, behavioral health, safety from violence, housing and homelessness, and economic security. EBAC staff were able to draw upon these established community partnerships to fully serve ERASE clients through prevention and essential support strategies such as emergency housing vouchers and rental assistance.

External Partnerships

Other HIV Service Providers: EBAC is a member of the Family Care Network, RWHAP-funded agencies who make up the continuum of care for people affected by HIV in Alameda County. While EBAC provided all direct services under ERASE, the Case Managers and Social Worker were able to utilize the networks to cross-refer clients based on their specific needs. Additionally, EBAC collaborated with the Pacific Center for Human Growth (sliding scale mental health, support group, and 12-Step program for LGBTQ PWH) and the East Bay Community Recovery Project at LifeLong Medical Care (HIV services integrated with holistic health, tobacco cessation, and support for reentry and homeless individuals).

Community Services Providers: The Benefits Enrollment Specialist, Social Worker, and Case Managers were able to draw from strong partnerships with community service providers that offer wraparound supports. EBAC regularly partners with the East Bay Community Law Center (clean slate expungement services, legal representation, and legal education), Project Open Hand (meal delivery and congregate nutrition services for people with chronic conditions), Cardea (affordable housing navigation and placement), Allen Temple Baptist Church (faith-based community support services), the Oakland LGBTQ Center, and more than 15 other CBOs. EBAC linked 85 percent of ERASE clients to community and wraparound service providers.

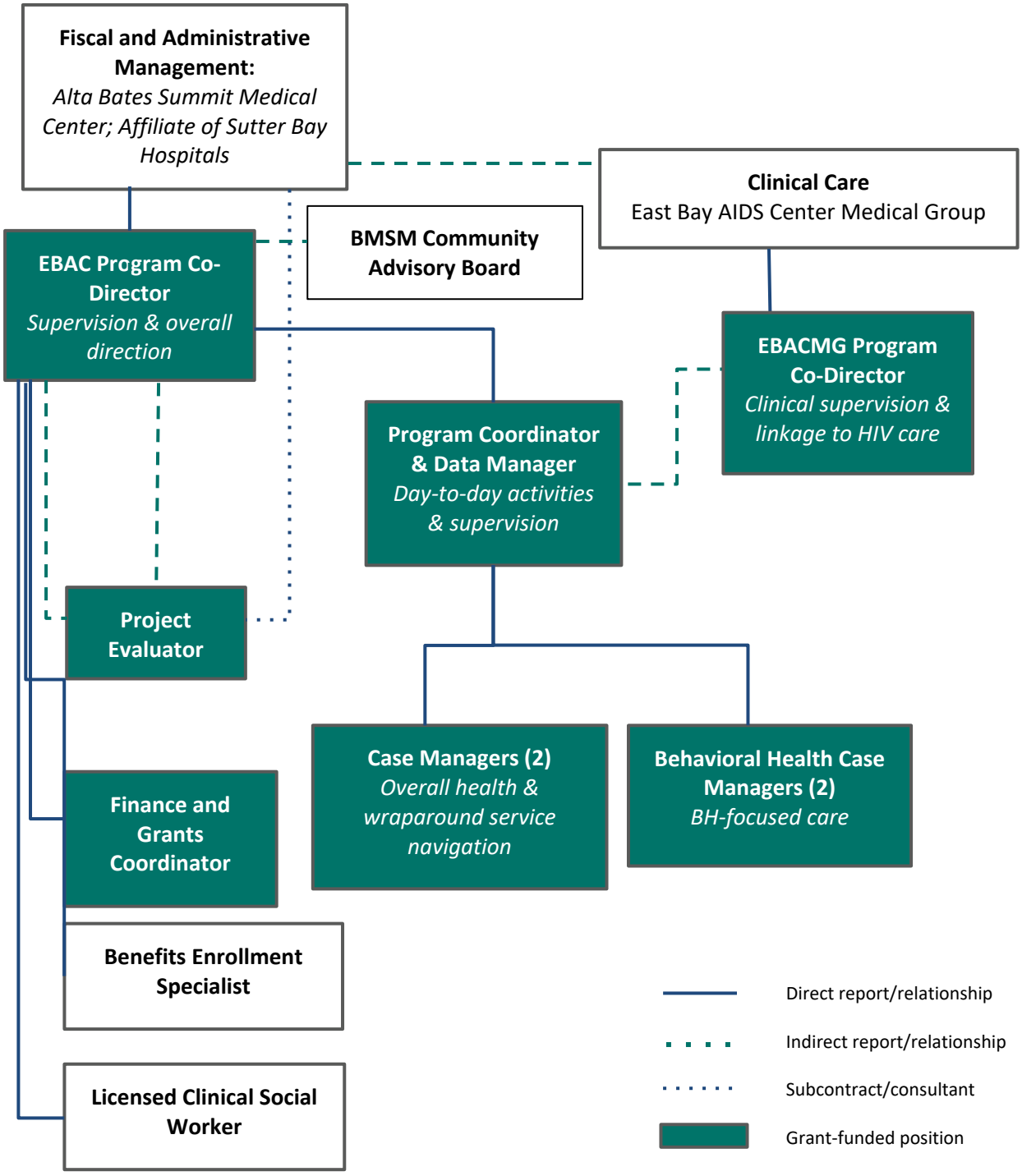
Health Departments: EBAC works with Alameda County Public Health Department's Office of AIDS and the California Department of Public Health's HIV Planning Council to share data, develop effective responses to community outbreaks, identify PWH's partners and connect them to care, and participate in regional collaboration efforts. These partnerships were important for raising program awareness, sharing information including a wide range of relevant webinars and trainings, and disseminating findings.

HIV Planning Collaboratives: EBAC staff members participate in steering committees and planning groups for the East Bay Getting to Zero Coalition, East Bay Prevention Network, East Bay HIV Linkage Advisory Group, and the Oakland Transitional Grant Area Network. These planning groups enable us to connect with over two dozen service providers and policymakers to monitor and better understand HIV data across the region, share best practices, coordinate our HIV prevention and intervention work, and develop long-range strategic plans.

Staffing and Supervision Model

Since 1994, EBAC has worked closely with the EBAC Medical Group (EBACMG or the Medical Group), which is a California C-Corporation that provides professional medical services integrated into EBAC and SBH. Staffing for ERASE was filled by both EBAC and EBACMG staff, and an experienced independent evaluator was contracted to provide the program's evaluation. The chart below displays ERASE's core staffing and supervision model.

Eradicating Racism and Striving for Excellence in HIV Care (ERASE)



The **Project Co-Directors**, one from EBAC and one from EBACMG, were responsible for the project's overall direction and supervision. These roles shared the responsibility for team management, oversight and quality assurance, developing and monitoring administrative and clinical care protocols, serving as contractual points of contact, and research and dissemination efforts.

The **Program Coordinator & Data Manager** managed the day-to-day operations of the program, including supervising Case Managers, overseeing client recruitment and retention strategies, coordinating client-clinical flow and case conferencing, and ensuring adherence to hospital policies. While Case Managers were responsible for entering client data, this position was responsible for ensuring accuracy and completion of those data, and for generating aggregated reports for continuous program improvement.

The **Case Managers** were the primary client liaisons for all ERASE clients, and were responsible for core activities including responding to all inquiries from individuals and community agencies about ERASE, scheduling and conducting all initial client assessments (in the clinic, community, and/or client homes), scheduling and supporting medical appointments (including sending appointment reminders, providing transportation, accompaniment, and/or rescheduling missed appointments), navigating clients through clinical visits and medication pick-ups, providing warm handoffs to medical and behavioral health providers and to wraparound supports or referrals to other agencies as needed, supporting client engagement and retention through regular communications, providing ongoing client education, and working with the client and all available resources to address barriers to care and overall well-being.

The **Behavioral Health Case Managers** provided mental health and substance abuse therapy in the community based on client needs, including one-on-one and group counseling.

The **Grants and Finance Coordinator** supported incentive distribution, reviewed staff documentation of effort tracking to facilitate effective project and budget management, and ensured compliance with federal standards related to documenting personnel costs.

The program was also supported by EBAC's **Benefits Enrollment Specialist** and Licensed Clinical **Social Worker** who provided one-on-one support to clients to enroll in public funding (Medi-Cal, CalFresh, CalWORKS, etc), receive psychotherapy or other mental health interventions, and navigate public systems of support.

Additionally, a **Community Advisory Board**, comprised of seven BMSM, met monthly to review program design and progress, provided regular insight into the project's direction, and designed the ERASE safe space.

Staff Trainings	
IRB Training	Training for staff on institutional review board regarding research on human subjects, provided by Collaborative Institutional Training Initiative (CITI) Program.
Workforce General Compliance Trainings	Mandatory trainings for Sutter Bay Hospitals and EBAC staff include: - Workplace Safety - Workforce Confidentiality, Privacy, and Information Security - The Stark Law and Anti-Kickback Statute Compliance - Code of Conduct - Electronic Health Record system - Emergency Management, Hazard Communication, and Infection Prevention
Cultural Competence, Accessibility, and Trauma-Informed Care	- Homeless Patient Discharge Planning - Understanding the Importance of Cultural Competence, Diversity, and Inclusion - Remote Interpretation for Sign Language - Assisting Patients and Visitors who are Deaf or Hard of Hearing - Disability Access Resources
Frontline Staff Self-Care	The ETAP provided self-care learning opportunities for frontline staff, including through HowRightNow and 6 Black Therapists on the Best Ways to Practice Self-Care Right Now.
Effective Racial Equity Conversations	The ETAP shared resources dedicated to learning and implementing effective conversations about racial equity, including through Race Equity Tools, Race Forward, and Equity in the Center. The California Department of Public Health Community Planning Group (network addressing HIV/AIDS throughout the state), promoted additional relevant resources that ERASE staff participated in including: The University of Illinois Chicago's Epidemics of Injustice Course, The University of California Davis' webinar on Addressing Privilege and Anti-Blackness in Academic Medicine, and the California Prevention Training Center's Moving from Bias to Engagement Using Cultural Humility.

Marketing and Promotion

ERASE marketing and promotion strategies included:

- **In-reach** through EBAC's current and past client roster, which included 1,700 clients with HIV, 45 percent of whom are Black and 70 percent of whom are MSM. Additionally, if

someone who was eligible tested positive for HIV within SBH, a clinician would walk them over to the ERASE program office to link them to care.

- **Referral & outreach partnerships** through other HIV service providers, community-based organizations, local health departments, and HIV Planning Collaboratives (see partnerships above) supported continued cross-referrals to ERASE. EBAC provided presentations to each core partner about the ERASE program, including information about eligibility and referral processes.
- **Other marketing and promotion strategies** included posting on the client-focused prevention and care website, EBAC510.org. In January 2020, EBAC relaunched the client focused website. This website is separate from the hospital-focused EBAC information page, providing updated information on EBAC, community events, and resources that many clients and clients from multiple target populations can benefit from.

Local Evaluation

Local Evaluation Overview

Outcomes of the original youth-focused case management intervention[xxvii] included significant improvements in attendance at HIV primary care appointments for clients whose initial status was intermittent in care. In keeping with the original MOC's evaluation design, the ERASE local evaluation focused on: 1) retention in HIV care (as documented by number of HIV medical appointments completed and number of appointment no shows), and 2) HIV-related health outcomes (as measured by viral load).

Process Evaluation

Process Evaluation Questions

1. What types of case management services were delivered?
2. What types of case management services were most needed and/or most well-received by ERASE clients?
3. What did ERASE clients perceive as most useful in the case management relationship?
4. What were ERASE clients' barriers to accessing needed services and what supportive factors/structures helped facilitate access?

Process Evaluation Design

EBAC utilized a non-experimental, time series design whereby data for ERASE clients were collected on an ongoing basis and compared for each 6-month period of the intervention. As an adaptation of a previously evaluated MOC, EBAC was especially interested in assessing the process of delivering the ERASE intervention. To this end, EBAC tracked all case management services delivered, including the number and type of visits, visit locations, total case management time, and referrals given and completed. By using dose-load analysis to link

services delivered with HIV outcomes, the process evaluation sought to better understand the threshold of services needed to support increased retention in HIV care.

Process Evaluation Data Collection

a. ERASE Tracker: All ERASE case management services (including referrals given and completed) were documented on the ERASE Tracker spreadsheet. Case Managers had access to this spreadsheet and entered data in real time.
b. Brief Monthly Assessment: Surveys were administered to clients once a month, as a paper form, by their Case Managers. The survey included both qualitative and quantitative questions about usefulness of services, connection to medical care, medication adherence, and urgency of needs.
c. End of Program Survey: This survey contained primarily qualitative (open-ended) questions exploring clients' perceptions of the usefulness of a range of services delivered, including referrals for behavioral health and supportive services. This survey was administered during the last study visit (at 12, 18, or variable months depending on the cohort), either as a paper form or an electronic survey.

Please see the Implementation Toolkit for examples of these data collection tools.

Process Evaluation Data Analysis

The ERASE Tracker and Brief Assessment forms were reviewed monthly by the Program Coordinator and quarterly by the Evaluator for quality assurance and internal program improvement purposes. Every six months, the data from these sources were analyzed for reporting to the ETAP and HRSA, and the findings were reviewed during team meetings to monitor the interventions' progress toward its stated goals. End of Program Surveys were analyzed only once at the end of the ERASE program when dose-load analysis was also conducted to link services delivered with HIV outcomes. All analysis was conducted in Excel.

Outcome Evaluation

Outcome Evaluation Questions

1. In what ways (if any) did ERASE clients report benefitting from participation?
2. Did ERASE clients show increased retention in HIV medical care? If yes:
    - At what time point did the increase begin?
    - How long did it last?
    - For whom (which types of clients) were increases most significant?
3. Did ERASE clients show improved HIV-related health outcomes (viral load)? If yes:
    - At what time point did the improvement begin?
    - For whom (which types of clients) were improvements most significant?
4. What was the threshold of case management necessary to successfully retain clients in HIV medical care?

Outcome Evaluation Design

EBAC utilized a non-experimental, time series design whereby data for ERASE clients were collected on an ongoing basis and compared for each 6-month period of the intervention. As the evaluation's primary outcome measures were retention in HIV care and HIV-related health outcomes, EBAC compared the number of HIV medical appointments completed, number of appointment no shows, and average viral load from the six months prior to enrollment in ERASE to the number of HIV medical care appointments completed, no shows, and average viral load for each 6-month period of the intervention.

Outcome Evaluation Data Collection

Every six months, ERASE clients' HIV medical visits (# attended/# no shows) and viral load were extracted from the EBAC/ABSMC electronic medical record system (EPIC). Data on referrals given and completed was documented in the ERASE Tracker (described above).

Outcome Evaluation Data Analysis

All outcome data were aggregated and analyzed every six months both for internal program improvement purposes as well as for reporting to the ETAP and HRSA. At the end of the program, dose-load analysis was conducted to link services delivered with HIV outcomes. All analysis was conducted in Excel. Paired t-tests or chi-squared tests were used to assess statistical significance of changes. Where numbers allowed, pre-post analysis was also done by sub-group (for example, by age or by level of engagement in care at the start of the study) also using t-tests or chi-squared tests to determine statistical significance of differences. Level of case management services received (number and type of visits, total case management time, referrals received and completed, etc.) were linked to outcomes and dose-load analysis was conducted (also using t-tests or chi-squared tests) to better understand the threshold of services needed to support increased retention in care.

Logic Model

The theory of change for both the original MOC intervention and the ERASE program was that by 1) increasing the intensity of case management, 2) utilizing Case Managers with whom clients could develop trusting relationships, and 3) expanding the support available for clients' mental health, substance use, and basic needs, clients would be better able to connect, and stay connected, with HIV medical care, thereby improving their overall health.

THE GOAL of ERASE is to demonstrate the ability of an intensive peer case management program, linking clients to integrated medical and behavioral health services, to improve HIV outcomes for Black Men who have Sex with Men (BMSM) at the East Bay AIDS Center (EBAC).

BMSM in the East Bay face structural barriers, stigma, & discrimination resulting in disparities in HIV infections, linkage to and retention in care, and health outcomes.

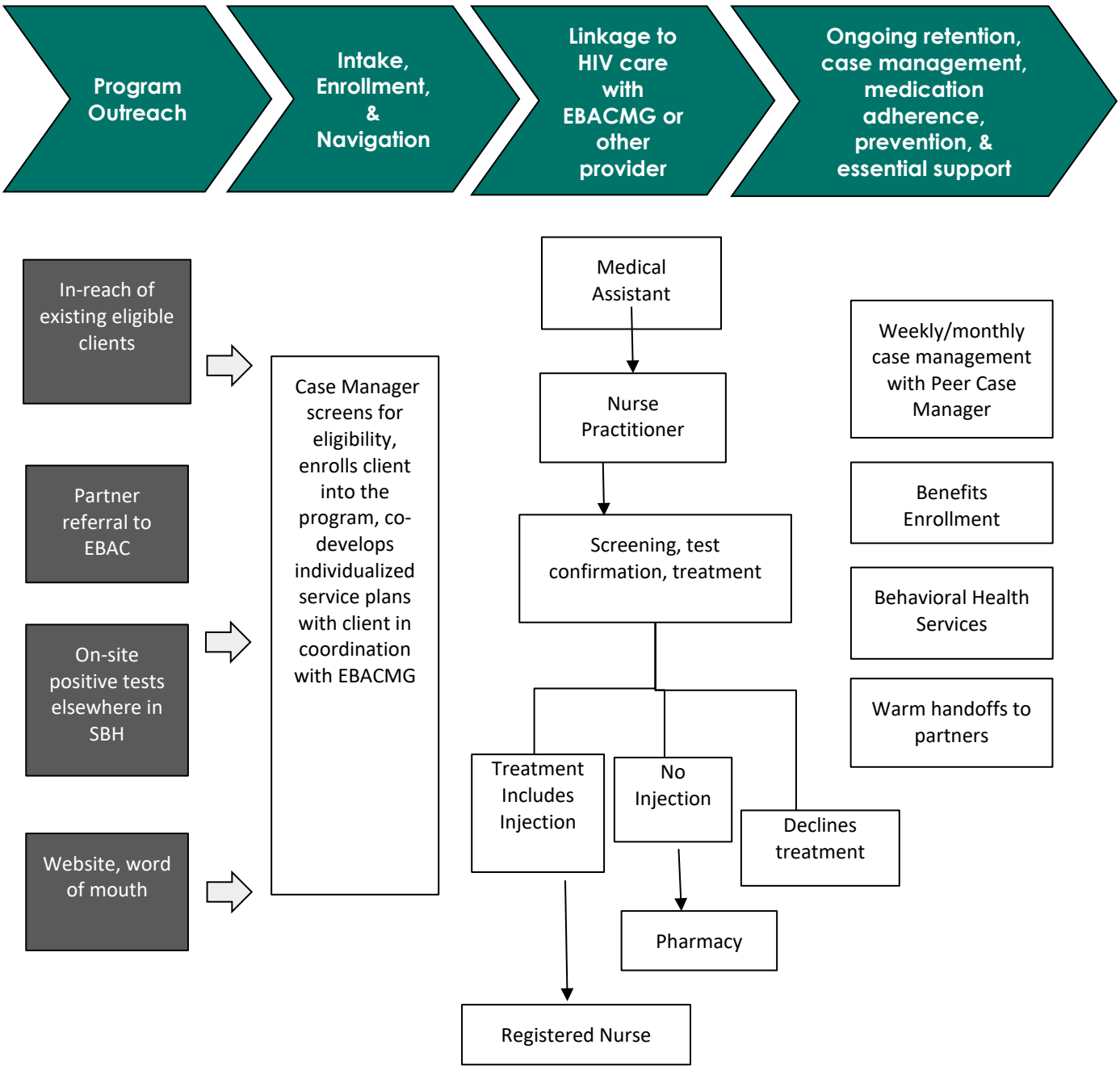
Inputs	Outputs		Outcomes-Impact		
	Activities	Participation	Short Term	Medium Term	Long Term
A culturally appropriate, welcoming, safe space in a geographically and temporally accessible location. Culturally competent peer staff. Seamlessly integrated, wrap-around medical, behavioral, and social services.	Provide: Culturally appropriate weekly (2 mo.) & then monthly peer case management Transportation, onsite insurance enrollment, medical and mental health care, lab services, pharmacy, social work, and support services. Referrals for outside services as needed including substance use treatment, housing and employment. assistance.	120 HIV+ BMSM enroll in program, ≥100 complete at least 90% of scheduled case management visits. BMSM with HIV receive services or referrals to address all areas of unmet need within 30 days of identification.	BMSM with HIV: Feel safe, welcomed, and accepted. Understand their options and know where to go for insurance, medical and mental health care, labs, pharmacy, and support services. Have transportation and the ability to attend care appointments.	BMSM with HIV: Experience reduced isolation, stigma and discrimination. Develop trusting relationships with care providers. Feel empowered to access services they need and take control of their health.	BMSM with HIV: Are linked to care within 90 days of new HIV diagnosis, are successfully retained in care (medical visits every 6 months) for at least 18 months and reach viral suppression.

Assumptions: BMSM with HIV will decrease fear of stigma/discrimination and increase willingness to connect to medical and behavioral care when linked by peer case managers. Reduced logistical barriers (transportation, benefits enrollment, drop-in appointments, and multiple services in one location) as well as meeting the mental and behavioral health needs of BMSM with HIV will increase their retention in HIV care and ultimately lead to improved rates of viral suppression and better HIV-related health outcomes.

Implementation Activities

Core Components

The chart below illustrates the program's core components and flow, including the primary avenues for program outreach, the intake, enrollment, and navigation process, the linkage to care model, and ongoing retention strategies, each of which is described in more detail below.



Culturally-Responsive Case Management
Meetings between clients and Case Managers occurred weekly for the first two months of enrollment, then monthly thereafter until the end of the intervention. Because of staggered enrollment periods, the duration of the intervention was for 12 months, 18 months, or variable. Case Managers were peers with lived experiences and/or significant cultural competency, which provided the foundation of offering culturally-responsive case management that created a safe and trusting relationship between the client and the program. Meetings occurred in the dedicated ERASE program office, in clients' homes or community spaces, and remotely through telemedicine meetings, which was a key part of integrating our culturally-responsive "clinic without walls" approach.

Immediate Linkage to Medical Care
After an initial HIV positive diagnosis, the first 24-48 hours are critical when it comes to linking clients to care. EBAC has a long-held practice of linking new clients to HIV medical care on the spot, while simultaneously providing warm, welcoming, and affirming messages and connections with staff to minimize the fear or anxiety that can accompany an HIV positive diagnosis. When a new client receives a diagnosis at the clinic, elsewhere in SBH, or in the community, they are greeted by EBAC staff and usually within the hour (and in the same office) meet with a licensed HIV specialist to confirm the diagnosis, go over clinical options, and receive a prescription, which they can fill immediately at our on-site pharmacy.

For ERASE, the Case Managers helped schedule medical appointments and link clients to HIV care, directly within EBAC through the EBACMG. Case Managers provided intensive services, understanding that simply setting up an appointment and sending a client to a different address is not always sufficient. Case Managers were able to schedule HIV care, primary care, and other specialty health appointments (including behavioral health) while talking directly to the client, drastically reducing the structural barriers often involved with scheduling regular care (e.g., appointments only available weeks out, traveling to multiple locations, etc.). Case Managers also provided transportation to/from appointments as needed, accompanied clients to the medical appointments themselves as an advocate (as requested), and, importantly, held regular case conferences with the client's medical practitioners to keep apprised of their needs and support accurate client education for medication adherence and long-term health goals.

Referrals and Warm Handoffs
EBAC staff were provided with training and written information about all available resources in the community, both through public agencies and through community-based organizations. ERASE clients received warm handoffs to a wide variety of resources, most commonly Cardea (housing and food) and the East Bay Community Recovery Project (substance use and mental health). During the individualized planning process for each client, the Case Manager helped them identify areas that they might benefit from wraparound supports, and then followed up

with those agencies to schedule appointments and introduce the client to a relevant Case Manager.

For examples of the intake and case management forms used by ERASE, see the Implementation Toolkit.

Behavioral Health Integration

EBAC anticipated that behavioral health would be a significant need among ERASE clients, designed the program to include a full-time behavioral health Case Manager, and quickly found the need for behavioral health services was extensive. To respond to this need, six months into the program, EBAC added a second behavioral health Case Manager as well as an on-site psychiatrist. The behavioral health Case Managers were licensed therapists who provided one-on-one counseling. Case Managers referred ERASE clients to the behavioral health Case Managers, who scheduled appointments in-person in the community as well as through telecare, whichever was more convenient for the client. The psychiatrist was also added to the team, offering services on-site twice a week for clients who need more intensive psychiatric support and medication management.

Project Coordination & Meeting Structure

- **Project Meetings**. The team met in various configurations to communicate and coordinate on project updates and case conferencing, developed new tools and systems, reviewed project performance data, and discussed successes and challenges.
- **ERASE Team Meetings**. The Project Coordination & Data Manager met with the Case Managers weekly to review and monitor program operations, including conferencing about client linkage and follow-up needs, reviewing upcoming intakes, and monitoring the efficacy of client and clinical flows.
- **Clinical Coordination Meetings**. Monthly clinical coordination meetings between the EBACMG Co-Director, Project Coordinator, other EBAC medical providers, nurses, medical assistants, and Case Managers helped ensure high quality care coordination.
- **Evaluation Meetings**. Discussions regarding data collection and analysis, led by the program evaluator, were scheduled as part of regular ERASE team meetings, and as needed with various team members.

Additional Adaptations

In addition to the inclusion of a second behavioral health Case Manager and psychiatrist (see above), the following adaptations occurred during implementation of ERASE as EBAC responded to client needs and the coronavirus disease 2019 (COVID-19) pandemic.

ERASE Support Group

In addition to one-on-one case management and health navigation, ERASE began offering a monthly support group. This support group was initiated approximately two months into the program, facilitated by a Program Co-Director and Social Worker. The support group was started through ERASE but was available to all MSM, though throughout its duration the vast majority of participants were ERASE participants, averaging 10-12 participants per meeting. This group began in person, then was shifted to virtual during the pandemic, and transitioned to meeting in a park near the EBAC office toward the end of the intervention.

Delivery in the Community

While EBAC designed the program to include Case Manager home visits, one key adaptation that was critical for retention in care was using those home visits to deliver food, medication, and other essential needs to the clients. Community/home visits were included in the program structure by design from the beginning, but increased from the expected 20 percent of visits to 90 percent of visits for the majority of the intervention, with Case Managers out in the community almost daily. This adaptation received positive verbal feedback from clients. ERASE purchased food, as well as collected donations, to provide to food-insecure clients during these visits. Some clients were enrolled while living in Alameda or Contra Costa Counties but had moved further away to find affordable or more stable housing, and Case Managers traveled as far as 70+ miles from the EBAC offices to meet with clients at their homes.

Incentives

EBAC provided financial incentives (via gift cards) to clients as a strategy for program recruitment and completion of evaluation activities. After the initial intake, the client received $60. In subsequent months, they received $20. The client also received an additional bonus of $20 at 6 months and 12 months ($40 total in those months), and an additional bonus of $40 at 18 months ($60 total).

COVID-19 Adaptations

The most significant change was a large drop-off in in-person visits due to the COVID-19 pandemic. As mentioned above, this required going out into the community for many visits, but also transitioning to virtual service delivery. Each client had differing preferences for how they would meet with their Case Manager, and many preferred a combination of in-person in the community and virtual. Because ERASE was centered on integrated delivery, and one of the tenets of the program was offering services under one roof and in the dedicated safe space, the ERASE program staff needed to be even further equipped to provide client-centered, whole-person services while adapting to virtual service delivery. This required learning strategies to establish the same level of rapport and trust virtually as would come more naturally in-person.

EBAC found that recruiting, enrolling, and conducting intake for 150 clients in the first few months of the program start was not feasible, so the team pivoted to three cohorts with

different levels of program dosage. The first cohort was those who were enrolled in the program for 18 months, the second was those enrolled for 12 months, and the third was variable, between six and 12 months. All services were provided exactly the same for all clients (including weekly visits for the first two months and monthly thereafter), with dosage being the only difference.

COVID-19 Impact		
 Recruitment	 Program Delivery	 Evaluation & Data Collection
• Recruitment shifted from one 18-month cohort to accommodate clients who were enrolled later on. ERASE had three cohorts -- one for 6-12 months (variable), one for 12 months, and one for 18 months.	• EBAC offered clients the option to hold medical appointments, case management, and support groups via Zoom/HIPAA-compliant telemedicine. • Case Managers increased in-community/in-home visits after Shelter-in-Place was enacted, as clients were not easily able to go to EBAC's offices due to logistical restrictions and/or preferred it for their safety. • A Case Manager began delivering food, medication, and gift cards directly to clients' homes.	• EBAC offered options for data collection (e.g., self-assessments/ surveys) in-person, online, during the visit, and in the client's own time, to meet the needs of each client.

Costs

In total, EBAC received $974,806 from HRSA for conduct of the BMSM Initiative, broken out across project years as follows:

Year 1: $299,920
Year 2: 300,000
Year 3: $374,886

Category	Budgeted	Projected Actual	Actual %
Personnel Salaries & Benefits	**$551,106**	**$432,697**	55%
Operating Expenses	**$115,086**	**$59,792**	8%
Materials & Supplies	*$1,500*		
IRB Fees	*$6,500*	$1,500	0%
Marketing & Outreach Events	*$4,500*		
Staff Telecoms	*$5,760*	$1,920	
Local Mileage	*$5,846*	$4,512	1%
Participant Incentives	*$68,400*	$50,060	6%
Participant Transportation	*$17,280*	$1,800	0%
ERASE Space Improvements	*$3,300*		
Staff Training	*$2,000*		
Travel & Conferences	**$37,107**	**$33,872**	4%
Subcontractors	**$114,768**	**$120,368**	15%
EBAC Medical Group	*$29,468*	$29,468	4%
Evaluator	*$85,300*	$90,900	12%
Administrative Supplement	**$74,932**	**$74,932**	10%
Subtotal	***$892,999***	***$721,661***	92%
Indirect Costs	**$81,807**	**$64,674**	8%
Total	**$974,806**	**$786,335**	100%

Unanticipated Cost Changes

EBAC found over the course of the Initiative that transportation needs were much higher than anticipated, as the team adapted to COVID-19. While the Case Managers had planned on conducting occasional home or community visits, the Case Managers found themselves needing to offer and conduct frequent visits (i.e., four times a week) and food/medication drop-offs directly to clients, significantly increasing mileage.

Additionally, because of the extensive behavioral health needs of the enrolled clients, EBAC added a second behavioral health Case Manager and a psychiatrist dedicated to the program, which increased program costs.

ERASE received an administrative supplement from HRSA in Year 3, which included housing assistance (deposits, back rent, etc.) for 26 clients, food vouchers for 130 clients, utility assistance for 65 clients, and PPE supplies.

Intervention Outputs and Outcomes

The Case Managers, Data Manager, and local Evaluator contributed to data collection, drawing from self-reported client surveys, medical records, and case management records and assessments. These data were analyzed to establish a baseline, quantify what the intervention did (outputs), and measure the outcomes of the intervention as they relate to ERASE clients' health and well-being.

Intervention Outputs

Over the 22 months of ERASE implementation (September 27, 2019 to June 30, 2021), 160 clients were enrolled. Over the course of ERASE implementation, 144 clients completed the intervention – defined as being immediately linked to HIV medical care and receiving ongoing case management and service referral/navigation assistance for 12 to 18 months, depending on the cohort to which they were assigned. Ten of the initially enrolled clients (6.3 percent) exited the intervention through one of the following: lost to follow up (2), declined participation (2), incarceration (1), or death (5). Another six of the 160 clients (3.8 percent) were enrolled within three months of the formal end of the program and were not counted as either exited or completed.

Participants Recruited	**160**
Average Age	**43.2**
Average Income	**$10,001 to $20,000 (39.7%)**
Unemployed within past 12 months	**82.5%**
Housing Instability within past 12 months	**40%**

	Received Behavioral Health Services within past 12 months	**45.6%**
	Received Social Support Services within past 12 months	**48.3%**

*** Self-reported survey data collected at baseline**

ERASE Participant Demographics

ERASE clients ranged in age from 20 to 72. Approximately 21 percent were 30 or younger, 46.4 percent were between 31 and 50, and 32.6 percent were 51 and over. Additional demographics can be seen in the tables below.

Race/Ethnicity[xxviii]	**Percent**
American Indian/Alaska Native	1.4%
Asian	0.7%
Black or African American	97.9%
Native Hawaiian/other Pacific Islander	0.0%
White	2.7%
Some other race	2.1%
Hispanic, Latino, or Spanish origin	4.1%

Gender Identity	**Percent**
Male	98.6%
Female	0.7%
Transgender man/ transman/female to male (FTM)	0.0%
Transgender woman/ transwoman/male to female (MTF)	0.0%
Gender queer/gender non-conforming	0.0%
A different gender category	0.0%
Don't know	0.7%

Relationship Status	**Percent**
Single, looking for relationship	44.1%
Single, not looking for relationship	37.9%
Married/civil union/legal partner	1.4%
Divorced/separated/widowed	3.4%
Living with primary partner	7.6%
Have primary partner, not living together	6.2%
Other	1.4%

Sexual Partners	**Percent**
All men	82.1%
All women	0.7%
Both men and women	15.2%
I don't know	2.1%

ERASE Participants' Baseline Needs

The vast majority of ERASE clients identified significant support needs upon entry in the program. Approximately 88 percent reported currently needing HIV care, over 80 percent reported being unemployed for at least three of the past 12 months (average reported annual income was between ten and twenty thousand dollars per year), over 50 percent felt they currently needed support for emotional issues such as anxiety or depression, and 40 percent had experienced housing instability in the past year. A list of the top eight needs and their frequency at entry into the program can be seen in the table below.

Baseline Needs	Percent
Currently need HIV medical care.	88.4%
Been unemployed for at least three of the past 12 months.	82.5%
Currently need help for emotional issues like stress, anxiety, or depression.	50.4%
Not had stable housing at some point in the past 12 months.	40.0%
Feel like drugs or alcohol are currently causing issues in their life.	34.0%
Been released from jail or prison within the past 12 months.	20.0%
Have severe or moderately severe depression (based on score from PHQ-8).	18.9%
Had bad experience with HIV health care provider within past 12 months.	18.6%

ERASE Services Received

Of the 160 ERASE clients as of June 30, 2021, ten (6.3 percent) exited the intervention and six (3.8 percent) were enrolled within three months from the end of the program, leaving 144 (90.0 percent of those initially enrolled) clients who completed the full intervention. This is defined as being immediately linked to HIV medical care and receiving ongoing case management and service referral/navigation assistance for 12 to 18 months, depending on the cohort to which they were assigned.

Across all clients (including those lost to follow-up or withdrawn), a total of 2,722 case management visits were completed, averaging 17.01 per client (ranging from 1 to 24). When including only those who completed the intervention, an average of 18.19 case management visits were completed per client (ranging from 5 to 24).

On average, case management visits lasted 24.38 minutes (ranging from less than five to more than 90 minutes), for an average of 418.34 minutes received per client (ranging from less than 5 to more than 90 minutes) across the entire time of their participation. Participants had an average of 2.43 missed visits across all clients (ranging from 1 to 23), 35.5 percent of which occurred during the first two months of the program when visits were scheduled weekly. When

just including clients who completed the intervention, the average number of missed visits was 1.47 (ranging from 1 to 19). Participants who were lost to follow-up or withdrew averaged 2.61 months in the program (ranging from one week to 15 months) before their departure.

Of the 2,722 case management visits documented, 24.4 percent were in-person in the clinic, 28.7 percent were in-person in the community, and 46.9 percent were virtual. This proportion shifted with the onset of COVID-19 in March of 2020 as seen in the table below.

	Total Visits	% In Clinic	% In Community	% Distance-based
Pre COVID-19	559	34.6%	26.3%	39.4%
Post COVID-19	2,163	21.6%	30.0%	48.4%

Between 9/27/2019 and 06/30/2021, 744 referrals were given for a wide variety of behavioral health and supportive services. As described earlier under Core Components, giving referrals was an active component of Case Managers' work and typically included either a warm handoff (to services provided internally) or a direct handoff to a known service provider and a scheduled appointment. Often Case Managers provided transportation for ERASE clients to attend initial appointments, ensuring that the referral connection was actually made. Referrals were never passively given to ERASE clients (for example, being handed a list of service providers). The table below shows types of referrals given and completed.

Type of Referral	Number Given	% of Total Referrals Given	% Completed	% of Total Referrals Completed
Housing	138	18.6%	100%	100%
Health insurance eligibility/ enrollment support	25	3.4%	100%	100%
General Assistance (cash) benefits	77	10.4%	100%	100%
Food services	208	28.0%	100%	100%
Mental Health resources	140	18.8%	100%	100%
Substance Use resources	87	11.7%	100%	100%
Legal services	2	0.3%	100%	100%
Employment services	19	2.6%	100%	100%
Other	48	6.5%	100%	100%

Intervention Outcomes

Satisfaction with the Program

Based on data from Brief Monthly Assessments (1,854 of which were collected, averaging 11.59 per client), ERASE clients generally rated program services highly, with notable improvements over time. For instance, on a 0-5 scale:

- Regarding the usefulness of case management services, average satisfaction ratings were 4.38 after the first case management visit, 4.78 after the last visit, and 4.66 overall.
- Regarding how well clients felt connected to medical care, average ratings were 3.77 at the time of clients' first case management visit and 4.15 at the time of their last self-assessment, with 4.04 overall.
- Clients reported notable gains in their overall physical and mental well-being, improving from an average 3.08 rating at their first visit to 4.06 at their last visit, with a 3.79 average overall.

Although the EBAC team had hoped for more dramatic increases in clients' ratings over time, it is important to contextualize that 2020 and 2021 were extremely challenging years with COVID-19 and nationwide demonstrations around racial injustice. While the peer Case Managers increased the flexibility and range of services in response to COVID-19 (for example, offering more telephone visits and community visits, and adding food and personal protective equipment to the list of support items offered), the dramatic shift to more distance-based services may have impacted ERASE clients' sense of connectedness.

Changes in Needs from Baseline to End of Program

When comparing individual ERASE clients' needs for behavioral health and supportive services from beginning to end of program, EBAC saw decreased needs in a number of areas, as shown in the table below.

Needs	N =	Baseline	End of Program
Currently need HIV medical care	153	88.4%	76.25%
Been unemployed for at least three of the past 12 months	153	82.5%	75.00%
Currently need help for emotional issues like stress, anxiety, or depression	153	50.4%	31.25%
Not had stable housing at some point in the past 12 months	153	40.0%	30.00%
Feel like drugs or alcohol are currently causing issues in their life	153	34.0%	21.88%
Been released from jail or prison within the past 12 months	153	20.0%	0.00%
Have severe or moderately severe depression (based on score from PHQ-8).	153	18.9%	13.75%
Had bad experience with HIV health care provider within past 12 months	153	18.6%	24.38%
Don't currently have health insurance	153	4.8%	9.38%

Increased Access to Supportive Services

Over the course of ERASE, 130 individuals were given referrals for supportive services (housing, health insurance eligibility/enrollment support, General Assistance benefits, food services, legal services, employment services, and other), 100 percent of which were documented as having been received (verification from the agency or client that services or assistance was actually initiated and utilized). In the end-of-program survey, clients reported high levels of satisfaction with these supportive services.

Increased Access to Behavioral Health Services

Increased engagement in behavioral health care

Over the course of ERASE, 95 individuals were given referrals for behavioral health services (including mental health resources and substance use resources), 100 percent of which were documented as completed. In the end of the program survey, 50.9 percent of clients reported seeing a counselor within the past 12 months as compared to 45.6 percent reporting this upon entry into the program. In general, satisfaction with these behavioral health services also increased over the course of the program with 43.1 percent reporting feeling satisfied (somewhat satisfied, satisfied, very satisfied) with counseling services at the end of the program as compared to 37.4 percent reporting satisfaction at the beginning of the program. Similar trends were seen with satisfaction with substance use services, rising from 35.4 percent at the beginning of the program to 39.2 percent at the end of the program.

HIV Care and HIV-Related Health

In addition to improvements in linkage to HIV care, ERASE clients demonstrated improved HIV-related health outcomes as well. At the time of enrollment in the program, 54.5 percent of ERASE clients reported having had at least two HIV medical visits within the 12 months prior to enrolling in ERASE. This number increased during participation in ERASE. Among clients who completed at least 12 months of case management services, 70 percent reported they had completed at least two HIV medical visits within the prior 12 months; upon verification, this turned out to be the case for 74 percent of clients.

In addition to improvements in linkage to HIV care, ERASE clients demonstrated improved HIV-related health outcomes as well. There was 3.3 percentage point increase in clients rating their overall HIV health as good or very good from beginning of program to end of program as well as an 11.33 percentage point increase in clients reporting taking their HIV medications as prescribed. Changes in viral load were harder to measure given the short time frame of the program; however, small changes can be seen in the table below.

HIV linkages and HIV-related health	N=	Baseline	End of Program
Negative experience with an HIV health care provider within past 12 months	160	18.6%	24.38%
Currently need HIV medical care	160	88.4%	88.75%
Self-reported having two HIV care visits within past 12 months	160	54.5%	70.00%
Verified as having two HIV care visits within past 12 months	135		74.07%
Reported being satisfied with current HIV care	132	66.7%	80.30%
Rated overall HIV health as good or very good.	160	44.2%	47.50%
Rated ability to manage HIV as good or very good.	160	61.9%	65.00%
Currently taking HIV medications as prescribed.	132	72.0%	83.33%
Self-reported most recent viral load undetectable.	160	46.5%	49.38%
Verified undetectable viral load.	104		49.04%

Beyond what can be seen through the quantitative data on the program's services and impact, ERASE Case Managers observed a widespread acceptance of and engagement in the intervention among clients. Clients welcomed the case management meetings and other support as they progressed and over time participated more in the program.

One notable moment during the program's run involved one of the clients who had given up and resigned himself to his fate. Through the persistent counseling of one of EBAC's doctors and a Case Manager, the client was able to pick himself up and battled through his ailments. He was medically cleared by the same doctor after several months. This emotional moment was shared by everyone involved in his recovery afterward. He has since been regularly visiting EBAC for check-ins.

Lessons Learned and Best Practices

Implementation

The ERASE pilot was highly successful, and EBAC intends to continue using this model, offered as a standard program as part of the SBH network. As noted above, ERASE is the first program in the Easy Bay geographic area to directly address the structural barriers faced by BMSM in receiving equitable access to care.

Challenges and Lessons Learned

Implementing this pilot program, particularly in the context of a global pandemic and climate of a rising racial justice movement, brought challenges and lessons learned. The clients were inherently at higher risk of suffering from COVID-19. While EBAC still offered services in the clinic throughout the pandemic, the team pivoted as many services as possible online (including medical visits, case management, and support groups). EBAC offered these as options, and ERASE clients continued to come into the clinic in-person throughout the pandemic.

The racial justice movement, which surged in the middle of the Initiative and continues on today, was felt very heavily by the community, who are disproportionately discriminated against as BMSM. ERASE clients experienced emotional trauma and increased substance abuse and violence as a result of being at the center of this uprising. ERASE Case Managers used their regular check-ins to provide emotional support and affirmations, as well as responded to this need by increasing the number of referrals to the in-house behavioral health Case Manager, who provided counseling to 86.3 percent of ERASE clients over the course of the intervention.

Additionally, EBAC served a large number of people living in poverty and people who were chronically homeless or housing insecure. Retention for these individuals was the most challenging, as they may not have had a phone or other consistent means to communicate with the Case Manager. EBAC found that these individuals tended to have less frequent contact with the Case Manager unless there was a more urgent "need". The Case Managers continued to remind them that they were always welcome, could rejoin the program at any time even if they had dropped out of care, and could be met in the community at their convenience.

EBAC found that working within a large hospital system bureaucracy continued to be a challenge, from onboarding contractors (such as the program evaluator), hiring, invoicing, program expense reimbursements, and other administrative functions. Relatedly, the process for navigating and obtaining urgently needed supports (such as housing, medical insurance, food, legal aid, etc.) is highly complex and bureaucratic, and even with an in-house benefits specialist, this remained a structural barrier to responsive and equitable care for many clients. Especially during the early stages of COVID-19, many governmental agencies temporarily ceased operations, limited their services, or otherwise were difficult to navigate.

Given the deeply emotional work of peer staff supporting and uplifting ERASE clients, especially during a global pandemic that disproportionately affected MSM clients and staff, the Case Managers went above and beyond to try to find every avenue available for the clients. As a result, several staff experienced stress and burnout. EBAC saw increased mental health struggles among staff and increased physical complaints and fatigue. EBAC offered weekly mental health support to staff in addition to the program clients. Furthermore, in the medical field there is staff turnover and attrition for a variety of reasons, and EBAC found that creating a step-by-step program orientation and procedures manual was essential for speeding up the onboarding process for new staff entering the program.

Facilitators and Best Practices

The ERASE program design facilitated high rates of success for our clients. EBAC's strategies of 1) utilizing client-centered case management, led by peers with lived experience, 2) creating a comfortable, de-medicalized, and culturally-responsive safe space, 3) integrating medical care, behavioral health, and wraparound supports, and 4) coordinating closely with partners were all

instrumental in the program's high rates of engagement and retention in care for BMSM. EBAC found that:

- Focusing on culturally-responsive, peer-led retention strategies, including a dedicated safe space, led to more clients feeling integrated into the program and accepting mental health/substance abuse treatment.
- Providing human touch throughout, including de-medicalizing interactions and shifting perceived power dynamics between clients and staff, was key in engaging, supporting, and retaining clients.
- Focusing on relationship building with clients helped ERASE staff to understand the issues clients face and provide informative feedback and relevant support, which create greater trust and healthier bonds, and in turn lead to deeper client engagement in the program.
- Providing one-on-one services between the Case Manager and client, in which the client has a single and consistent point of contact for linkage to all specialized services, improved the likelihood of clients engaging with whole-person care.
- Through case conferencing, each Case Manager was up to date on all critical information related to the clients' health, ensuring ERASE clients felt confident that there was a dedicated person who understood their full spectrum of needs and could advocate in partnership with them.
- ERASE staff presented the project to each collaborative meeting team, each conference attended, and each community Case Manager meeting with other providers. Building and reestablishing collaborations with existing community partners strengthened relationships between frontline staff and other providers, making warm handoffs seamless for clients. Many referrals and resources provided came directly from warm handoffs from these community meetings.
- Offering support services, such as housing, utilities, food, and transportation, promoted ERASE client wellbeing and retention in care.
- Engaging clients' natural support systems also helped staff effectively address clients' needs and promote their retention in the program.
- Transitioning to telemedicine for medical visits, case management, and support groups helped increase access to care.
- Utilizing a BMSM Community Advisory Board consistently throughout the program (monthly), provided valuable and meaningful input on program design, appropriate marketing materials and project branding, recruitment and retention strategies, safe space design, and how best to address changing client needs.
- Providing financial incentives via gift cards supported retention in the program and completion of evaluation activities.

IMPLEMENTATION	
Challenges/Lessons Learned	Facilitators/Best Practices
Bureaucratic barriers within a large medical system (hiring, invoicing, etc.)	Human touch & de-medicalizing client-staff interactions including through home visits
In-person support groups and medical appointments, especially during COVID-19	Culturally-responsive, peer-led case management
Housing and food insecurity are still pervasive needs and barriers to retention	Single point of contact for clients (Case Manager), who is informed about whole-client needs through case conferencing
Current racial justice movement & climate	Strong community collaboration and communication
Staff burnout and turnover > need for a plan and process in case of staffing changes	Dedicated safe space, designed by and for BMSM
Navigating urgently-needed public benefits & supports	Access to support services for clients, such as housing, utilities, food, and transportation.
	Engaging clients' natural support systems in their care
Other agencies closed during COVID-19 or had limited hours	Telemedicine/remote services for medical, case management, and support groups
	Utilizing a BMSM Community Advisory Board
	Offering client incentives
	Access to therapy/behavioral health services for staff

Evaluation

Overall, EBAC was very pleased with the data collected and knowledge gained through evaluation of the ERASE program. While the data collection burden was high, it enabled the team to learn more deeply what the clients needed and how to best support them in strengthening their connection to HIV care.

Challenges and Lessons Learned

One primary and unexpected barrier was the difficulty of retrieving data from our electronic medical record system (EPIC). As EBAC began working with SBH's IT team, the team discovered that a significant portion of the data the team was expecting to be able to easily retrieve was structured in such a way that it was not retrievable via reporting functions. This data, including initial enrollment data and ongoing visit notes, had to be manually pulled every six months for each ERASE client. This created a much higher data burden than initially anticipated. Even the data which were structured to enable automatic reporting were initially much more complicated to define parameters for and resulted in approximately six months of back and forth with the IT department and repeat test pulls of data which all had to be manually checked to identify formula and parameter errors. Eventually EBAC was able to rely on automatic reporting for a small portion of the data, but in the end it may have been more efficient to manually pull it all from the start.

Facilitators and Best Practices

EBAC had very high levels of engagement by ERASE clients in completing all surveys and required data collection. EBAC felt this was due to the strong connection clients had with their Case Managers and their interest in helping EBAC to ensure that the program was as effective as possible. Given prior experiences of feeling disconnected from HIV services, many ERASE clients enthusiastically embraced the goal of the ERASE program and were extremely willing to help facilitate its success.

In addition, Case Managers ensured data collection was as flexible as possible, utilizing both paper forms and electronic systems, as deemed most appropriate and comfortable for clients. Surveys and data collection could also be completed during in-person visits to the clinic or via distance based or community visits, again as deemed most appropriate and comfortable for clients. This flexibility enabled EBAC to meet clients' needs while still ensuring high levels of data completion.

EVALUATION	
Challenges/Lessons Learned	Facilitators/Best Practices
Difficulty retrieving data from the electronic medical record system, which caused an unexpected administrative burden	Strong, trusting connections between clients and Case Managers
	Flexible data collection (paper and electronic, in-person and distanced) based on needs/preferences of clients

Dissemination Activities

To Learn More

Visit our website at www.EBAC510.org.

Contact Information

- **Tony Sillemon, Psy.D.**, Project Co-Director
  - Email: sillemt@sutterhealth.org
  - Phone Number: (510) 869-8485
- **Jeffrey Burack, M.D.**, Project Co-Director
  - Email: burackj@sutterhealth.org
  - Phone Number: (510) 869-8482

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[xxviii] Participants were instructed to select all that applied thus total does not add up to 100%.