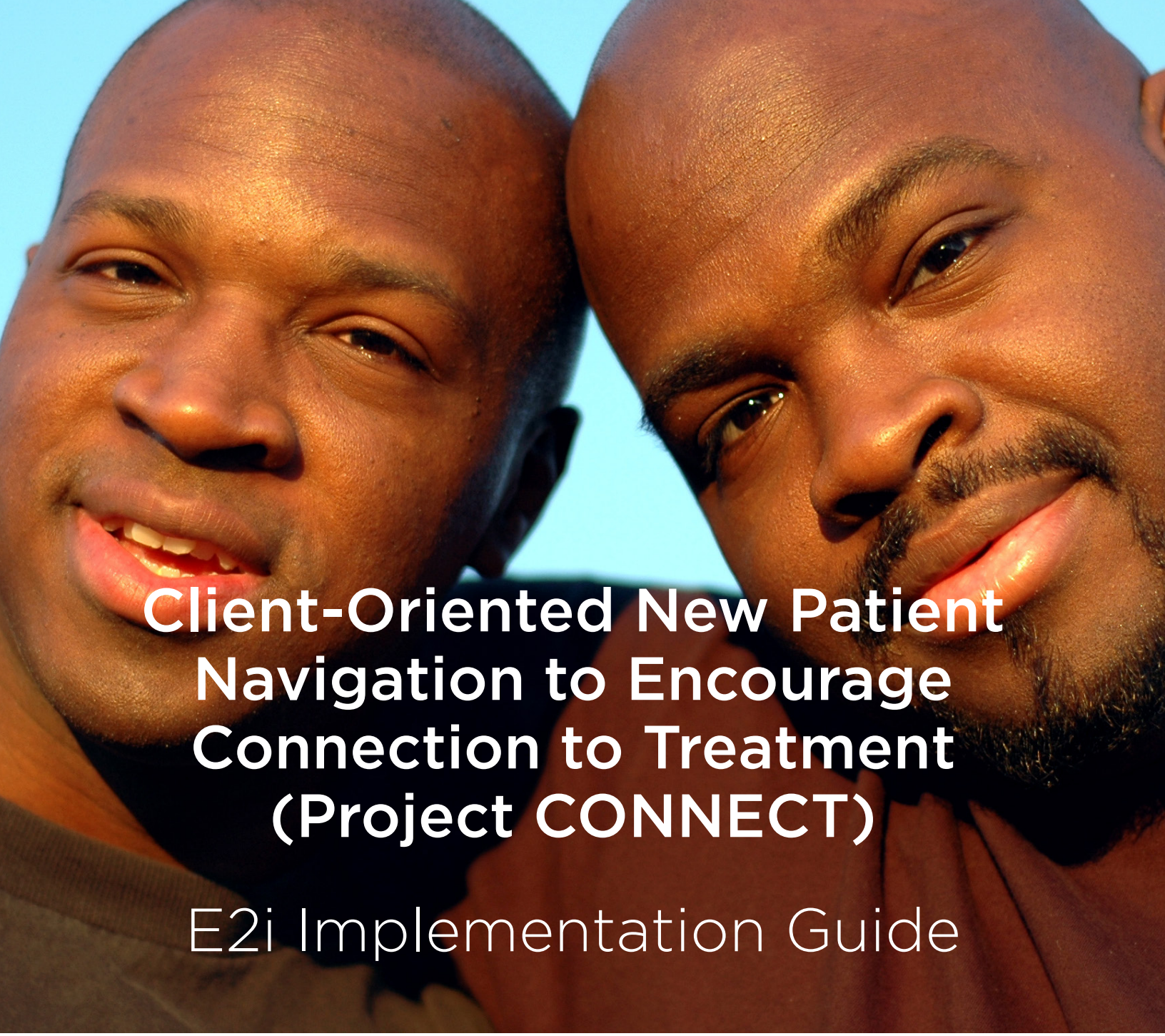

# Client-Oriented New Patient Navigation to Encourage Connection to Treatment (Project CONNECT)

## E2i Implementation Guide

**An evidence-informed intervention, adapted for the Health Resources and Services Administration's Ryan White HIV/AIDS Program, that engages Black men who have sex with men with HIV into medical care through early orientation to the clinic, relationship building, and enhanced personal contact.**

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**FALL 2021**

RYAN WHITE E2i HIV/AIDS PROGRAM

A SPECIAL PROJECT OF NATIONAL SIGNIFICANCE

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# Acknowledgments

We would like to thank the following organizations for piloting the implementation of the intervention at their organization. We are especially grateful to the following people who led the implementation at their organization and provided their stories, experiences, and feedback for this Implementation Guide:

**AIDS Taskforce of Greater Cleveland**
Deairius Houston, Rashawn Bradford, Anthony Forbes, Vesna Pasalic, Rebecca Strong

**California Prostitutes Education Project**
Angela Green, Stephanie Cornwel, AP Thomas, Sharon Broach, Michelle Cunningham, Bambi Phu, Shakema Snow, Michael Benjamin, Lisa Ryan

Thank you also to Rachel Kohn, John Snow, Incorporated; and Erica Sawyer, Jordan Hutensky and Katie Burkhart of Fenway Health for designing the Implementation Guide.

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**Suggested citation:** *Client-Oriented New Patient Navigation to Encourage Connection to Treatment (Project CONNECT): E2i Implementation Guide*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2021.



**Funding statement:** This product was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of Ryan White HIV/AIDS Program (RWHAP) Part F - Special Projects of National Significance (SPNS) Program awards totaling $20,307,770 with 0% financed with non-governmental sources, and $2,200,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, RWHAP SPNS, or the U.S. Government. For more information, please visit HRSA.gov.

# Table of Contents

# EXECUTIVE SUMMARY

Client-Oriented New Patient Navigation to Encourage Connection to Treatment (Project CONNECT) is an evidence-informed intervention developed by HIV experts in collaboration with community members to improve health outcomes among people with HIV, and adapted to focus specifically on Black gay, bisexual, same-gender loving, and other men who have sex with men (Black MSM). The intervention engages people with HIV into primary HIV medical care through early orientation, relationship building, and enhanced personal contact. Clients who are newly diagnosed with HIV, re-entering care, or transferring from another clinic receive an early orientation from a linkage coordinator within five business days of initial contact. During orientation, clients receive a biopsychosocial assessment, learn more about the care they will receive, and set up a time to have their first primary care visit. Linkage coordinators accompany clients to their first primary care visit and check in regularly with the client to maintain personal contact. Additional coaching, case management, supportive services, and referrals are provided to clients as needed.

This Implementation Guide was developed for *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i),* which tested Project CONNECT within Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) settings and evaluated its impact. Additional easy-to-use implementation tools, tips, and resources to support replication of Project CONNECT in the RWHAP and other HIV service organizations can be found in the ***Project CONNECT E2i Toolkit***.

# INTRODUCTION TO THE IMPLEMENTATION GUIDE

# INTRODUCTION TO THE IMPLEMENTATION GUIDE

## What is Project CONNECT?

Project CONNECT engages Black gay, bisexual, same-gender loving, and other men who have sex with men (MSM) with HIV into primary HIV medical care through early orientation, relationship building, and enhanced personal contact. Clients who are newly diagnosed with HIV, re-entering care, or transferring from another clinic receive an early orientation from a linkage coordinator within five business days of initial contact. During orientation, clients begin to establish a relationship with the clinic, receive a biopsychosocial assessment, learn more about the care they will receive, and set up a time to have their first primary HIV care visit. Linkage coordinators accompany clients to their first primary care appointment and check in regularly with the client to maintain personal contact. Additional coaching, case management, supportive services, and referrals are provided to clients as needed.

## Purpose of the Implementation Guide

The purpose of this Implementation Guide is to provide essential information and tools necessary for understanding, planning, and delivering Project CONNECT in the RWHAP and other HIV service organizations. This Guide is part of the ***Project CONNECT E2i Toolkit***, a comprehensive collection of helpful resources for implementing Project CONNECT.

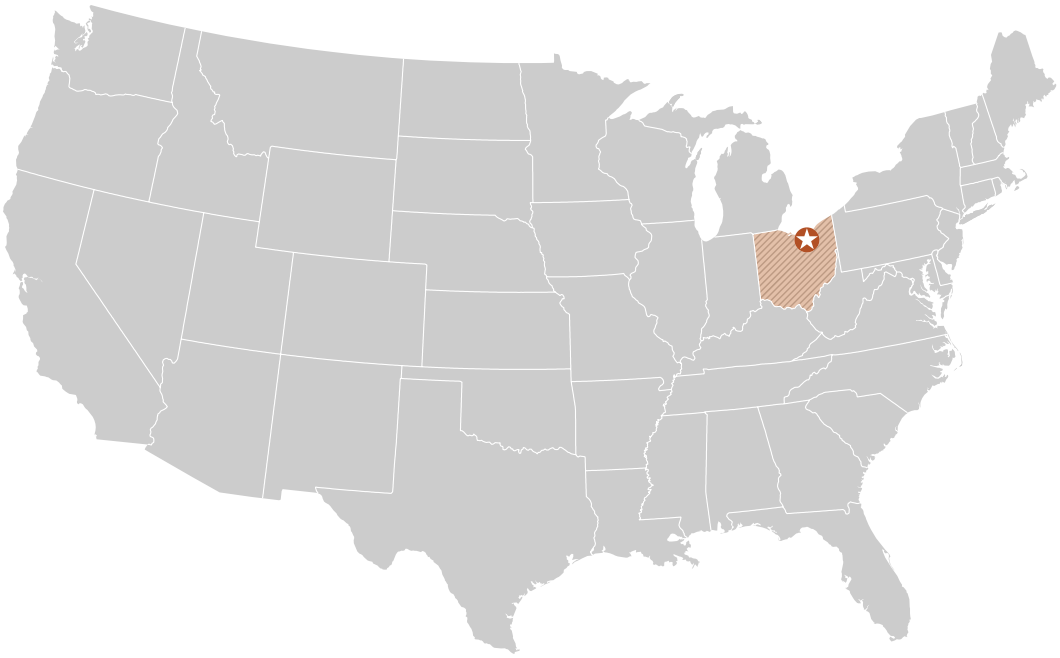
## Implementation Guide Background

This Guide was developed under the RWHAP Part F Special Projects of National Significance (SPNS) Program entitled *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, a four-year initiative (2017-2021) funded by the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) of the U.S. Department of Health and Human Services. E2i was designed to improve HIV health outcomes for people with HIV who experience persistent gaps along the HIV care continuum, such as engagement in care, retention in care, adherence to antiretroviral therapy (ART), and viral suppression. Black MSM with HIV are among the priority populations most in need of interventions that promote high quality and culturally-tailored services.

The E2i initiative chose to pilot and evaluate Project CONNECT because of its demonstrated effectiveness in improving HIV health outcomes for people with HIV, including Black MSM. Through a competitive request for proposals, one HIV service organization in the RWHAP was selected to implement Project CONNECT between 2018 and 2020. This site reported implementation and client outcome data to a team of evaluators who then analyzed these data. The stories, experiences, and evaluation outcomes of these E2i sites are integrated and highlighted throughout this Guide.

# The E2i Implementation Sites

**FIGURE 1.** Location of the site that implemented Project CONNECT through the E2i initiative.



**AIDS Taskforce of Greater Cleveland (Cleveland, Ohio)**

- AIDS service organization/Community-based organization
- Recipient of RWHAP Part A funding
- 1,200 clients with HIV a year
- 25 employees provide HIV services
- Most common services accessed by clients with HIV: emergency financial (79%), health education (77%), non-medical case management (77%)

## Implementation Science Evaluation

E2i used an implementation science approach to evaluate Project CONNECT. The evaluation aimed to answer the following questions:

- "What does it take to implement Project CONNECT in an HIV service organization?"
- "To what extent is successful implementation related to better HIV outcomes for the clients?"

E2i evaluators collected Project CONNECT client data from the E2i site throughout the initiative to measure engagement in care, prescription of ART, retention in care, and viral suppression. They also collected and reviewed site staff surveys, client encounter forms, site visit reports, and meeting notes in order to learn more about the key factors for: successful implementation, challenges encountered by the interventionists, and adaptations made to meet the needs of local settings and priority populations. The major findings from the evaluation are reported throughout this Guide. For additional detail on the theoretical approach and methods, see ***Appendix A***. See also the ***Project CONNECT E2i Toolkit*** for additional evaluation findings reported in manuscripts.

# PROJECT CONNECT OVERVIEW

# PROJECT CONNECT OVERVIEW

## Goal

The primary goal of Project CONNECT is:

- To promptly link and engage people with HIV into HIV primary care

## Description

Project CONNECT has four phases:

- **Phase one** involves scheduling a new client early orientation (the CONNECT visit) within five business days of a client's initial contact with the organization.
- **Phase two** is the CONNECT visit, during which a linkage coordinator establishes a trusting relationship with the client; administers a biopsychosocial assessment to enable provision of, or referrals to, supportive services; and schedules a first primary care appointment to occur as soon as possible, but within six weeks at most.
- **Phase three** is the client's first primary care visit, during which the linkage coordinator accompanies the client.
- **Phase four** involves maintaining a positive, trusting relationship with clients to improve engagement and retention in care. This aspect of the intervention was adapted from the evidence-based intervention Retention through Enhanced Personal Contacts.[1] The linkage coordinator, registered nurse, or other staff member regularly checks-in with clients in person or over the phone or video conference software. Enhanced personal contact also occurs through personalized appointment reminders to clients. If desired, clients may also receive one-on-one coaching to identify unmet needs, tap into personal strengths, and accomplish individualized goals.

[1] Gardner LI, Giordano TP, Marks G, et al. Enhanced personal contact with HIV patients improves retention in primary care: A randomized trial in 6 US HIV clinics. Clin Infect Dis. 2014;59(5):725-734.

## Priority Population

- People with HIV who are newly diagnosed, who have been out of HIV care for over 12 months, or are transferring care from another provider.
- Project CONNECT has demonstrated effectiveness with people with HIV, including Black MSM.[2,3]

**Project CONNECT Enrollment at the E2i Site**

**61** men

**25–29** years old

**100%** Black

**100%** MSM

## Rationale

- Timely linkage to care is essential for successful HIV treatment and outcomes, but people with HIV often have to wait several weeks or months for a first primary care visit.
- Long wait times are associated with "no shows" and failure to establish care.[4,5] Project CONNECT overcomes long wait times by ensuring that new clients establish a connection to the organization within five business days of first contact.
- Project CONNECT also increases linkage and engagement by having linkage coordinators establish a relationship with the client, remind clients of primary care appointments, accompany new clients to their first appointment, and refer clients to psychosocial services.

[2]Mugavero MJ. Improving engagement in HIV care: what can we do? Top HIV Med. 2008;16(5):156-161.

[3]Centers for Disease Control and Prevention. Compendium of Evidence-Based Intervention and Best Practices. Available at https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/lrc/cdc-hiv-lrc-project-connect.pdf and https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/lrc/cdc-hiv-intervention-lrc-eb-retention-enhanced-personal-contacts.pdf.

[4]Mugavero MJ, Westfall AO, Cole SR. Beyond core indicators of retention in HIV care: Missed clinic visits are independently associated with all-cause mortality. Clin Infect Dis. 2014;59(10):1471–1479.

[5]Mugavero MJ, Lin HY, Allison JJ, et al. Failure to establish HIV care: Characterizing the "no show" phenomenon. Clin Infect Dis. 2007;45(1):127-130.

## Intervention Background

» Project CONNECT was originally launched in 2007 at the University of Alabama at Birmingham ***1917 Clinic*** to address the issue that one-third of new clients did not attend their first scheduled HIV primary care appointment.[5]

» Recognizing that the lag time between initial clinic contact and first appointment was strongly associated with missed visits, the Project CONNECT developers scheduled an orientation for new clients within the first five business days of their initial call. Evaluation of the pilot program found that a significantly greater percentage of Project CONNECT clients attended a primary care visit within six months of orientation compared to clients from the pre-CONNECT period (81% vs. 69%, $p<0.01$).[3]

» To improve retention in care after initial engagement, the researchers adopted the intervention Retention through Enhanced Personal Contacts.[1]

» Both ***Project CONNECT*** and ***Retention through Enhanced Personal Contacts*** are included in the ***Centers for Disease Control and Prevention's Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention***.[3]

## Duration

» Project CONNECT begins as soon as a client initiates contact with the organization, and it continues until the client has achieved effective linkage to care as evidenced by establishing care with an HIV medical provider.

» Some organizations may choose to continue enhanced contact until a client achieves and maintains viral suppression over several months.

## Setting

» Project CONNECT can be implemented in any organization that provides HIV primary care or has a robust referral system to an HIV primary care clinic.

*For E2i, Project CONNECT was implemented by an AIDS service organization that offers medical services through an onsite affiliated clinic.*

## Staffing

Staffing for Project CONNECT depends on the unique structure of each organization.

### Core staff

At minimum, staffing requires:

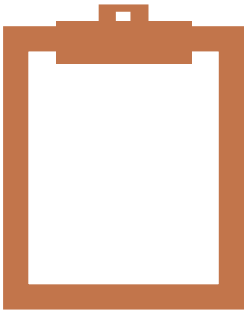
- **Linkage coordinator(s):** Medical case managers, Masters-level licensed social workers, or other health care professionals who are skilled at establishing rapport and knowledgeable about the medical, social, and psychological aspects of HIV. Hiring peers (i.e., people with HIV who represent the priority population) as linkage coordinators can help with building trust and engaging clients. The role of linkage coordinators is to schedule and lead the CONNECT visit, identify and introduce the primary care team, accompany clients to the first primary care visit (if desired by the client), and provide enhanced personal contact.
- **Primary care teams**, which typically consist of:
  - **Primary care provider(s):** Provides HIV care and treatment.
  - **Registered nurse:** Acts as the main contact between the client and the primary care provider once care is established; however, the linkage coordinator may continue to fulfill this role.
  - **Social worker/medical case manager:** Helps clients obtain insurance and medication, initiate and follow up on referrals, and potentially provide psychosocial assessments and counseling once care is established.

### Additional recommended staff

To successfully implement Project CONNECT, organizations may also need support from:

- **Non-medical case managers:** Help clients access housing, employment, transportation, and other basic needs and services.
- **Administrative director:** Oversees integration of services into the organization and supervises linkage coordinators
- **Finance staff:** Support providers in billing for services.

*To make Project CONNECT more culturally relevant for Black MSM clients, the E2i site named their program "Brothers Health Connection" and hired two Black MSM peers to be full-time "Life Coaches." The Life Coaches provided linkage coordinator services, including early orientations and enhanced personal contact; in addition, they provided weekly coaching sessions to help clients meet personal health goals. The Life Coaches were supervised by a full-time project manager who also oversaw intervention administration and provided direct case management to clients. The Brothers Health Connection team worked in close collaboration with staff from the medical clinic.*



# CORE ELEMENTS

# CORE ELEMENTS

Core elements are the "active ingredients" essential to achieving an intervention strategy's desired outcomes. It is critical to adhere to the core elements when implementing an intervention; otherwise, the intervention may not work as intended.[6] All other activities, such as staffing arrangements and clinical workflows, can be adapted to fit the unique circumstances of an organization and the priority population(s). However, adaptations should not compete with or contradict the core elements of Project CONNECT. **Project CONNECT has three core elements:**

### 1. Early orientation (CONNECT visit)

Linkage coordinators conduct the CONNECT visit within five business days of a new client's first contact with the organization.

*Why is early orientation important?*

- Testing positive for HIV can cause anxiety and confusion. Not everyone has a social support system already in place. Early orientation to HIV care and treatment provides newly diagnosed clients with crucial support.
- Clients who are returning to care or transferring care from another clinic often need reassurance from a staff member that they will be taken care of.
- It is common for new clients with HIV to miss their first appointment, particularly if the first visit cannot be scheduled for many weeks or months. By scheduling an orientation within five business days of initial contact, a clinic has a greater chance of the new client showing up. At that point, the linkage coordinator is able to begin building a trusting relationship with the client, who then will be more likely to attend their first primary care visit.

[6]Psihopaidas D, Cohen SM, West T, et al. Implementation science and the Health Resources and Services Administration's Ryan White HIV/AIDS Program's work towards ending the HIV epidemic in the United States. PLoS Med. 2020;17(11):e1003128.

### 2. Enhanced personal contact

Linkage coordinators and primary care teams establish and maintain a trusting relationship with clients through personalized, supportive communication during phone, online, and face-to-face connections. Contact may be in the form of reminder calls, in-person or virtual check-ins, or one-on-one counseling and coaching.

*Why is enhanced personal contact important?*

- Enhanced communication, connection, and relationships significantly improve retention in HIV care.
- Enhanced personal contact helps build personal relationships between clients and their HIV care teams by providing extended face-to-face communication.
- People with HIV who receive enhanced personal contact have improved rates of retention in care and fewer "no show" visits.[1]

### 3. Biopsychosocial assessments

Clients receive a biopsychosocial assessment at orientation and during regularly scheduled check-in visits. Assessments include a semi-structured interview, psychosocial questionnaire, and laboratory testing. Based on the assessment, clients are referred to supportive services as needed.

*Why are biopsychosocial assessments important?*

- The assessments enable the care team to understand the client's medical, social, and behavioral health needs and to expedite referrals to supportive services.
- Clients are more likely to stay in HIV care when their ancillary needs are met.

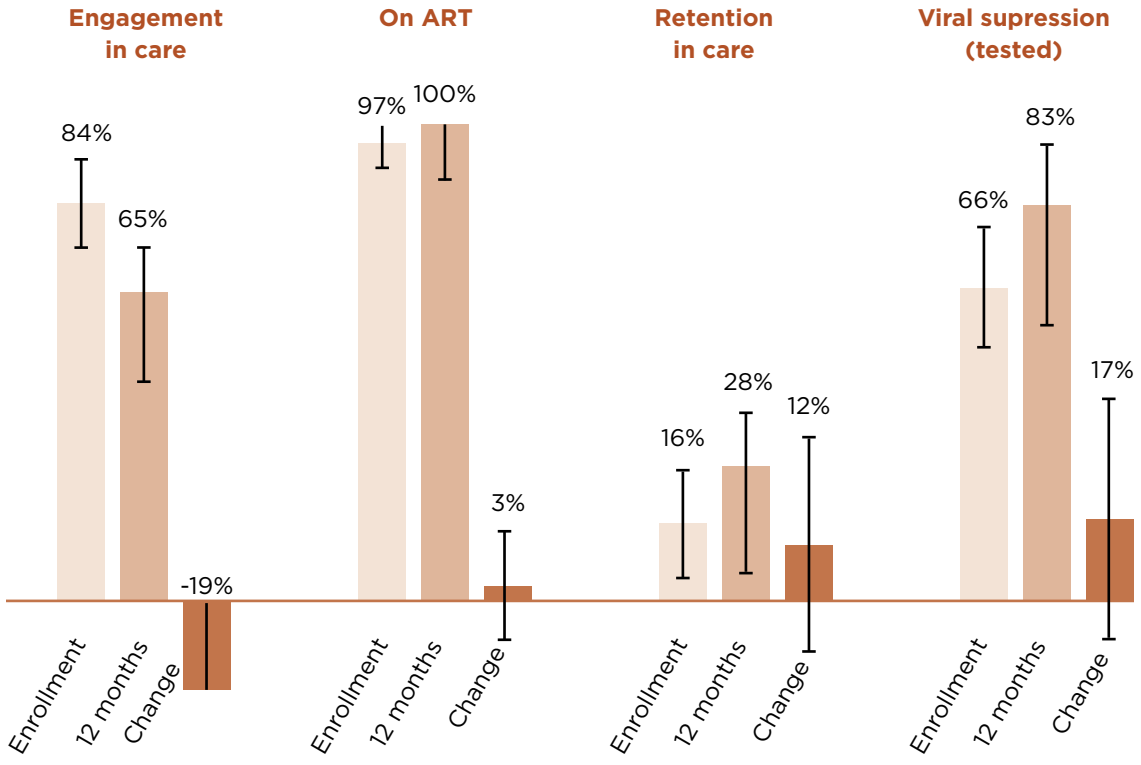
## E2i EVALUATION:
## PROJECT CONNECT ADAPTATIONS

During implementation, the E2i site made changes to the original intervention to meet the specific needs of their clients and staff members. While planning to implement Project CONNECT, the E2i site saw a need to expand services beyond linking and engaging new clients in HIV care. They found that many of their Black MSM clients with HIV who were already established in care still had a detectable viral load and had unmet needs. Although these clients did not need an early orientation, they did need enhanced personal contact, biopsychosocial assessments, and referrals to supportive services. Thus, the E2i site broadened the role of the linkage coordinator into a peer Life Coach role, adding weekly coaching sessions for clients. The coaching sessions were similar to intensive case management services. Coaches used motivational interviewing techniques to help clients meet their personal health goals and promote positive behavioral change. For clients who struggled to meet their goals, the Life Coaches developed a contract or agreement with the client that included a tailored plan and action steps. Once a client "graduated" from the program, they were placed back into the general case management system and given a new long-term case manager.

# E2i EVALUATION:
## PROJECT CONNECT HIV CARE CONTINUUM OUTCOMES

- **Enrollment:** During a 15 month period, the E2i site enrolled 61 Black MSM with HIV in Project CONNECT. The enrolled men were between the ages of 25 and 29 years.
- **Outcomes:** E2i measured HIV care continuum outcomes of each client at time of enrollment in Project CONNECT and 12 months later. There were no significant changes in any outcomes during this time period, possibly because the small number of clients made it difficult to detect significance. Engagement in care was high at time of enrollment, indicating that most clients were not newly diagnosed or out of care.

**FIGURE 2.** HIV care continuum outcomes among the 61 Black MSM clients enrolled in Project CONNECT as part of the E2i initiative.




**Note:** E2i used the following HRSA definitions for HIV care continuum outcomes:

- *Engagement in care* = At least one primary HIV care visit in the previous 12 months
- *On ART (adherence)* = Having been prescribed ART in the past 12 months
- *Retention in care* = At least two HIV care visits in the past 12 months
- *Viral suppression* = Having an HIV viral load test in the past 12 months AND having a result of less than 200 copies/mL at the last viral load test

# PLANNING ACTIVITIES

# PLANNING ACTIVITIES

This section provides recommended activities for planning to implement Project CONNECT. For helpful tools to support the planning of Project CONNECT, see:

***Appendix B:*** Organizational Readiness Checklist

***Appendix C:*** General Best Practices for Planning to Implement an Intervention Strategy

***Appendix D:*** Project CONNECT "Go Live" Worksheet

## Identify and Train Staff

» Identify or hire one or more linkage coordinators who are skilled in building rapport with clients.

» Train linkage coordinators in all aspects of providing Project CONNECT, as needed. Sample topics include:

- HIV infection and treatment basics
- HIV medication adherence education and counseling
- Screening and referral for substance use disorders, psychiatric disorders, and supportive services
- Trauma-informed approaches
- For peers: training on boundaries with clients and professional expectations; consider state or national peer specialist certification training

» Familiarize all relevant staff on Project CONNECT's core elements and process flow.

*Additional professional development and training are important for new hires, especially if hiring peers or others who have not yet had professional work experience. E2i has found the following training topics to be very useful for peers:*

- *Self-Care and resiliency*
- *Restorative and healing justice*
- *Facilitation skills*
- *HIV "101"*
- *Trauma-informed care*

*Organizations that offer training and resources on these topics include* ***Black Emotional and Mental Health Collective*** *(BEAM) and* ***AIDS United****.*

# Develop an Outreach and Recruitment Plan

To identify potential clients for Project CONNECT, organizations can do the following:

**In-reach**

» Ask for referrals of potential clients from staff who provide non-clinical services to people with HIV.

» Search organizational databases of clients for people who meet your enrollment criteria (e.g., clients who are newly diagnosed, out of care). Develop a process to recruit these clients.

**Outreach**

» Develop printed and electronic recruitment materials to increase awareness of your organization and Project CONNECT.

» Enlist the help of peer staff to develop recruitment messaging and strategies.

- What social media platforms does the priority population use?
- What kinds of messages and images appeal to the priority population?
- What are strategic places to post flyers and hand out brochures?

» Distribute and post recruitment materials at HIV testing sites, House and Ball Community events, nightclubs, Pride events, and community-based organizations that serve the priority populations.

» Post outreach messages on websites and social media.

- Co-host outreach events with community partners.

*The House and Ball Community celebrates all forms of gender and sexual expression, while providing many youth and adults with a chosen family structure. Balls are extravagant and competitive social events co-organized by leaders in the community. During House Balls, participants compete in a variety of artistic categories. HIV organizations can partner with the local House and Ball Community to get the word out about their services.*

**Incentives**

» Consider offering incentives, such as gift cards to local stores, for attending the CONNECT visit and first primary care visit.

**Community referrals**

» Organizations can develop partnerships with other community agencies to create bi-directional referral systems. Partners may include housing agencies, food assistance programs, health departments and other HIV testing sites, criminal justice partners, mental health and substance use treatment and counseling agencies, and other community-based organizations.

*To recruit clients, the E2i site posted on social media, talked to people in the social networks of peer staff and volunteers, and conducted in-reach with clients already accessing the site's youth services, such as housing assistance. Staff also reached out to community partners for bi-directional referrals. Clients were given gift card incentives for enrolling.*

## Choose Biopsychosocial Assessment Tools

A core element of the CONNECT visit is to assess clients for additional service needs, such as substance use treatment, social support, and mental health counseling. Organizations can use their existing biopsychosocial assessment tools for this process, or can use the validated assessments listed in ***Appendix E***.

## Design a Process Flow

The Project CONNECT process flow is flexible and can be based on an organization's unique programs, resources, and staffing.

» Collaborate with all relevant staff to decide and clarify the roles of Project CONNECT team members (i.e., who is doing what, when, where, and how?).

» Write down or draw a map or diagram to illustrate the proposed process flow.

» Identify office space for the CONNECT visit.

» Ask for input and feedback from all staff affected by Project CONNECT.

## Consider Non-Traditional Hours and Meeting Places

To accommodate transportation barriers and busy schedules of clients, consider the following strategies:

- Offer early morning or evening hours for CONNECT visits, primary care clinic visits, and coaching sessions.
- Provide bus passes, gas cards, and car service vouchers.
- Offer to have check-ins and coaching sessions via smartphone apps or in the client's home.

## Develop a Sustainability Plan

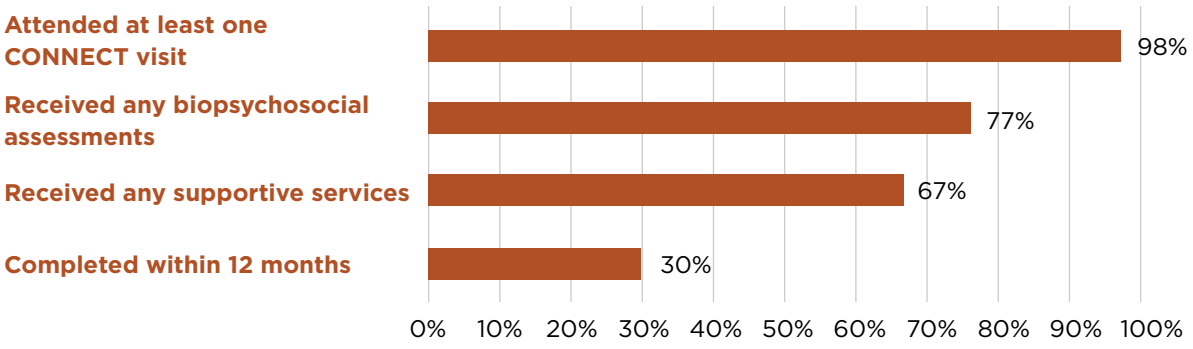
Sustainability refers to the ability to maintain programming and its benefits over time. A helpful resource for building capacity for sustainability is the ***Program Sustainability Assessment Tool*** developed by the Center for Public Health Systems Science at the Brown School, Washington University in St. Louis. This tool helps program planners achieve the following:

1. **Understand** the factors that influence a program's capacity for sustainability
2. **Assess** the program's capacity for sustainability
3. **Review** results from the Assessment
4. **Plan** to increase the likelihood of sustainability by developing an Action Plan

Achieving sustainability typically involves both applying for grants and accessing available reimbursement options. Organizations that employ peers to deliver services as part of Project CONNECT may be able to cover all or part of those services through their state's Medicaid program. RWHAP-funded organizations may be able to fund Project CONNECT under Early Intervention Services, and can receive technical assistance on health coverage options from the ***Access, Care, and Engagement Technical Assistance (ACE TA) Center***.

# E2i EVALUATION:
## PROJECT CONNECT PARTICIPATION OUTCOMES

**FIGURE 3.** Participation outcomes among the 61 clients enrolled in Project CONNECT as part of the E2i initiative.




- **Attendance:** Nearly all (98%) clients had a CONNECT visit (early orientation), and 97% had additional life coaching sessions.
- **Timing of CONNECT visit:** About half (52%) of clients had a CONNECT visit within 5 days of enrollment, and 77% within 30 days.
- **Number of life coaching sessions:** The number of life coaching sessions per client ranged from 4 to 10 sessions over 12 months.
- **Biopsychosocial assessments:** Over three-quarters (77%) of clients were given at least one biopsychosocial assessment.
- **Supportive services:** Two-thirds (67%) of clients received supportive services, consisting of case management and navigation services.
- **Completion:** About one-third (30%) of clients completed Project CONNECT within one year. The site defined completion as maintaining viral suppression for at least three months.[7]

[7]Some clients who were maintaining viral suppression stayed in the program longer than three months if staff determined the client needed additional supportive services.

# E2i EVALUATION:
## PROJECT CONNECT IMPLEMENTATION OUTCOMES

To learn more about how Project CONNECT was viewed by the leadership and staff members at the E2i sites, E2i collected data from the people implementing the intervention. The data included: (1) an organizational survey completed by site leadership once during the planning period, and every six months during implementation; and (2) review of site documents created during implementation, including site visit reports, meeting notes, and cost workbooks (See *Appendix A*).

| Measure (definition) | Results at the E2i sites |
|---|---|
| **Acceptability:** how well staff and leadership regard the intervention | Site staff found that Project CONNECT was a good fit for their organization's mission and goals. Acceptability of CONNECT remained high for the entire initiative. |
| **Adoption:** the intention, initial decision, or action to implement the intervention | Site staff reported consistently high adoption throughout the initiative. |
| **Appropriateness:** the compatibility of the intervention to address a particular issue or problem | Site staff reported that Project CONNECT addressed a service need in their organization. |
| **Feasibility:** the extent to which the intervention can be successfully carried out | At first, site staff found Project CONNECT to be somewhat feasible. By the end of the three years of implementation, however, they found it to be highly feasible. |
| **Fidelity:** the degree to which a site felt able to (a) implement the intervention as it was intended by the program developers, and (b) monitor progress | The site reported lower fidelity at first, but believed they attained fidelity by the end of the initiative. Fidelity may have been affected by challenges with staff hiring and turnover. |
| **Penetration:** the integration of the intervention within the organization | After an initial decline in penetration, the site was able to integrate Project CONNECT into their operations over time. Having the peer Life Coaches participate in team-based morning huddles helped to facilitate integration. |
| **Cost:** the costs associated with planning and implementation, such as: personnel, training, supplies, incentives, and outreach activities | Costs included both direct and in-kind expenses. The site expenditures were:<br>• *Planning period:* $34,517<br>• *Recruitment:* $199 per client enrolled<br>• *Implementation activities:* $3,199 per client enrolled<br>• *Supervision and management:* $1,477 per client enrolled<br>These numbers do not necessarily reflect what it would cost to implement Project CONNECT at other HIV service organizations. Costs per client would be lower in settings with larger populations of Black MSM with HIV, because more participants could be recruited. |

# IMPLEMENTATION ACTIVITIES

# IMPLEMENTATION ACTIVITIES

Clients in Project CONNECT progress through four phases to become linked to and engaged in care. The **Project CONNECT Client-level Implementation Checklists (*Appendix F*)** can be used to help guide staff through each phase.

## Phase One: Initial Contact

Phase One begins when a new client contacts the clinic for an appointment, or when a potential client is referred to Project CONNECT. The linkage coordinator or other team member establishes rapport with the client, screens for eligibility, collects enrollment information, and schedules the CONNECT visit to occur within five business days. Sometimes the CONNECT visit can take place immediately after enrollment.

## Phase Two: CONNECT Visit

The CONNECT visit is critical for setting up a new client for successful treatment engagement. Ideally, the client meets with the same linkage coordinator they spoke to during the initial clinic contact. During the CONNECT visit, the linkage coordinator meets with the client for one to two hours to complete the following:

- Give a tour of the clinic so the client can become familiar with services offered.
- Conduct a biopsychosocial assessment consisting of a semi-structured interview. Use the tools in *Appendix E* or other validated questionnaires.
- Arrange and complete initial lab work.
- Discuss the importance of staying in care.
- Discuss members of the client's primary care team.
- Schedule the first primary care appointment to occur as soon as possible (within six weeks).

» Identify and make referrals for additional sources of care, based on needs identified in the biopsychosocial assessment. These may include:

- Insurance coverage / AIDS Drug Assistance Program
- HIV testing for sexual partner(s)
- Mental health counseling and peer support groups
- Substance use counseling and peer support groups
- Housing support
- Food assistance
- Childcare services
- Transportation services and vouchers
- Chaplain services (spiritual, faith, and grief issues)
- Other health specialists (e.g., dentist, endocrinologist, nephrologist, psychiatrist, nutritionist)

» Answer client's questions and concerns.

## Phase Three: First Primary Care Visit

Phase Three of the intervention marks the beginning of the client's transition into HIV medical treatment. During this phase, the client attends their first primary care appointment, which was scheduled by the linkage coordinator during the CONNECT visit. To provide comfort and security at this critical juncture, the linkage coordinator offers to accompany the client to the appointment. Clients may or may not feel it necessary to have the linkage coordinator attend the appointment with them.

*The E2i site reports that they were able to schedule most of their client's primary care visits within one week of the CONNECT visit.*

## Phase Four: Check-ins and Enhanced Personal Contact

After each primary care visit, a member of the primary care team schedules a quarterly (or sooner) check-in with the client. Some organizations may continue to include the linkage coordinator in this process. Because primary care visits may only occur every six months, check-ins help maintain the relationships between the client and the clinic. Check-ins can occur in person, over the phone, or over video conference software. During these check-ins, the care team member:

- Monitors the client's health
- Ensures the client understands medical advice and the treatment plan
- Reinforces action plans
- Checks on medication and appointment adherence
- Answers questions

*The E2i site's Life Coaches found that their many young clients preferred using smartphone applications over face-to-face meetings for check-ins and coaching sessions. While young clients often have unpredictable schedules, they always have their phones with them.*

The following retention strategies were adapted from the Retention through Enhanced Personal Contacts intervention and can be used to improve engagement and retention for Project CONNECT clients.

- **Frequent Reminders:** To increase the likelihood that clients will attend orientation, check-ins, and primary care visits, the linkage coordinator or other team member sends clients a personalized, enhanced reminder call, text, and/or email at set times prior to the appointment date. It is recommended to send reminders at seven and two days before the scheduled appointment. However, some clients need additional reminders and encouragement.

  When clients miss an appointment, the team member contacts the client within 24 hours of the missed visit and attempts to reschedule the appointment as soon as possible, offering transportation or other support as needed and available.

» **Relationship building:** To enhance the personal connection with clients, linkage coordinators and other team members aim to do the following in all communication with clients:

- Consistently treat the client with dignity and respect
- Express empathy and compassion
- Get to know the client better as a person
- Carefully listen to the client
- Provide affirmations/recognition of effort
- Focus on the client's strengths
- Create a shared vision of treatment success with the client

A self-rating scale for these relationship-building components can be found in the **Client-Level Implementation Checklists** *(Appendix F)*.

## **E2i EVALUATION:** CHALLENGES, SUCCESSES, AND LESSONS LEARNED

The E2i site shared barriers and facilitators to meeting their implementation goals. Here is a summary of lessons learned. Additional information about the site's experience can be found in the Program Spotlight below.

- **Peers as Life Coaches:** The E2i site found that hiring well-known and respected Black MSM as Life Coaches greatly enhanced client engagement in CONNECT visits and coaching sessions.
- **Privacy needs:** The Life Coaches recognized the importance of being sensitive to clients' need for privacy about their HIV status. They worked with clients to make them feel safe when entering the facility, such as allowing clients to enter through the back door of the clinic. Life Coaches also offered to meet for coaching sessions in public places rather than the main facility, due to concerns by clients about being seen in an HIV services facility.
- **Social, economic, and behavioral health barriers:** Several clients struggled with poverty, food insecurity, and especially housing instability. Many also had untreated substance use and/or mental health disorders. HIV treatment was not necessarily a priority for clients with a high level of unmet needs. Staff found they needed to address these issues with a greater intensity than expected. Having robust internal services and referral networks was an absolute necessity for this community of young Black MSM with HIV.
- **Partnerships to meet social determinants of health:** The Life Coaches built partnerships with local educational institutions to offer clients opportunities for continuing education, and met with landlords to expand housing opportunities to clients.
- **Appointment attendance:** Due to competing priorities and barriers, clients struggled with appointment attendance. Some needed a lot of outreach to return to the clinic. Life Coaches recommend being flexible with the timing and location of check-ins and coaching.
- **Primary care visit accompaniment:** Life Coaches reported that most clients told them they did not want or need the Life Coach to attend their medical appointments with them. Life Coaches did, however, try to meet the clients in the lobby or at the back door prior to medical visits.

# PROGRAM SPOTLIGHT

PROGRAM SPOTLIGHT

# AIDS Taskforce of Greater Cleveland


## Organizational Background

As the oldest and largest AIDS service organization in Ohio, AIDS Taskforce of Greater Cleveland (ATGC) provides case management, a community youth drop-in center, and prevention, education, and social services for over 25,000 clients, about 1,200 of whom are people with HIV. ATGC receives RWHAP Part A funding and is an affiliate of the AIDS Healthcare Foundation, which provides HIV medical care and a pharmacy under the same roof as ATGC.

## Implementation Goals and Context

ATGC rebranded Project CONNECT as Brothers Health Connection, a new initiative providing linkage, retention, and case management services to mostly young Black gay, bisexual, and same-gender loving men. Brothers Health Connection employs two full-time Life Coaches and a full-time project manager who oversees intervention administration and also provides direct case management to clients.

## Recruitment and Delivery

Brothers Health Connection staff have a multi-prong recruitment strategy that includes posting friendly messages about their services on social media; talking to people in the social networks of ATGC peer staff and volunteers; and conducting in-reach with clients already accessing ATGC's youth services, such as housing assistance. Brothers Health Connection staff also reach out to community partners for bi-directional referrals.

To enroll in Brothers Health Connection, clients first meet with ATGC's general intake specialists. All young Black MSM with HIV are then referred to the Life Coaches who call the client to schedule an orientation. During orientation, the Life Coaches build rapport, conduct biopsychosocial assessments, order lab tests if needed, make referrals to other services, and coordinate with the medical case manager to schedule a client's first primary care appointment within two weeks of the orientation. To prevent missed medical visits, Life Coaches send reminder texts or calls to their clients and offer to escort clients to the medical clinic. Some clients request to meet the Life Coach at the back door of the clinic, rather than the main lobby, to better protect their privacy.

Brothers Health Connection clients receive a non-cash transferrable gift card upon enrollment, and weekly transportation vouchers (e.g., bus passes and gas cards) to attend appointments. Life Coaches have found that handing out weekly bus passes is a reliable way to ensure regular interaction and general check-in with clients. Still, client homelessness and undiagnosed substance use and mental health disorders present major barriers to attending primary care and coaching appointments. Staff send frequent texts, phone calls, emails, and letters to remind clients to attend. Life Coaches may begin implementing home visits with clients in an effort to remove some of these barriers.

## Adaptations for Local Context

» **Weekly coaching:** Life Coaches provide weekly coaching sessions to Black MSM clients who have intensive support needs, including clients who are already linked to care. Life Coaches use motivational interviewing techniques to help guide clients to behavioral change. For clients who struggle to meet their goals, the Life Coaches develop a contract or agreement with the client that includes a tailored plan and action steps.

» **COVID-19 pandemic:** When the COVID-19 pandemic began in spring 2020, Life Coaches began conducting assessments and coaching via videoconference, phone, and texting as appropriate. Coaches have also met clients in outdoor spaces, such as parks or cafes, or in the ATGC lobby for short visits, while masked and socially distant. Staff have noted that in some ways, connecting through smartphones has been better than in-person for their young clientele who often have unpredictable schedules, but always have their phones with them.

## Program Integration

ATGC has successfully integrated Brothers Health Connection into their daily operations. Key to integration was having the Life Coaches join the medical clinic's morning huddles as a way to identify more clients who may benefit from the intervention and to share pertinent information about clients, as needed. ATGC intends to continue the Brothers Health Connection indefinitely, as it provides a welcome service to a community in need. They have shifted internal funds to cover the program and are seeking additional funding from other sources.

*"We are so happy with CONNECT and have seen a lot of success. It fills a great need in the community, and we really want to keep it going."* —ATGC Life Coach

## Contact Information

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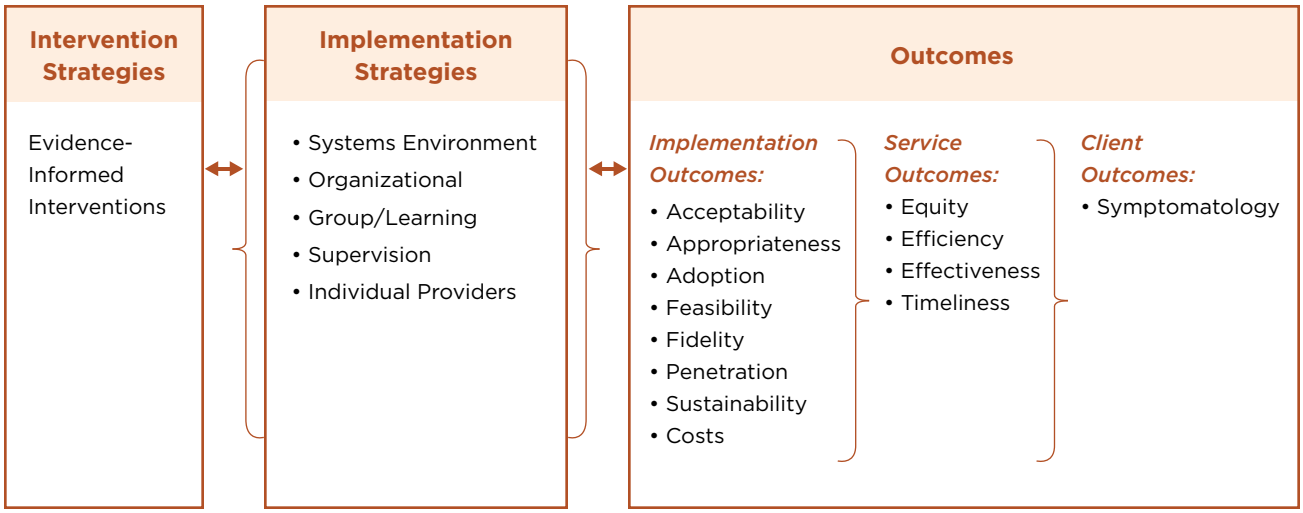
# APPENDICES

# **APPENDIX A.** IMPLEMENTATION SCIENCE AND EVALUATION: FRAMEWORK AND METHODS

The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco conducted the evaluation of the E2i program implementation. The evaluation used the Proctor Model Framework for Implementation Research.[8] This approach suggests that program assessment should include an understanding of the process of implementation and its impact on all people and systems that are involved in the implementation:

1. The core elements of the program (intervention strategies).
2. The efforts to put the program into place (implementation strategies).
3. How the program is viewed by the people involved (implementation outcomes).
4. How the program is delivered (service outcomes).
5. The impact on the participants (client outcomes).

The E2i Proctor Model




[8] Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76.

Six types of information were gathered over the three years of program implementation. These include:

**Organizational Assessment:** Every six months the program director completed a survey. This survey had questions about the organization (e.g., number of patients, types services provided, and staffing). It also included questions about program delivery and staff views of the program.

Proctor Concepts

- Implementation strategies (systems environment, organizational, group/learning, supervision)
- Implementation outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability, costs)

**Document Review:** Evaluators reviewed documents that were created during implementation and technical assistance activities. Documents were created by either the sites themselves or by Fenway/AIDS United and included grant applications, site visit reports, quarterly reports, monitoring call notes, cohort call notes, and presentations in meetings.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual patients)
- Implementation Outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability)

**Observations:** Sites participated in two Learning Session Meetings each year. Evaluators took notes on discussions and presentations. These notes focused on barriers and facilitators to implementation.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual patients)

**Costing Data:** Program managers and financial administrative staff completed two cost workbooks. One was for the three-month preparation/planning period and the first year of program implementation. The other was for the second year. These included personnel and expenses paid for by E2i as well as in-kind donations.

Proctor Concepts

» Implementation Outcomes (costs)

**Intervention Exposure:** Information was collected on participants who enrolled between September 2018 and December 2020. Demographic information was collected on enrollment forms. Intervention exposure forms were collected whenever staff had program-related interactions with participants. These forms included the things like the date of the interaction, the staff person who had contact, type of interaction, activities completed, and outcomes of the activities.

Proctor Concepts

» Service Outcomes (fidelity, penetration, equity, efficiency, effectiveness, timeliness)

**Medical Records:** Medical records were collected on participants for the 12 months before enrollment in the program and for the 12 months after enrollment in the program. The information was specific to HIV-related medical care, such as: appointment dates; prescription of ART; viral load test dates; and viral load test results.

Proctor Concepts

» Client Outcomes (symptomatology)

**Quantitative Analysis:** Organizational assessment data was used to describe organization characteristics and readiness for implementation based on Proctor Concepts. Client level enrollment and intervention exposure data was analyzed using descriptive statistics to understand client demographics, proportions of clients receiving intervention services, and frequencies of exposures. When appropriate, proportion of clients completing the intervention was included. Repeated measures modeling methods were used to assess changes in HIV Care Continuum outcomes for clients enrolled in the intervention. This compared data from 12 months prior to enrollment to 12 months following enrollment. Costing data was analyzed to provide information on cost of intervention implementation per client enrolled.

**Qualitative Analysis:** Documents and observations were thematically analyzed using the Proctor Concepts. The intervention was the primary unit of analysis.

# **APPENDIX B.** ORGANIZATIONAL READINESS CHECKLIST

Please check the box under the column that **most accurately** represents your organization. You should choose **one** answer for each of the essential components listed.

| Essential Components for Implementation | Yes, we have this | No, but it is possible to obtain this | No, and it is not possible to obtain this |
|---|---|---|---|
| Organization provides medical services to people with HIV, or provides robust referral to HIV medical services | | | |
| Clients with HIV have access to a primary care provider within six weeks of referral | | | |
| Clients with HIV have access to a social worker/case manager | | | |
| Clients with HIV have access to a registered nurse | | | |
| Organization has the financial means necessary to provide new clients with orientation, case management, and primary care | | | |
| Organizational leadership and governing body support Project CONNECT implementation and maintenance | | | |
| Organization has onsite ancillary services, or can provide referral and transportation to access ancillary services | | | |
| **Suggested Organizational Components for Implementation** | **Yes, we have this** | **No, but it is possible to obtain this** | **No, and it is not possible to obtain this** |
| Organization uses a secure electronic health record system for storing client data | | | |
| Organization has the capacity to collect and evaluate program data to monitor progress and success | | | |

# **APPENDIX C.** GENERAL BEST PRACTICES FOR PLANNING TO IMPLEMENT AN INTERVENTION STRATEGY

The following are general recommendations for planning an intervention in an HIV service delivery organization.

## Create a Planning Team

» Assemble a team of staff "champions" who are invested in the success of the intervention: who will meet regularly to drive planning, implementation, and sustainability; and who will remain committed to overcoming hurdles and moving implementation forward.

» Consider how to meaningfully involve at least one peer (a person who represents the priority population) in the planning and implementation of the intervention (see ***AIDS United's resources on meaningful involvement of people with HIV***).

» Hold weekly team meetings or daily "huddles" (i.e., short meetings at the beginning of the day to review client status and discuss recruitment and retention issues, etc.).

## Engage Leadership and Staff

Implementing a new service into an established program may require changes in routines, job duties, and administrative procedures. It is essential to obtain buy-in and a firm commitment from the entire organization as early in the planning process as possible.

» Meet with executive leadership to discuss:

- How the intervention will support the organization's mission and goals
- The benefits of the intervention for clients and the organization as a whole
- The resources needed to implement the intervention
- The organizational systems and procedures that will be affected by implementation
- The importance of leadership communicating their commitment to the intervention to all staff
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

» Meet with staff members directly and indirectly affected by the intervention to discuss:

- The benefits of the intervention for clients and the organization as a whole
- How staff can help with recruitment and referrals
- Suggestions for outreach and implementation processes
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

## Assess Community Needs

Early in the planning process, organizations should consider conducting an informal or formal needs assessment to better understand the needs of the priority population(s) and how to best tailor the intervention to their needs. Engaging with the local community also helps to establish trust, build recruitment visibility, and grow your referral networks.

Community needs assessment strategies include:

» Reviewing existing client data on engagement and retention:

- How many newly diagnosed, re-entering, and transferring clients does your organization see in a year?
- What percentage of new clients miss their first HIV care appointments?
- Are certain populations more likely to miss appointments?
- Do missed appointments occur more frequently at certain times of the day?

» Holding forums, interviews, or focus groups with community leaders, residents, clients, and providers from other local agencies to ask for their input on the intervention:

- What are the populations' major barriers to engaging in HIV care (e.g., stigma, confidentiality, competing needs)? How might we adapt the intervention to address these barriers?
- What are facilitators to engaging in HIV care? How might we adapt the intervention to incorporate these facilitators?
- What can we do to make the intervention appealing and accessible?
- How can we work together to enroll new clients?

## Train All Staff

When implementing an intervention for people with HIV, it is important to train all organizational staff in reducing stigma, identifying and addressing trauma, enhancing cultural humility, and providing affirming, culturally responsive care to all people with HIV, including lesbian, gay, bisexual, queer, transgender, and gender diverse people. Training and resources are available from ***TargetHIV***, ***AIDS Education and Training Center Program***, and ***National LGBTQIA+ Health Education Center***. Peer hires may also need additional training to acquire office skills and other professional competencies.

## Conduct a Pilot Test

Prior to full implementation, conduct a pilot test under "real world" conditions to evaluate the feasibility and acceptability of the process flow, forms, and procedures.

- Consider piloting Project CONNECT with a small group of clients; for example, start with only newly diagnosed clients.
- Use a validated ***quality improvement method*** to guide your pilot test.
- After the pilot, communicate to all staff the results of the pilot: what worked, what did not work, and what changes were made to improve operations.

# **APPENDIX D.** PROJECT CONNECT "GO LIVE" WORKSHEET

## Purpose

The purpose of the "Go Live" Worksheet is to:

1. Guide organizations in carrying out the intervention's planning steps and activities
2. Monitor progress in meeting implementation goals and objectives

## Instructions

The team that is leading the intervention should identify a team member to complete this worksheet over time. Use the worksheet to:

- Develop and drive team meeting agendas
- Document decisions made by the team
- Track progress towards goals

| | |
|---|---|
| **Name of organization/ clinic** | |
| **Name** (Who is completing this worksheet?) | |
| **Intervention goal** | To promptly link and engage people with HIV into primary HIV medical care |
| **Core elements** (These are essential to the intervention and cannot be changed) | **1.** Early orientation (the CONNECT Visit) occurs within 5 days of initial contact with client<br>**2.** Enhanced personal contact (linkage coordinator and care teams support client during phone and face-to-face connections)<br>**3.** Biopsychosocial assessments at baseline and check-ins, followed by appropriate referrals |
| **Planning Steps** | |
| **Planning Team** (Who is on the planning team?) | **1.** |
| | **2.** |
| | **3.** |
| | **4.** |
| | **5.** |
| **Eligibility criteria** | **1.** One of the following:<br>• Newly diagnosed with HIV<br>• Out-of-care for at least 12 months<br>• Transferring care from another provider<br>**2.** Priority population demographic criteria (e.g., identifies as Black/African American; is a man who has sex with men) |
| **Priority population(s)** (Who will you recruit for the intervention?) | **1.** |
| | **2.** |
| | **3.** |
| | **4.** |

| | |
|---|---|
| **Geographic catchment area(s)** (From which communities will you recruit clients?) | **1.** |
| | **2.** |
| | **3.** |
| **Language(s)** (In what languages will you deliver the intervention?) | **1.** |
| | **2.** |
| **Engaging stakeholders** (What strategies will you use to gain "buy-in" and feedback?) | **1.** Organizational leadership: |
| | **2.** Relevant staff: |
| | **3.** Local community members: |
| | **4.** Clients: |
| **Recruitment and outreach** (What are your recruitment strategies?) | **1.** |
| | **2.** |
| | **3.** |
| | **4.** |
| | **5.** |

| | | |
|---|---|---|
| **Intervention Staff** (Who will do what?) | **Role/Task** | **Staff Responsible** |
| | Outreach/recruitment | |
| | Eligibility screening | |
| | Intake/enrollment | |
| | Schedule CONNECT visit | |
| | Host CONNECT visits (including biopsychosocial assessment, tour, etc.) | |
| | Conduct enhanced personal contacts (e.g., check-ins, reminder calls) | |
| | Conduct coaching (if using) | |
| | Primary care team | **1.**<br>**2.**<br>**3.** |
| **Staff training requirements** (Check each box when completed) | ☐ Inform all staff about CONNECT<br>☐ Train linkage coordinator(s) to deliver CONNECT<br>☐ Train linkage coordinator(s) in HIV infection and treatment basics<br>☐ Train all staff on stigma reduction and providing culturally affirming care | |
| **Staff training plan** (When, where, and how will staff be trained?) | | |

| | |
|---|---|
| **Incentives** (What participation incentives are you giving, if any?) | |
| **Bio-psychosocial assessment tools** (What tools will you use?) | **1.** Medical and social history |
| | **2.** Depression, anxiety, substance use, safety, social support, quality of life, and HIV stigma |
| | **3.** Laboratory tests (e.g., viral load, CD4, STIs) |
| **Additional Tools** (e.g., screening forms, enrollment forms, referral forms, client satisfaction and feedback forms) | **1.** |
| | **2.** |
| | **3.** |
| **Enhanced contact** (How often will you check-in with clients? When will you make reminder calls/texts?) | **1.** Check-in schedule: |
| | **2.** Reminder calls/texts schedule: |
| | **3.** How else will you enhance personal contact? |
| **Referrals** (who will you partner with for services not offered by your organization?) | **1.** |
| | **2.** |
| | **3.** |
| | **4.** |

| | |
|---|---|
| **CONNECT process flow** (Describe or draw the process from recruitment/referral through first primary care visit. Consider: who, when, what, and where) | |
| **Sustainability** (What are you doing to make your program sustainable?) | |
| **Pilot the intervention** (When and how will you test a pilot of the intervention?) | |
| **After pilot:** What worked, what did not work? What changes will you make? | |
| **SMART goals** (What are your **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-Bound goals?) | **1.** |
| | **2.** |
| | **3.** |
| | **4.** |
| | **5.** |

# **APPENDIX E.** RECOMMENDED BIOPSYCHOSOCIAL ASSESSMENTS

Below are recommended assessment tools to use during the CONNECT visit (early orientation) and check-in visits:

- **Depression:** *Patient Health Questionnaire*-9 item (PHQ-9)[9,10]
- **Anxiety:** *Generalized Anxiety Disorder-7 item* (GAD-7)[11]
- **Adherence to Antiretroviral Therapy:** Self-Rating Scale, 30-day visual analog scale, AACTG adherence instruments (7-day missed dose, last missed dose, weekend missed dose)[12–14]
- **Substance use:** *Alcohol Use Disorders Identification Test (AUDIT/AUDIT-C)* for alcohol use; adapted *Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)* for other substances[15–18]
- **Alcohol dependence:** *Mini-International Neuropsychiatric Interview (M.I.N.I.)*[19]

[9]Spitzer RL, Kroenke K, Williams JB. Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA. 1999;282(18):1737-1744. Available at: https://www.phqscreeners.com/select-screener

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[14]Lu M, Safren SA, Skolnik PR, et al. Optimal recall period and response task for self-reported HIV medication adherence. AIDS Behav. 2008;12(1):86-94.

[15]Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. Arch Intern Med. 1998;158(16):1789-1795.

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[17]Newcombe DA, Humeniuk RE, Ali R. Validation of the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Report of results from the Australian site. Drug Alcohol Rev. 2005;24(3):217-226.

[18]WHO ASSIST Working Group. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Development, reliability and feasibility. Addiction. 2002;97(9):1183-1194.

[19]Sheehan DV, Lecrubier Y, Sheehan KH, et al. The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. J Clin Psychiatry. 1998;59 Suppl 20:22-33;quiz 34-57.

- **Alcohol/drug treatment modality:** *Treatment Service Review*[20]
- **Sexual risk behavior:** Sexual Risk Behavior Inventory[21]
- **HIV-related stigma:** HIV Stigma Mechanism Measure[22]
- **Intimate partner violence:** *Various measures*[23,24]
- **Childhood violence:** *Adverse Childhood Experiences International Questionnaire (ACE-IQ)*[25]
- **HIV-related symptoms:** HIV symptom index[26]
- **Physical activity:** Lipid Research Clinics questionnaire[27]
- **Health-related quality of life:** *EuroQol (EQ-5D)*[28]
- **Social support:** Multifactorial Assessment of Perceived Social Support (MAPSS-SF)[29]

Other factors to assess can include:

- **Demographics:** *sexual orientation and gender identity*;[30] education; employment; housing; incarceration history (e.g., *PRAPARE* tool)
- **Insurance status**
- **Family history:** diabetes, high blood pressure, heart disease, kidney disease
- **HIV medical history:** HIV testing and treatment history
- **List of medications and allergies**

[20]McLellan AT, Alterman AI, Cacciola J, Metzger D, O'Brien CP. A new measure of substance abuse treatment. Initial studies of the treatment services review. J Nerv Ment Dis. 1992;180(2):101-110.

[21]Fredericksen RJ, Mayer KH, Gibbons LE, et al. Development and content validation of a patient-reported sexual risk measure for use in primary care. J Gen Intern Med. 2018;33(10):1661-1668.

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[27]Fredericksen RJ, Fitzsimmons E, Gibbons LE, et al. Development and content validation of the Multifactorial Assessment of Perceived Social Support (MAPSS), a brief, patient-reported measure of social support for use in HIV care. AIDS Care. 2019:1-9.

[28]Grasso C, McDowell MJ, Goldhammer H, Keuroghlian AS. Planning and implementing sexual orientation and gender identity data collection in electronic health records. J Am Med Inform Assoc. 2019;26(1):66-70.

# **APPENDIX F.** PROJECT CONNECT CLIENT-LEVEL IMPLEMENTATION CHECKLISTS

## Purpose

The purpose of the client-level implementation checklists is to:

- Guide staff on important components of the intervention
- Encourage staff to reflect on what activities they did or did not complete and how well they delivered the intervention
- Monitor how closely staff is delivering the intervention as intended
- Serve as a tool for supervisors to provide feedback to staff who are delivering the intervention

## Instructions

Use the checklist that matches the session conducted. One checklist should be completed for each client. The checklist can be completed during the interaction with the client (to serve as a guide) and/or shortly after the interaction.

There are two sections to the checklist.

1. **"Activities"** tracks what activities staff have completed. Staff should check "Yes" for all activities completed and provide an explanation for activities that were not carried out.
2. **"Relationship Building"** requires staff to reflect on how well they delivered the intervention. Staff should rate themselves on the various elements and provide a short reflection on ways to improve future client interactions.

Date: _____ Staff: _____ Client: _____

## Phase One: Initial Contact Checklist

Did you complete the following activities?

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Build rapport with client |
| ☐ | ☐ | Screen for client's eligibility (one or more of the following): |
| ☐ | ☐ | New diagnosis of HIV |
| ☐ | ☐ | Transferring care from another HIV provider |
| ☐ | ☐ | Has been out of care for over 12 months |
| ☐ | ☐ | Schedule CONNECT Visit (New Client Early Orientation) |
| ☐ | ☐ | Visit will occur within 5 days from initial contact. |
| | | Date of CONNECT Visit: _____ |

If any item on this list is not done or is incomplete, explain why below:

_____

_____

_____

_____

_____

_____

_____

Date: _____ Staff: _____ Client: _____

## Phase Two: CONNECT Visit Checklist

Did you complete the following activities?

| Yes | No | |
|---|---|---|
| | | **Reminder Call/Text/Email** |
| ☐ | ☐ | Make a personalized reminder call/text/email 7 days before appointment |
| ☐ | ☐ | Make a personalized reminder call/text/email 1-2 days before appointment |
| ☐ | ☐ | Call/text/email client within 24 hours of missed appointment |
| ☐ | ☐ | Client did not miss appointment |

| Yes | No | |
|---|---|---|
| | | **CONNECT Visit** |
| ☐ | ☐ | Conduct semi-structured interview |
| ☐ | ☐ | Have client complete biopsychosocial assessment tools (see ***Appendix E***) |
| ☐ | ☐ | Ask client about insurance status |
| ☐ | ☐ | If uninsured, assess for ADAP eligibility |
| ☐ | ☐ | Give a tour of the clinic |
| ☐ | ☐ | Collect samples (or make sure samples are/will be collected) for initial lab work |
| ☐ | ☐ | Discuss the importance of staying in care |
| ☐ | ☐ | Discuss members of the client's primary care team |
| ☐ | ☐ | Schedule first primary care appointment |
| ☐ | ☐ | Appointment scheduled within six weeks from today |
| | | Date of next primary care visit: _____ |
| ☐ | ☐ | Help client identify additional sources of care based on the interview and the results of the biopsychosocial assessment (e.g., HIV testing for partner, mental health services, substance use disorder support, housing support, food assistance, and transportation services) |
| ☐ | ☐ | Refer client to additional services |
| ☐ | ☐ | List referrals here: _____ |
| | | _____ |
| ☐ | ☐ | Answer client's questions |

If an activity is not completed, explain why below:

_____

_____

_____

## Phase Two: Relationship Building Self-Rating Sheet

Below are the important elements in client interaction. Rate how well you did the following during the CONNECT visit:

| | Can do better | | Did okay | | Did well |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Treat client with dignity and respect | ☐ | ☐ | ☐ | ☐ | ☐ |
| Initiate empathy and compassion | ☐ | ☐ | ☐ | ☐ | ☐ |
| Get to know client as a person | ☐ | ☐ | ☐ | ☐ | ☐ |
| Listen carefully to client | ☐ | ☐ | ☐ | ☐ | ☐ |
| Provide affirmations/recognition of effort | ☐ | ☐ | ☐ | ☐ | ☐ |
| Focus on client's strengths | ☐ | ☐ | ☐ | ☐ | ☐ |
| Create a shared vision of treatment success with client | ☐ | ☐ | ☐ | ☐ | ☐ |

Reflect on how you can improve your interaction with the client:

Date: _____ Staff: _____ Client: _____

## Phase Three: The First Primary Care Provider Visit Checklist

Did you complete the following activities?

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Give client a personalized reminder call/text/email 7 days before appointment |
| ☐ | ☐ | Give client a personalized reminder call/text/email 1–2 days before appointment |
| ☐ | ☐ | Accompany client to first primary care visit |
| ☐ | ☐ | Call/text/email client within 24 hours of missed appointment |
| ☐ | ☐ | Client did not miss the appointment |

If an activity is not completed, explain why below:

Date: _____ Staff: _____ Client: _____

## Phase Four: Quarterly Check-ins and Enhanced Personal Contact Checklist

Did you complete the following activities?

| Yes | No | |
|---|---|---|
| | | **Check-In** |
| ☐ | ☐ | Monitor client's health |
| ☐ | ☐ | Ensure client understands medical advice and treatment plan |
| ☐ | ☐ | Reinforce client's action plans |
| ☐ | ☐ | Check on medication adherence |
| ☐ | ☐ | Check on appointment adherence |
| ☐ | ☐ | Answer client's questions |
| | | **Primary Care Appointment** (Complete if there is a primary care appointment scheduled) |
| ☐ | ☐ | Give client a personalized reminder call/text/email 7 days before appointment |
| ☐ | ☐ | Give client a personalized reminder call/text/email 1–2 days before appointment |
| ☐ | ☐ | Call/text/email client within 24 hours of missed appointment |
| ☐ | ☐ | Patient did not miss the appointment |

If an activity is not completed, explain why below:

_____

_____

_____

_____

## Phase Four: Relationship Building Self-Rating Sheet

Below are the important elements in client interaction. Rate how well you did the following during the check-in:

| | Can do better | | Did okay | | Did well |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Treat client with dignity and respect | ☐ | ☐ | ☐ | ☐ | ☐ |
| Initiate empathy and compassion | ☐ | ☐ | ☐ | ☐ | ☐ |
| Get to know client as a person | ☐ | ☐ | ☐ | ☐ | ☐ |
| Listen carefully to client | ☐ | ☐ | ☐ | ☐ | ☐ |
| Provide affirmations/recognition of effort | ☐ | ☐ | ☐ | ☐ | ☐ |
| Focus on client's strengths | ☐ | ☐ | ☐ | ☐ | ☐ |
| Create a shared vision of treatment success with client | ☐ | ☐ | ☐ | ☐ | ☐ |

Reflect on how you can improve your interaction with the patient: