



# Friends Research Institute: *Building Brothers Up (2BU)*

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Implementation Toolkit



# Authors

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## **Friends Research Institute**

### **Building Brothers Up Team**

**Kimberly A. Kisler, PhD, MPH**, Research Scientist  
Principal Investigator

**Cathy J. Reback, PhD**, Senior Research Scientist  
Co-Investigator

**Jesse B. Fletcher**, Research Scientist  
Evaluator & Data Manager

**Bill Le**  
Program Coordinator/Peer Case Manager

**Prudence Mendiola**  
Research Assistant

**Cur'Shauna Wyatt, MPH(c)**  
Intern

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## **Funding Statement**

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## Introduction

Building off the overview provided in the Implementation Manual, this Implementation Toolkit provides additional guidance on how to adapt and implement Friends Research Institute (FRI)'s ***Building Brothers Up (2BU)*** project. This Toolkit is designed to provide more detailed information to support future replicators, especially community based organizations, HIV service providers and on-the-ground clinic staff, who are planning for implementation or are in the process of implementing *2BU* components.

Specifically, this Toolkit provides samples of tools we found useful for building community partnerships, hiring qualified staff, recruiting potential participants, and assisting participants within the peer case management sessions. The Toolkit also provides tools and other materials to tailor and use when replicating. Replicators are encouraged to reach out directly to FRI's team with questions or for additional information (see the Manual for the team's contact information).

Implementing *2BU* required activities related to these areas:

- **Building External Partnerships:** External partnerships were essential to the success of *2BU* to assure quality medical services for our participants and to gain access to medical records needed for evaluation purposes. This section provides information on how to establish Memoranda of Understandings (MOUs) with partnering organizations.
- **Recruitment:** To aid in recruitment and promotion efforts, several materials were designed in collaboration with the Community Advisory Board (CAB) and design professionals (see the Implementation Manual for further details on this process). This section provides copies of each material designed to promote *2BU*.
- **Peer Case Management Tools:** Tools to be utilized during the peer case management sessions were tailored to the unique needs of Black men who have sex with men (BMSM). This section provides information on and copies of the Needs and Barriers Assessment (NBA) and the Participant-centered Treatment Plan.

## Building External Partnerships

### Establishing Memoranda of Understanding (MOUs)

FRI is a 501(c)(3), private, non-profit corporation established in 1955. Friends Community Center (FCC), a division of FRI, is the community research center of FRI, located on the border of Hollywood and West Hollywood in Los Angeles County (LAC), where *2BU* was implemented. FCC is a non-clinical site and thus formal partnerships with four medical clinics that provide HIV primary care and behavioral health services were essential to the success of the project. MOUs with each clinic were established prior to implementation to determine a process for seamless entry into HIV care and behavioral health services (e.g., simple and timely process ["red carpet treatment"] for making an appointment, facilitating a "warm hand-off" to clinical staff, and connecting participants to resources through the partnering clinic to facilitate access to care, such as transportation vouchers, etc.). Partnering HIV clinics also assisted with promotion of and referral to *2BU* for existing BMSM patients who could benefit from the peer case management intervention.



The process of establishing an MOU included:

- Identifying a contact person within each organization who could connect the Peer Case Manager to a person in a leadership position at the organization. The first point of contact was usually a frontline staff person who had worked with intervention staff at FCC on other projects. The point of contact would then send an e-introduction between the *ZBU* team and the person within the organization who would be best suited to establish an MOU.
- Once contact was made, a meeting was held to explain the project, describe what the relationship would include, and establish the elements of the MOU.
- The MOU was typically drafted using a template provided by FCC. The draft of the MOU often went through several rounds of revisions between the two organizations.
- Once the draft of the MOU was completed, it often went to additional legal counsel at one or both organizations to ensure language was appropriate. This review typically established the final version of the MOU.
- The MOU was then signed by both organizations.
- Once the MOU was established, *ZBU* staff maintained regular contact with both frontline staff and leadership within the partnering organization to ensure all elements of the MOU were being followed and upheld.

### **Sample: Memorandum of Understanding**

Pending award of the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) funding opportunity, entitled *Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men Who Have Sex with Men – Demonstration Sites*, #HRSA-18-047, we agree to work collaboratively to support the provision of quality, comprehensive HIV/AIDS services for Black men who have sex (BMSM) living with HIV/AIDS in Los Angeles County, with the goals of identifying and successfully engaging and retaining in care BMSM who are infected with HIV but are unaware of their HIV status; are aware of their HIV infection but have never been engaged in care; are aware but have refused referral to care; or have dropped out of care. We willingly support the required multi-site evaluation efforts led by the Evaluation and Technical Assistance Provider (ETAP) and Special Projects of National Significance (SPNS) Program staff as outlined in the Memorandum.

**[HIV PRIMARY CARE MEDICAL FACILITY]** will:

- Ensure that all HIV-positive BMSM receive appropriate medical evaluation and clinical care;
- Collect and report client-level data required by the ETAP to FRI. This data may include but are not limited to client characteristics; biomedical and behavioral health indicators; barriers to access and factors facilitating the utilization of core HIV medical and support services; medications adherence; and other outcome measures as defined by the ETAP. For the length of the project, **CLINIC** will submit these data sets to FRI using an encrypted web-based data message program (i.e., Microsoft Office 365) OR submit data in person to the project staff using an encrypted flash drive OR submit data on hard copy data abstraction forms. Due dates will be determined once funding has been awarded.



**Friends Research Institute will:**

- Refer HIV-positive BMSM to HIV medical care;
- Facilitate and promote treatment adherence and achievement of HIV care milestones;
- Obtain Institutional Review Board (IRB) approval and annual renewals;
- Submit client-level data received from **CLINIC** to ETAP. Such data will be de-identified and contain a global unique identifier to avoid duplication of client numbers and data; and
- Obtain a client Release of Information form to facilitate interagency communication for data collection.

The parties agree that this MOU shall continue in effect until terminated by either party, and that either party may terminate this MOU at any time and for any reason by giving the other party written notice at least 30 days prior to the intended termination date.

The parties agree to maintain client confidentiality in compliance with Federal and State laws, including but not limited to the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

[NAME]	Date	Cathy J. Reback, Ph.D.	Date
[TITLE]		Executive Director	
[MEDICAL FACILITY]		Friends Community Center	
		Senior Research Scientist	
		Friends Research Institute, Inc.	

## Recruitment

### Recruitment and Outreach Materials

Three materials were designed by a graphic designer to aid in recruitment efforts: a full-page recruitment flyer, a postcard-sized material, and a business card-sized material. Each material, though similar in content, served a different purpose during outreach efforts.

- The **full-page flyer** was designed to include maximal information on the project and was shared most often with service providers and local outreach venues. The full-page flyer was intended to be hung at service providers’ facilities or where services were advertised within the community.
- The **postcard-sized** material included less information and was intended to be distributed during venue-based outreach and in-reach within FCC. The postcard-sized material was ideal for distribution directly to potential participants.
- The **business card-sized** material included only the most important information on *2BU* and was included in outreach kits (e.g., small kits comprised of hygiene and/or risk reduction supplies such as condoms and lubricant). The business card-sized material also allowed for the most discreet distribution during large public events, within commercial sex venues, or while conducting street-based outreach.





Although the logo and recruitment materials were designed by professional consultants, the revisions to all recruitment and outreach materials were made in concert with the CAB.

### Sample: Recruitment Materials

Full-page Flyer

**Are you a Black man living with HIV  
who has sex with men?**

**2BU**

**BUILDING BROTHERS UP**

You may be eligible to participate in a 3-month Peer Case Management program where you will attend 6 sessions, complete surveys at baseline, during sessions, and at 6- and 12-month follow-ups. You may earn up to \$330 in gift cards.

**For more information,  
please call or text  
Friends Community Center  
(323) 422-2913**

*Friends Community Center*  
A Division of Friends Research Institute, Inc.  
**6910 Santa Monica Blvd.  
Los Angeles, CA 90038**

This material is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a Special Projects of National Significance award.

Postcard-sized Material

Front

**Are you a Black man living with HIV  
who has sex with men?**

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## Business Card-sized Material

Front



Are you a Black man living with HIV who has sex with men?

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## Peer Case Management Tools

### Needs and Barriers Assessment (NBA)

The NBA was adapted by the Co-Investigator in 2012 from a CDC-funded risk counseling program to be used in an earlier HRSA-funded SPNS demonstration project, and has since been utilized in several case management programs at FCC. The NBA identifies behavioral health cofactors that may impede a participant's ability to enter into or remain in HIV care, such as poverty, dental care, food insecurity, homelessness, transportation, legal restrictions, exposure to physical or sexual violence, substance use disorder, and mental health disorder. The NBA was adapted for *2BU* to address some of the culturally specific needs and barriers identified through the literature and from conversations with CAB members. The NBA was used at the first peer case management session to develop the individualized Participant-centered Treatment Plan, to assess progress through the HIV Care Continuum, and to reset priorities and identify possible new barriers. A shorter version of the NBA, the NBA-Lite, was utilized at peer case management sessions 2-6 to reassess needs and barriers as they changed during intervention participation.



## Sample: Needs and Barriers Assessment (NBA)

### Building Brothers Up (2BU) Needs and Barriers Assessment (NBA)

Date: \_\_\_/\_\_\_/\_\_\_ Staff ID: \_\_\_\_\_ Participant ID: \_\_\_\_\_

#### PSYCHOSOCIAL ASSESSMENT

##### BASIC NEEDS

Does the participant require food bank assistance?  No  Yes

Does the participant require clothing assistance?  No  Yes

##### Employment:

- Full time
- Part time
- Unemployed, not looking for work
- Unemployed, and looking for work

Annual income from employment: \$ \_\_\_\_\_

Income from other sources: \$ \_\_\_\_\_

##### Source(s):


- Disability
- GR
- SSI
- Unemployment
- Other: \_\_\_\_\_

##### INDEPENDENT LIVING

Does the participant have difficulties with self-care and personal hygiene activities, such as bathing or showering, getting dressed, fixing hair, brushing teeth, going to the bathroom, preparing meals or cleaning dishes?

No  Yes

If yes, please explain: \_\_\_\_\_



Does the participant require assistance accessing self-care and personal hygiene products, such as toothbrush, toothpaste, shampoo, and soap?

No  Yes

If yes, please explain: \_\_\_\_\_

**LIVING ARRANGEMENTS**

Has the participant had stable housing in the past 90 days?  No  Yes

What type of living arrangement has the participant had in the past 90 days?

- Permanent housing (apartment, condo, home, OWN; there is no time limit on staying privileges)
- Permanent housing (apartment, condo, home, RENT; there is no time limit on staying privileges)
- Renting a room in someone else's house, condo, or apartment
- Temporarily staying or sleeping on a couch in someone else's house, condo, or apartment
- Hotel
- Staying in a shelter, transitional housing, or boarding house where other services are provided
- Staying in a shelter, transitional housing, or boarding house or other temporary indoor situation without additional services
- On the streets (abandoned building, vacant lot, park, abandoned car, etc.)
- Institution (incarcerated, hospital, rehab, chronically ill, or handicapped)
- Refused to answer
- Don't Know
- Other (specify) \_\_\_\_\_

How satisfied is participant with living arrangement?

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

Does participant want to change his living situation?  No  Yes

If yes, please explain:

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Are there any other housing issues related to the health and safety of the participant?  No  Yes

If yes, please explain:

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How many people live in the participant's household? \_\_\_\_\_

Total number of children/dependents needing care from participant: \_\_\_\_\_

Who is responsible for care of children/dependents if participant is not available? \_\_\_\_\_

Describe people living in participant's household:

Name	Age	HIV Status
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____
(4)	_____	_____

**TRANSPORTATION**

Does participant have own transportation?  No  Yes

Does participant have access to and funds for public transportation?  No  Yes  Sometimes

Does participant have other transportation needs?  No  Yes  Sometimes

If yes or sometimes, please explain:

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**LEGAL NEEDS**

Is the participant on probation or parole?  No  Yes  Don't Know

Is the participant a registered sex offender?  No  Yes  Don't Know



Are there other legal issues (e.g., tickets, warrants, etc.)?  No  Yes  Don't Know

If yes, please explain:

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**SOCIAL SUPPORT**

What is the participant's overall level of satisfaction with support ("How satisfied are you with your level of social support? Social support means that you have someone who can help you out in a time of need, such as someone lending you things, including money, or driving you somewhere, or someone you can talk to.")

Not at all  Slightly  Moderately  Considerably  Extremely

Who does the participant trust and turn to for social support?

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Describe the participant's main partner relationship. A 'main partner' is someone with whom the participant has a close, intimate relationship, more than any other person.

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Does the participant identify with any social groups?  No  Yes

Please explain:

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Does the participant attend any social gatherings? (Support group, church, club/bar)  No  Yes

Please explain:





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**Is the participant associated with any communities? (Gang, religion, culture, spirituality)**  No  Yes

Please explain:

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**If the participant is associated with any social groups, does the participant feel acceptance and belongingness in the group?**  No

Yes

Please explain:

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**Does the participant feel comfortable talking about their sexual identity?**  No  Yes

Please explain:

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**Does the participant feel comfortable talking about their HIV status?**  No  Yes

Please explain:

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**Does the participant feel comfortable talking about sex?**  No  Yes

Please explain:



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Does the participant feel comfortable discussing experiences of being a Black man?  No  Yes

Please explain:

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**SAFETY**

Does the participant feel safe talking to an authority figure?  No  Yes

If no, please explain:

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**RISK ASSESSMENT**

**GENERAL HIV TRANSMISSION RISK FACTORS**


**SUBSTANCE USE RISK FACTORS**

Current substance use:  Currently using  Not using, in recovery  
 Not using  Never used

Does participant identify drugs/alcohol as a problem?  No  Yes

Does a significant other or family identify drugs/alcohol as a problem for the participant?  No  Yes

Has participant had previous substance abuse treatment?  No  Yes



If yes, please explain:

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Has the participant injected any of the following substances (check all that apply)?

Injection Substance	No	Yes
Heroin and cocaine together	<input type="checkbox"/>	<input type="checkbox"/>
Heroin alone	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine alone	<input type="checkbox"/>	<input type="checkbox"/>
Crack	<input type="checkbox"/>	<input type="checkbox"/>
Other narcotic drugs	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine, speed, ice, crystal	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>
Refused to Answer	<input type="checkbox"/>	
Don't Know	<input type="checkbox"/>	

Has the participant shared drug needles/syringes?  No  Yes

Has the participant used any of the following non-injection substances (check all that apply)?

Non-injection Substance	No	Yes
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine, speed, ice, crystal, crank	<input type="checkbox"/>	<input type="checkbox"/>
Crack	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (smoked, snorted)	<input type="checkbox"/>	<input type="checkbox"/>
Downers (Valium, Xanax, Ativan)	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens (such as LSD)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
Club drugs (such as GHB, Ketamine)	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (smoked, snorted)	<input type="checkbox"/>	<input type="checkbox"/>



Non-injection Substance	No	Yes
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
Refused to Answer	<input type="checkbox"/>	
Don't Know	<input type="checkbox"/>	

If using drugs or alcohol, collect the following information:

Drug of Choice	Amount/Frequency
1.	
2.	
3.	

[NOTE: Depending on the frequency of drug/alcohol use, the Peer Case Manager may want to have a participant further evaluated for substance abuse treatment.]

### SEXUAL RISK FACTORS

Has the participant had unprotected sex with anyone in the past 6 months?  No  Yes

In the past 6 months, who has the participant had unprotected sex with (check all that apply):

Male  Female  Transgender

What type(s) of unprotected sex has the participant had:

Anal Insertive  Anal Receptive  Vaginal Insertive  
 Oral  Other: \_\_\_\_\_

Has the participant had sex with HIV-negative partner(s) in the past 6 months?  No  Yes  Don't know

Has the participant had sex with HIV-positive partner(s) in the past 6 months?  No  Yes  Don't know

Has the participant had sex while high on drugs or alcohol?  No  Yes



Has the participant exchanged sex for money, drugs, food, shelter, or anything else?  No  Yes

**HEALTH EDUCATION/RISK REDUCTION**

**Does the participant know anything about reducing sexual risk?**

No  Yes

Please explain: \_\_\_\_\_

**Is there anything about reducing sexual risk the participant would like to know more about?**

No  Yes

If yes, please explain: \_\_\_\_\_

**Does the participant feel comfortable disclosing his HIV status to sexual partners?**

No  Sometimes  Yes

If no or sometimes, please explain:

\_\_\_\_\_

**Does the participant feel comfortable disclosing his HIV status to non-sexual partners?**

No  Sometimes  Yes

If no or sometimes, please explain:

\_\_\_\_\_

**Does the participant feel comfortable saying “no” to unprotected sex with sexual partners?**

No  Sometimes  Yes

If no or sometimes, please explain:

\_\_\_\_\_





**INTERPERSONAL VIOLENCE**

**Does the participant have a history of abuse or domestic violence?**

No  Yes

**Would the participant like to know more information about supportive services specifically for abuse or domestic violence?**

No  Yes

**MENTAL HEALTH**

**How troubled does the participant say he has been with mental health problems in the past 90 days?**

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely

**Current mental health treatment?**  No  Yes

If yes, specify provider, facility, diagnosis, and/or medications:

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**Prior mental health treatment?**  No  Yes

If yes, specify provider, facility, diagnosis, and/or medications:

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Are there any other mental health problems or issues the participant feels are related to how he is feeling or that are contributing to his behavior?  No  Yes

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL**

Does the participant have health insurance?

No  Yes

If yes, what kind:  Medi-Cal/Medicare Card

Private Insurance Card

Medicare Part D Card

Does the participant require health insurance assistance?  No  Yes

Place participant usually seeks medical care: \_\_\_\_\_

Name of participant's doctor/health care provider: \_\_\_\_\_

Date of last contact with participant's doctor/health care provider: \_\_\_\_/\_\_\_\_/\_\_\_\_ or  Don't know

Does the participant feel safe/comfortable talking to a medical provider?

Not at all  Slightly  Moderately  Considerably  Extremely

Does the participant feel their medical provider is culturally competent to the Black experience?

Not at all  Slightly  Moderately  Considerably  Extremely

Does participant have any medical conditions he thinks we should know about?  No  Yes

If yes, please explain: \_\_\_\_\_

Has the participant been diagnosed with syphilis, gonorrhea, or chlamydia in the past year?

No  Yes – Self-report  Yes - Laboratory confirmed  Don't know

Has the participant been tested for any other STIs or viral infections in the past year?

No  Yes  Refused to answer  Don't know

Which STIs or viral infections has the participant been diagnosed with in the past year?

Type: \_\_\_\_\_

Has the participant sought treatment?  No  Yes



If yes, how was the diagnosis or treatment confirmed?     Self-report     Laboratory confirmed

Type: \_\_\_\_\_    **Has the participant sought treatment?**     No     Yes

If yes, how was the diagnosis or treatment confirmed?     Self-report     Laboratory confirmed

**Level of satisfaction with health status (Choose one):**

Not at all     Slightly     Moderately     Considerably     Extremely

**HIV MEDICAL CARE**

**Is participant *currently* receiving medical care for HIV?**

No     Yes     Refused to answer     Don't know

**If yes, please list provider and/or case manager information:**

Primary care provider    \_\_\_\_\_    **Phone number** \_\_\_\_\_  
Address    \_\_\_\_\_  
Case manager    \_\_\_\_\_    **Phone number** \_\_\_\_\_  
Agency name and address    \_\_\_\_\_

**If participant is not currently in medical care for HIV, has participant *ever* received medical care for HIV?**

No     Yes     Refused to answer     Don't know

**If no, why not?** \_\_\_\_\_  
\_\_\_\_\_

**If yes, please list provider and/or case manager information:**

Primary care provider    \_\_\_\_\_    **Phone number** \_\_\_\_\_  
Address    \_\_\_\_\_  
Case manager    \_\_\_\_\_    **Phone number** \_\_\_\_\_  
Agency name and address    \_\_\_\_\_



**When was the last time the participant had a CD4 (or T-cell) count? (Choose one)**

- Never                       Within the last 3 months                       Within the last 6 months  
 Within the last 9 months                       Within the last year                       Don't know

**What was the CD4 (or T-cell) count at the participant's last measurement? \_\_\_\_\_ or  Don't know**

**When was the last time the participant had a viral load count? (Choose one)**

- Never                       Within the last 3 months                       Within the last 6 months

**What was the viral load count at the participant's last measurement? (Choose one)**

- Never had viral load measured  
 > 10,000 copies/mL (not undetectable)  
 > 200 copies/mL - ≤ 10,000 copies/mL (not undetectable)  
 ≤ 200 copies/mL (undetectable)  
 Don't Know

**Has participant ever been prescribed HIV antiretroviral drug therapy (ART) by a doctor?**

- No     Yes     Refused to answer     Don't know

**If no, does the participant know why not? \_\_\_\_\_**

**Is participant currently being prescribed HIV ART drugs?**

- No     Yes     Refused to answer     Don't know

**If yes,**

What medication(s) was he prescribed? \_\_\_\_\_

How many pills is the participant supposed to take a day? \_\_\_\_\_

How long has it been since the participant took his medication(s)? \_\_\_\_\_

**What is participant's understanding of medication?  Thorough     Average     Basic     Confused**

**Has the participant ever stopped taking ART without the doctor's permission?**

- No     Yes     Refused to answer     Don't know



**If yes, why?** (Check all that apply)

- Side effects                       Do not like taste                       Lack of funds to buy  
 Complicated regimen             Other (specify) \_\_\_\_\_

**What does participant identify as barriers to medication adherence? (Check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Depression/mental health             | <input type="checkbox"/> Undisclosed HIV status          |
| <input type="checkbox"/> Works outside the home               | <input type="checkbox"/> Side effects                    |
| <input type="checkbox"/> Alcohol and drug use/abuse           | <input type="checkbox"/> Lack of information             |
| <input type="checkbox"/> Care giving responsibilities         | <input type="checkbox"/> Lack of social support          |
| <input type="checkbox"/> Difficulty getting refills           | <input type="checkbox"/> Doubts medication effectiveness |
| <input type="checkbox"/> Lack of regular schedule             | <input type="checkbox"/> Needs assistance with ADLs      |
| <input type="checkbox"/> Taste of medication                  | <input type="checkbox"/> Size of pills                   |
| <input type="checkbox"/> Number of pills                      | <input type="checkbox"/> Other: _____                    |
| <input type="checkbox"/> Religious/Cultural/Spiritual beliefs |  |

**What complementary therapies does the participant use?** \_\_\_\_\_

**HIV MEDICAL CARE FACILITY**

**Which HIV medical care facility would the participant like to enroll in:**

- AIDS Healthcare Foundation (AHF)  
    Which AHF clinic:  
     Downtown  
     Hollywood  
     West Los Angeles  
     Other \_\_\_\_\_
- AIDS Project Los Angeles (APLA) Health  
 Charles R. Drew University/OASIS Clinic  
 Los Angeles LGBT Center  
 Men's Health Foundation (MHF)  
 Other \_\_\_\_\_

**Does the participant have the following enrollment documentation (For AHF, APLA, MHF, OASIS):**

**All participants must have the following:**





1) Photo I.D. Yes  No

If yes, what kind:

- |   |   |
|---|---|
| <input type="checkbox"/> Unexpired Driver's License     | <input type="checkbox"/> Birth Certificate                      |
| <input type="checkbox"/> Expired Driver's License       | <input type="checkbox"/> Certificate of Live Birth              |
| <input type="checkbox"/> Photo Copy of Driver's License | <input type="checkbox"/> Perm. Res. Alien Card Showing 5+ years |
| <input type="checkbox"/> State I.D./Matricula Consular  | <input type="checkbox"/> Passport (can be expired)              |
| <input type="checkbox"/> Immigration Card               | <input type="checkbox"/> School I.D.                            |

2) Proof of HIV Diagnosis Yes  No

If yes, what kind:

- Copy of Recent Labs (T-cell & Viral Load within last 6 months)
- Diagnosis Form (within last 6 months)

If participant HAS insurance, they must have the following:

2) Proof of Insurance Yes  No

If yes, what kind:

- Medical/Medicare Card
- Private Insurance Card
- Medicare Part D Card

If participant does NOT have insurance, they must have the following:

3) Proof of Residence Yes  No

If yes, what kind:

- |  |  |
|--|--|
| <input type="checkbox"/> Rental or Lease Agreement | <input type="checkbox"/> Current Car Registration                    |
| <input type="checkbox"/> W2                        | <input type="checkbox"/> Utility Bill (ONLY gas, light, house phone) |

4) Proof of Income Yes  No

If yes, what kind:

- W2 AND Tax Return w/1099 Schedule C
- ALL Pay Stubs for most recent 3 months (or 6 pay stubs)
- Award Letter for SSI/GR/Unemployment
- If self-employed & no tax forms, will complete self-attestation affidavit



Saving's Account Statement with more than \$2000 in account

If participant does not have any of the aforementioned documentation, what steps will be taken to obtain missing documentation?

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What is the date/time of the *FIRST* HIV medical care appointment: \_\_\_/\_\_\_/\_\_\_ at \_\_\_ AM \_\_\_ PM

**SUMMARY OF INITIAL SESSION, POTENTIAL NEEDS & BARRIERS, CURRENT SERVICES, & REFERRALS**

Barriers & Needs			Comments
Food Assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Clothing Assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Employment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Independent Living	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Living Arrangements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Transportation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Legal Needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Social Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Safety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	



Barriers & Needs			Comments
Substance Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sexual Risk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Health Education/Risk Reduction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Interpersonal Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mental Health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medical	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV Medical Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV Medical Care Facility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**Services participant is currently enrolled in:**

Type of service \_\_\_\_\_

Agency name \_\_\_\_\_

Provider name \_\_\_\_\_

Phone number \_\_\_\_\_

Type of service \_\_\_\_\_

Agency name \_\_\_\_\_

Provider name \_\_\_\_\_

Phone number \_\_\_\_\_

Type of service \_\_\_\_\_

Agency name \_\_\_\_\_

Provider name \_\_\_\_\_

Phone number \_\_\_\_\_

Type of service \_\_\_\_\_

Agency name \_\_\_\_\_

Provider name \_\_\_\_\_

Phone number \_\_\_\_\_



## Participant-centered Treatment Plan

Upon completion of the NBA, the participant and Peer Case Manager worked together to create a Participant-centered Treatment Plan. The Participant-centered Treatment Plan identified the participant's long- and short-term goals, and associated action steps, to work through identified needs and barriers to assist in reaching and sustaining viral suppression.

### Sample: Participant-centered Treatment Plan

**Building Brothers Up (2BU)**  
**Participant-centered Treatment Plan**

Date: \_\_\_/\_\_\_/\_\_\_

Staff ID: \_\_\_\_\_

Participant ID: \_\_\_\_\_

\_\_\_\_\_

### Long-Term Plan

To be completed in-full at the enrollment/baseline session after the completion of the NBA.

**Goal**

1 \_\_\_\_\_

Target Date \_\_\_\_\_

Objective

1 \_\_\_\_\_

Action Step 1

\_\_\_\_\_

Action Step

2 \_\_\_\_\_

Action Step 3

\_\_\_\_\_

Objective

2 \_\_\_\_\_

Action Step 1

\_\_\_\_\_

Action Step 2

\_\_\_\_\_



**Goal**

2 \_\_\_\_\_

Target Date \_\_\_\_\_

Objective

1 \_\_\_\_\_

Action Step 1

\_\_\_\_\_

Action Step

2 \_\_\_\_\_

Objective

2 \_\_\_\_\_

Action Step 1

\_\_\_\_\_

Action Step 2

\_\_\_\_\_



**Building Brothers Up (2BU)**  
**Participant-centered Treatment Plan**

Date: \_\_\_/\_\_\_/\_\_\_

Staff ID: \_\_\_\_\_

Participant ID: \_\_\_\_\_

**Short-Term Plan**

To be completed each time the NBA-Lite is completed.

Participant will...	Date Complete	Peer Case Manager will...	Date Complete
1.		1.	
2.		2.	
3.		3.	

Things that could make it difficult to achieve my goals include:

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My plan for overcoming these difficulties includes:

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My confidence that I can achieve my goal:

- |                    |               |          |           |                |
|--------------------|---------------|----------|-----------|----------------|
| <b>1</b>           | <b>2</b>      | <b>3</b> | <b>4</b>  | <b>5</b>       |
| Very not confident | Not Confident | Neutral  | Confident | Very confident |



**Building Brothers Up (2BU)**  
**Participant-centered Treatment Plan Agreement**

I agree to work on the goals set by myself and the Peer Case Manager.

Participant's Name (Print): \_\_\_\_\_

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Peer Case Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_