

Evidence-Informed Behavioral Health Models

**to Improve HIV Health Outcomes for Black
Men who have Sex with Men Initiative**





FUNDING STATEMENT

This publication was made possible by the U.S. Department of Health and Human Services, Health Resources and Services Administration under grant number U90HA31812 in the amount of \$2,504,591 awarded to NORC at the University of Chicago. No percentage of this project was financed with nongovernmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

SUGGESTED CITATION

NORC at the University of Chicago. Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who have Sex with Men Initiative Monograph. (2022). Available at: <https://targethiv.org/BlackMSM>



TABLE OF CONTENTS

YOUTH-FOCUSED BEHAVIORAL HEALTH CASE MANAGEMENT INTERVENTION

- 05 **BUILDING BROTHERS UP (2BU)**
Friends Research Institute, Inc. (FRI)
- 11 **THE VILLAGE PROJECT**
Parkland Health And Hospital System
- 18 **WITH U**
Project Ark At Washington University In St. Louis (Project Ark)
- 26 **ERASE**
East Bay Advanced Care-Sutter Bay Hospitals (Sutter Bay)
- 33 **CARE ENGAGEMENT PROJECT**
Christian Community Health Center

BROTHERS UNITED/THE DAMIEN CENTER LINKAGE TO CARE INTERVENTION

- 40 **+LOVE**
New Orleans Aids Task Force (Crescent Care)

STRENGTH THROUGH YOUTH LIVIN' EMPOWERED (STYLE) INTERVENTION

- 48 **STYLE 2.0**
Duke University, Center For Health Policy And Inequities Research

PROJECT SILK INTERVENTION

- 56 **PROJECT VOGUE**
Gay Men's Health Crisis, Inc. (GMHC)



YOUTH-FOCUSED BEHAVIORAL HEALTH CASE MANAGEMENT INTERVENTIONS



BUILDING BROTHERS UP (2BU)

FRIENDS RESEARCH INSTITUTE, INC.



FUNDING STATEMENT

This intervention was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$900,000 with 100 percent funded by HRSA/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

LOCATION

Los Angeles, CA

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

CONTACT INFORMATION

Kimberly A. Kisler, PhD, MPH

Principal Investigator

Email: kkisler@calstatela.edu

Phone Number: (323) 343-5866

Cathy J. Reback, PhD

Co-Investigator

Email: reback@friendsresearch.org

Phone Number: (323) 463-1601





INTERVENTION SUMMARY

Friends Research Institute, Inc. (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, located on the border of Hollywood and West Hollywood in Los Angeles County (LAC), where the Ryan White HIV/AIDS Program (RWHAP) Special Projects of National Significance (SPNS) intervention Building Brothers Up (2BU) was implemented. FCC provides services for and conducts research with gay and bisexual men, other men who have sex with men (MSM), and transgender women and gender-expansive individuals, all of whom are experiencing multiple health disparities. The goal of FCC is to reduce HIV transmission and acquisition, reduce the risks that can result from substance use, and link and retain appropriate participants to HIV prevention (PrEP/PEP) or HIV care services, as well as all necessary behavioral health and support services. As FCC is a non-clinical research site, the implementation of 2BU relied heavily on partnerships with HIV clinics and behavioral health and support service providers.

2BU was an adaptation of the evidence-informed Youth-Focused Case Management (YCM) Intervention to Engage and Retain Young Gay Men of Color in HIV Care. 2BU targeted highly impacted Black men who have sex with men (BMSM) who were living with HIV, were between the ages of 18 and 65, and were not engaged in HIV care or were at risk of falling out of HIV care.

The primary goal of 2BU was to link or re-engage and retain BMSM living with HIV, who were heavily impacted by the intersectionality of other behavioral health issues, in HIV care so they could reach and sustain viral suppression.



The adapted 2BU intervention was delivered across three months and included a total of six sessions (Sessions 1-4 were delivered weekly in month one, Session 5 in month two, and Session 6 in month three). The intervention was delivered by a Peer Case Manager with assistance and oversight by a Project Coordinator who also served as a Peer Case Manager, when needed.



Case management sessions included detailed assessment of participants' needs and barriers to treatment, all which led to the development of a participant-centered treatment plan.

The Peer Case Managers worked with participants to increase HIV health literacy, identify and remove barriers to optimal HIV healthcare, and directly link participants to much-needed behavioral health and other support services.

2BU began recruitment on October 1, 2019, the first participant was enrolled on October 28, 2019, and enrollment concluded on December 31, 2020. Implementation of the three-month intervention concluded on March 2, 2021.



RATIONALE & NEED

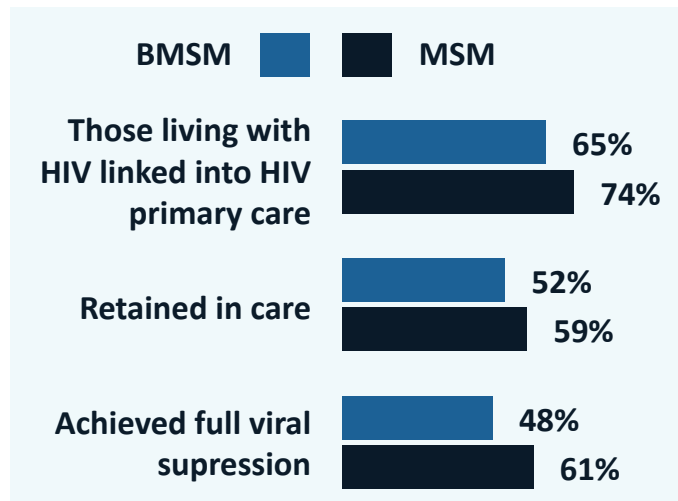
Epidemiological evidence from 2013-2015 in Los Angeles reveals that BMSM are the most HIV-impacted group in LAC displaying:

- an estimated prevalence rate of 40.5 percent (more than double the overall rate among MSM in LAC of 18.4 percent), and
- an incidence rate of 18 per 1,000 for adult BMSM and a staggering rate of 45 per 1,000 among young BMSM (each the highest rate of any comparable age group in LAC).²

HIV surveillance in LAC reveals that:

- only 65 percent of BMSM living with HIV are

- linked into HIV primary care (compared to an overall rate of 74 percent among MSM in LAC),
- 52 percent are retained in care (vs. 59 percent among MSM overall), and
- only 48 percent have achieved full viral suppression (vs. 61 percent among MSM overall).³



Further evidence demonstrates that increased rates of undiagnosed HIV infection and deficits in HIV primary care observed among BMSM in the US are the function of several interrelated and reinforcing behavioral health issues including but not limited to substance use (especially before/during sex),⁴⁻⁷ mental health disorder(s),⁸ poverty and food insecurity,⁹ exposure to violence/trauma,¹⁰ and prejudice/discrimination,^{11,12} each of which disproportionately affect communities of BMSM in the US.⁵ Among all persons recently receiving Ryan White HIV/AIDS Program (RHWAP)-funded services in LAC, 20 percent were BMSM,² and this population demonstrated significant structural behavioral health obstacles to HIV primary care, including homelessness (11.2 percent), recent incarceration (20.4 percent), and poverty (77.0 percent).

2BU provided participant-centered, individualized intensive case management that walked participants through the various systems of healthcare



2BU utilized three innovative strategies to integrate individualized behavioral health case management to overcome behavioral health and other barriers to good health and optimal HIV care. First, 2BU provided participant-centered, individualized intensive case management that walked participants through the various systems of healthcare, helping them navigate and understand processes that seemed basic but which may have acted as barriers to their healthcare. Participants were treated to “red carpet treatment” at partnering HIV, behavioral health, and other support service organizations with the ability to make timely appointments and be seamlessly linked into these services via a “warm hand-off.” Second, 2BU offered culturally sensitive direct assistance by using a Peer Case Manager who built trust and rapport with participants in a way that fostered their engagement and participation. Third, the six intervention sessions were used as an opportunity to overcome a fundamental deficit in the target population: lack of HIV health literacy; better informed participants were not only more engaged in the intervention, but were better able to understand and engage with their own healthcare. These three innovative strategies compensated for the specific deficits facing BMSM living with HIV in LAC, filling gaps in connecting these BMSM to the knowledge and services they most required, and building upon evidence-informed strategies identified in the original YCM intervention, tailored for highly impacted adult BMSM living with HIV.

IMPLEMENTATION

The initial 2BU session included a detailed assessment of the participant’s needs and barriers using the Needs and Barriers Assessment (NBA). The NBA was designed to be participant-centered; as such the needs and barriers reviewed may or may not have been directly connected to HIV care (e.g., housing needs, food insecurity, substance use services, mental health counseling). Additionally, the NBA was tailored to be responsive to the unique cultural needs of BMSM (e.g., experiences with racism, concerns regarding faith and

spirituality). Once key issues were identified, the Peer Case Manager worked with the participant to develop a participant-centered treatment plan. The participant-centered treatment plan identified both long-term goals (e.g., reach undetectable viral load, secure housing) and short-term actions (e.g., make an appointment with an HIV care provider, attend an appointment with a housing specialist) that were to be taken by the next scheduled meeting by both the participant and Peer Case Manager to help the participant meet identified needs and/or overcome identified barriers. A priority of the first session was to schedule an HIV care appointment if the participant was not yet linked into HIV care. During Sessions 2-6, the participant’s needs and barriers were reviewed and re-assessed using a reduced version of the NBA called the NBA-Lite, and both parties once again agreed to short-term action steps for the subsequent session.

Additionally, the long-term goals identified in the participant-centered treatment plan were revised, as needed. An integral component of all six sessions was the assessment of behavioral health and other support service needs and the delivery of directly linked referrals through a “warm hand-off” to partnering agencies. Since all HIV care and most behavioral health and other support services needed to be accessed at a partnering clinic or organization, many of the Peer Case Manager duties included assisting the participant with making appointments, arranging for transportation, ensuring all documentation and required forms were in place, and facilitating a “warm hand-off” to the contact person at the partnering agency. Building strong, personal relationships with staff at partnering organizations and having protocols in place for “red carpet treatment” were vital to the success of 2BU, given that 2BU was delivered at a non-clinical site.



FINDINGS

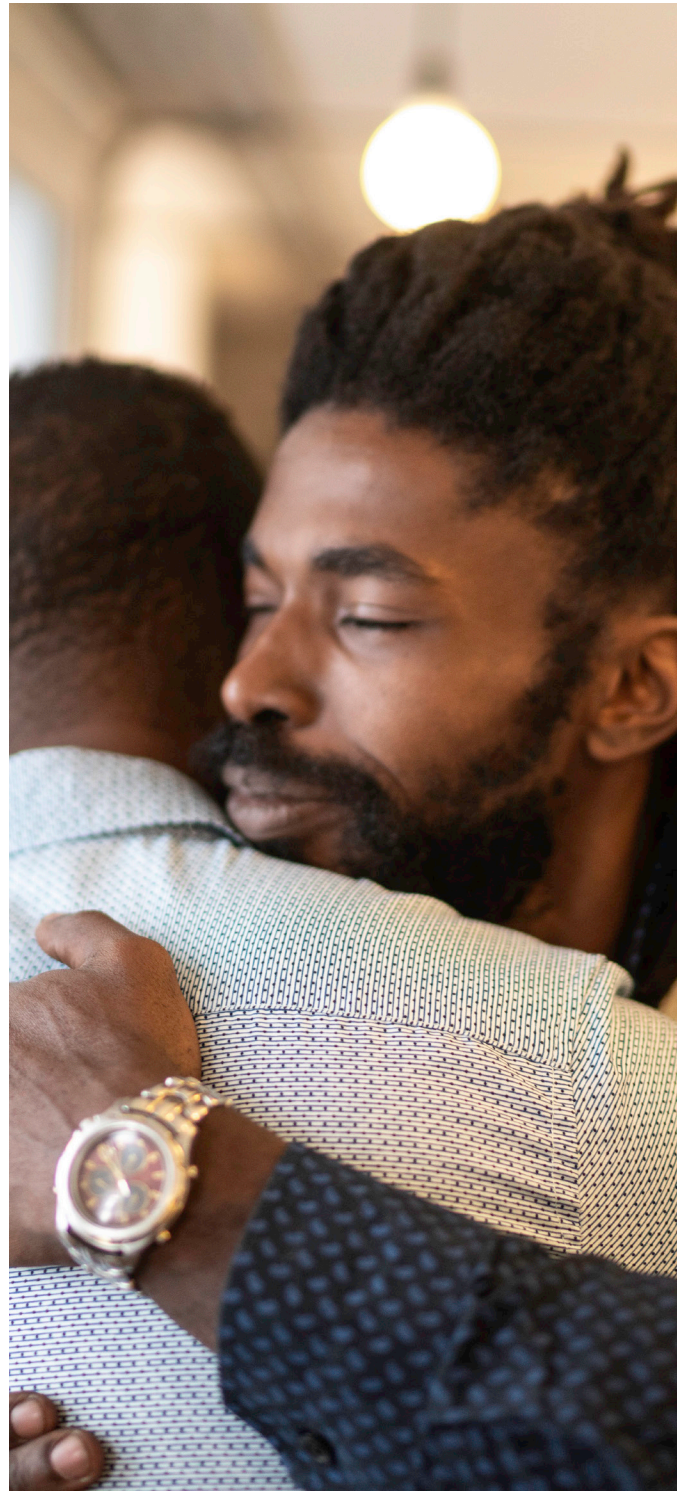
Study participants predominantly identified as gay (71.4 percent), all identified as Black, and more than a quarter also identified as Latinx (28.6 percent), and they averaged 45.3 years of age (Standard Deviation = 11.3; Median = 45.5). At baseline (N = 69), only 75.4 percent of 2BU participants had achieved an undetectable HIV viral load, yet all showed at least some risk of falling out of care (an eligibility requirement). By the six-month follow-up, 83.9 percent of participants successfully reached for follow-up (n = 31) had achieved undetectable status.

By the 12-month follow-up, 96.3 percent of participants assessed (n = 27) had achieved an undetectable viral load.

Though high rates of attrition due to the onset of the coronavirus disease 2019 (COVID-19) public health emergency shutdown protocols within LAC prevents any causal inference from these results, retention in 2BU was at face value associated with increases in achievement of an undetectable viral load.

Preliminary analyses also indicate retention in 2BU was associated with significant increases in self-efficacy.

This was theorized to be a primary mechanism through which the intervention would promote medication adherence and sustained viral suppression in participants.



REFERENCES

- 01** Wohl, A. R., Garland, W. H., Wu, J., Au, C., Boger, A., Dierst-Davies, R., Carter, J., Carpio, F., & Jordan, W. (2011). A youth-focused case management intervention to engage and retain young gay men of color in HIV care. *AIDS Care*, 23(8), 988-997. <http://www.tandfonline.com/doi/abs/10.1080/09540121.2010.542125>
- 02** Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health, DHSP. LAC Comprehensive HIV Plan (2017-2021), September 2016:1-165.
- 03** Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health, DHSP. An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.
- 04** Morgan E, Khanna AS, Skaathun B, Michaels S, Young L, Duvoisin R, et al. Marijuana use among young black men who have sex with men and the HIV care continuum: findings from the uConnect Cohort. *Substance use & misuse*. 2016;51(13):1751-9.
- 05** Maulsby C, Millett G, Lindsey K, Kelley R, Johnson K, Montoya D, et al. HIV among black men who have sex with men (MSM) in the United States: a review of the literature. *AIDS and Behavior*. 2014;18(1):10-25.
- 06** Hightow-Weidman L, LeGrand S, Choi SK, Egger J, Hurt CB, Muessig KE. Exploring the HIV continuum of care among young black MSM. *PLoS ONE*. 2017;12(6):e0179688.
- 07** Voisin DR, Quinn K, Kim DH, Schneider J. A Longitudinal Analysis of Antiretroviral Adherence Among Young Black Men Who Have Sex With Men. *Journal of Adolescent Health*. 2017;60(4):411-6.
- 08** Magnus M, Jones K, Phillips G, Binson D, Hightow-Weidman LB, Richards-Clarke C, et al. Characteristics associated with retention among African American and Latino adolescent HIV-positive men: results from the outreach, care, and prevention to engage HIV-seropositive young MSM of color special project of national significance initiative. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2010;53(4):529-36.
- 09** Arnold EA, Weeks J, Benjamin M, Stewart WR, Pollack LM, Kegeles SM, et al. Identifying social and economic barriers to regular care and treatment for Black men who have sex with men and women (BMSMW) and who are living with HIV: a qualitative study from the Bruthas cohort. *BMC health services research*. 2017;17(1):90.
- 10** Quinn K, Voisin DR, Bouris A, Schneider J. Psychological distress, drug use, sexual risks and medication adherence among young HIV-positive Black men who have sex with men: exposure to community violence matters. *AIDS Care*. 2016;28(7):866-72.
- 11** Bogart LM, Wagner GJ, Galvan FH, Klein DJ. Longitudinal relationships between antiretroviral treatment adherence and discrimination due to HIV-serostatus, race, and sexual orientation among African-American men with HIV. *ann behav med*. 2010;40(2):184-90.
- 12** Singh S, Bradley H, Hu X, Skarbinski J, Hall HI, Lansky A. Men living with diagnosed HIV who have sex with men: progress along the continuum of HIV care—United States, 2010. *MMWR Morb Mortal Wkly Rep*. 2014;63(38):829-33.





THE VILLAGE PROJECT

PARKLAND HEALTH & HOSPITAL SYSTEM



FUNDING STATEMENT

This intervention was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$872,928.34 with 100 percent funded by HRSA/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

LOCATION

Dallas, TX

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

CONTACT INFORMATION

Jonathan Gute

Project Manager

Email: jonathan.gute@phhs.org

Crystal Curtis

Principal Investigator

Email: crystal.curtis@phhs.org





INTERVENTION SUMMARY

Parkland Health & Hospital System (Parkland) is the safety net hospital system for the Dallas, Texas metroplex area. Parkland HIV Services Department (PHSD) is one of the largest HIV service providers in Dallas County, providing care to over 6,000 patients annually. The Ryan White HIV/AIDS Program (RWHAP) has funded HIV care services at Parkland for 30 years, and Parkland has proven itself to be a mainstay in the community with well-known clinics like the ACCESS Clinic, Amelia Court, and Bluit-Flowers. The Case Management Department is the hub of the program with pathways reaching outside the organization to bridge referrals with other clinics within the community and throughout the hospital system. The population served by Parkland, including in this intervention, is largely composed of individuals who are low income and marginalized who need a wide variety of services, including medical care, social support services, and behavioral health services.

The Village Project was a 9-month intensive program to engage young HIV-positive Black men who have sex with men (BMSM) ages 17-34 into medical care and support services. The Village Project utilized a Case Manager, a Peer Patient Navigator, an HIV Counselor, and a Client Advocate to facilitate improvements in linkage to care, retention to care, access to behavioral health services, and viral suppression. The Village Project consisted of intense case management, peer navigation, and integrated behavioral health care and support services. The program was

supported by a psychosocial support group, known as Heart & Soul, a rapid start protocol iSTAT Clinic for same-day access to care and medication, a mentorship program, a weekly multi-disciplinary case conference, and direct access to onsite mental health and substance use resources. The dedicated staffing resources coordinated care and worked together to assess and support patients through their journey along the HIV continuum of care.

This project aimed to address social risk factors and establish clear linkages to improved health outcomes via enhanced social support systems. The goals of the program were to improve access to behavioral health, linkage to care by 27 percent, retention in care by 15 percent, and viral suppression by 12 percent. The intervention took place from August 2019 to July 2021 in Dallas, Texas at PHSD. Patients were enrolled through September 2020.



RATIONALE & NEED

According to the Centers for Disease Control and Prevention (CDC),¹ linkage to care and viral load suppression are lowest among younger men who have sex with men (MSM), and all care and treatment outcomes are least favorable for Black males. Additionally, the CDC suggests implementing tailored strategies for MSM that increase access to care and achieve viral suppression among young MSM and BMSM to reduce HIV infections, improve health outcomes, and reduce HIV-related health disparities.

In 2018, Black/African American individuals accounted for 42 percent of all new HIV diagnoses, but only 13 percent of the overall population.

This intervention allowed PHSD to leverage existing primary medical care services while incorporating increased behavioral health integration and case management-initiated contact to help young BMSM access and remain in HIV primary medical care and support services to attain viral load suppression. Drawing on both anecdotal evidence and quantitative data, Parkland decided to pair intense case management with a Peer Navigator and a Mental Health Counselor in order to engage this hard-to-reach population and help address stigma, depression, and anxiety that can go along with being newly diagnosed or coming to a known HIV clinic. The Village Project coincided with PHSD's piloting of the rapid start iSTAT Clinic, which aimed to improve retention by getting patients on medication sooner and keeping patients out of the hospital; previously, the inpatient team had seen an uptake in young BMSM coming in with CD4 counts of less than 10 and extremely ill.

In addition, The Village Project collaborated with the community to build programming that resonated with the BMSM community. BMSM voiced the need for customized care that is

culturally attuned; they want to see providers that look like them and see programs that reflect their experience. At the beginning, a group of six carefully selected men who were in stable medical care and virally suppressed, known as Mentors of the Village Project (MVPs), advised Parkland on the development of The Village Project. For example, the MVPs advised on the creation of marketing materials, the intervention dosage, and how project staff contacted patients on an ongoing basis. In speaking with MVPs, aspects of the patients' lives other than their HIV status kept coming up as the main concerns/priorities for the patients. For example, patients were not able to come to appointments because they were dealing with housing and transportation issues, trying to find a job, or did not feel comfortable with the staff in the clinics.

IMPLEMENTATION

The Village Project began implementation in the late summer of 2019. The patients received weekly in-person and virtual visits from a team consisting of a dedicated Case Manager, a Peer Patient Navigator, and a Client Advocate for the first six months of the intervention, followed by monthly contact for three additional months through the transition to the standard of care. The team utilized various modes of communication including telephone (Village-specific line), text messaging, and Zoom to best meet the needs of each patient, while maintaining the protocols of a large hospital system. The Case Manager and the Peer Patient Navigator scheduled and documented all upcoming appointments with patients via EPIC, Parkland's electronic medical record. This schedule noted whether the contact was in-person or virtual and the purpose of the contact which helped the frontline team manage their caseload and assisted with maintaining patient expectations. The enrollment process included a comprehensive acuity scale assessment to advise needs and healthcare goals. This process included the integration of skills-building and health advocacy tools to help patients manage their healthcare more effectively and independently.



The Peer Patient Navigator also hosted a psychosocial support group, Heart & Soul, where he facilitated discussions on HIV, care/medication adherence, stigma, racial inequities, substance use/risk reduction, and other topics that nurtured growth and assisted in assessing patients' behavioral health needs.



Along with an acuity scale assessment that was administered every 90 days, the SAMISS, and a Knowledge, Attitude & Practice (KAP) + Groupwork Engagement Measure (GEM) assessment were used to gauge status and progress towards each patient's behavioral health goals. Each patient was introduced to one of the behavioral health counselors upon enrollment. This simple introduction alleviated stress and anxiety of meeting another new person on their care team.

“Sometimes as a Black, gay man, when you wanna talk to someone about something, you want it to be relatable. I want to see more gay, Black men in positions like Jason [Peer]. No one knows how it is to be Black unless you're black (but) I respect all the advocates.”

- The Village Project Client

One of the HIV Counselors was a young Black male who specializes in substance use, while the other was a queer female person of color that worked closely with The Village Project team. This was important in building trust and establishing rapport, especially with a group of people who have historically been hesitant to access mental health care services due to the layers of stigma that plague the community. Through the assessments completed by the patients as well as review of medical history, the team was able to assess whether or not the patient had a previous mental health diagnosis or by patient self-report of any current life stressors or past traumas that needed attention. If the patient needed an alternative option for accessing behavioral health care, Parkland had long standing relationships with key community providers that provide wide-ranging services throughout Dallas County.

In addition, a multi-disciplinary case conference was created to improve care coordination and to better identify and bridge gaps in care. The case conference was a weekly meeting with all members of the care team, during which the team discussed how to improve engagement in care. This conference rotated providers to allow fresh perspectives. Comprehensive notes were shared with other care team members. This dedicated conference enabled innovation, improved communication amongst the care team, and ultimately better integrated services by establishing new linkages, while reducing the duplication of efforts.

FINDINGS

The Village Project enrolled 151 men who identified as BMSM and were aged 17-34. The goals of the program aimed to link 62 percent of patients to care, engage 67 percent of patients to attend two primary care visits within a 12-month period, and support 80 percent of patients to achieve viral load suppression.

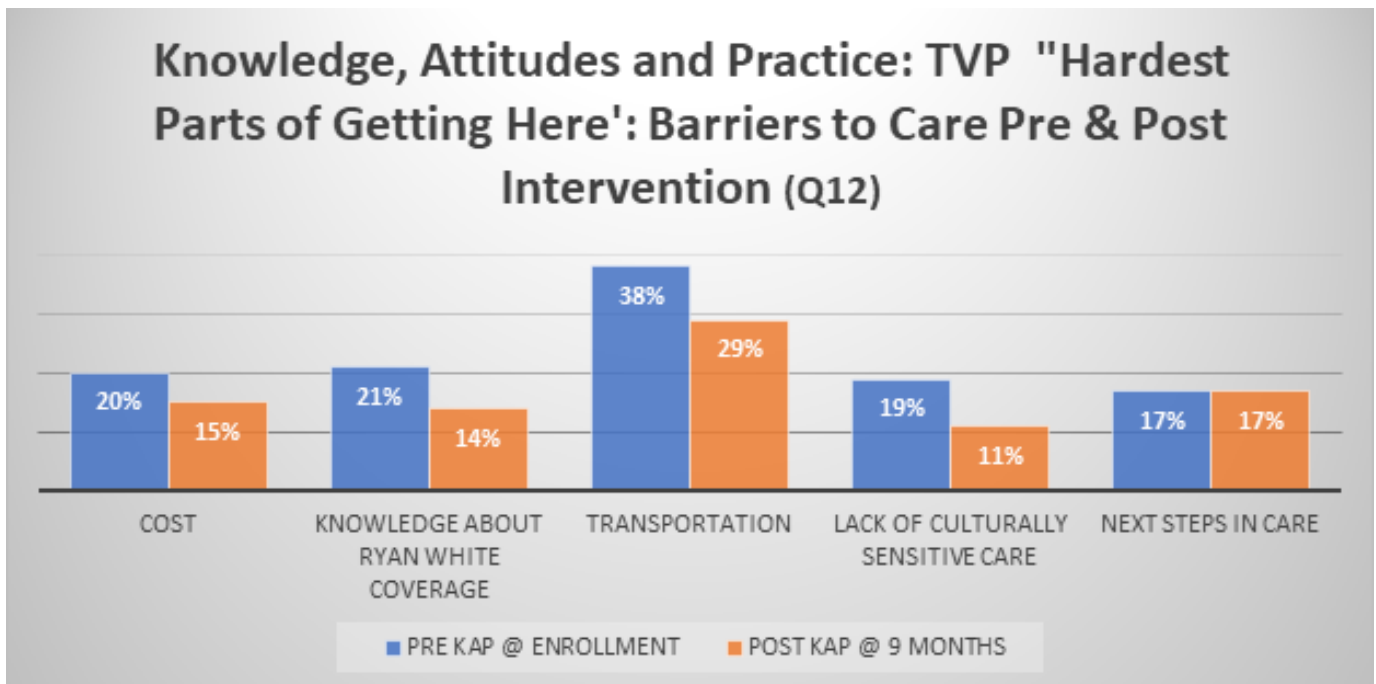
- Of the 151 enrolled patients, about 52 percent were either linked to care (newly diagnosed) or relinked to care through treatment and access to same-day medical care.










- Upon enrollment, 31 patients (20.5 percent) were retained in care. At 12 months post enrollment, 85 patients (56.3 percent) were retained in care by the clinic. The retention rate improved from 20.5 percent at enrollment to 56.3 percent upon completion of the program. As of July 2021, 59 patients (39.1 percent) maintained continuous retention in care. The current retention metric dipped by 17.2 percent and can be linked to the coronavirus disease 2019 (COVID-19) public health emergency and a shift to virtual care. The longer-term impact of the project was an increase of 15.3 percent in retention in care.
- Upon enrollment, 68 patients (45.0 percent) were on ART and had achieved viral suppression. At the conclusion of the intervention, 116 patients (76.8 percent) had achieved viral suppression, or an improvement of 31.8 percent. In terms of longer-term impact, 99 patients sustained viral

suppression as of July 2021. Thus, the Village Project assisted the cohort in improving viral suppression by 20.6 percent. The longer-term data point for retention and viral suppression illustrates that intensive models of care may see an immediate decrease in health outcomes upon project completion. A well thought out transition to the standard care must be individualized and supported in a continuous manner.

- In addition to primary objectives of the multisite evaluation, the local evaluation included secondary clinical outcomes such as integrated behavioral health, ED utilization, and acuity at baselines and at 12 months post enrollment for participants. Through a pre/post client experience survey as well as two follow up focus groups, TVP identified key considerations for models of care that include men within this cohort as decision makers.



	Number of Patients Enrolled	151
	Average Age of Patients	28
	Average Age of Patients at HIV Diagnosis	23
	Average Years Living with HIV at Enrollment	5
	% of Patients Navigating Late Stage HIV Diagnosis	6%
	% of Patients who Utilized ED within Year Prior to Enrollment	42% (60% “ever” prior to enrollment)
	% of Patients who Received Behavioral Health Services within Year Prior to Enrollment	15% (17% “ever” prior to enrollment)

“When I first came into the program, I was on the verge of just starting my recovery. I was addicted to methamphetamine; I was in poor health; I was a big ball of confusion. When I first met Jason and Catina I said, ‘I’m not about to talk to this gay man about what’s going on and... who is this lady? So, I had my own blockage. But they kept pressing and asking that my aunties, uncles would [be] concerned about my wellbeing. To be honest, they were the ones who kept me focused. Jason would check in and see about my meetings and how I was doing—that’s been a year and some months now! And now I have a full-time job; I just got a car; I’m clean and sober; I’m in good health. Where I first started the program where I was in a hole to now—I’m soaring like an eagle and can accomplish anything.”

- The Village Project Client



REFERENCES

- 01** Centers for Disease Control & Prevention. (n.d.). CDC Fact Sheet: HIV Among Gay and Bisexual Men. <https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf>
- 02** Texas Department of State Health Services. (n.d.). Case Management Acuity Scale. https://www.dshs.texas.gov/hivstd/contractor/cm/TXAcuityScale_pdf.pdf
- 03** Texas Department of State Health Services. (n.d.). Substance Abuse and Mental Illness Symptoms Screener (SAMISS). <https://www.dshs.texas.gov/hivstd/contractor/cm/SAMISStoolpluskey16Q.pdf>





WITH U

WASHINGTON UNIVERSITY IN ST. LOUIS



An adapted peer health navigation intervention to support and improve health outcomes for Black men living with HIV who have sex with men.

FUNDING STATEMENT

This intervention was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$975,000 with 100 percentage funded by HRSA/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

LOCATION

St. Louis, Missouri

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

CONTACT INFORMATION

Katie Plax, MD

Principal Investigator

Email: plax_k@wustl.edu

Phone Number: (314) 454-2468

Jeffrey Glotfelty, MPH

Project Coordinator

Email: jeffglotfelty@wustl.edu

Phone Number: (314) 584-0016





INTERVENTION SUMMARY

WITH U paired peer health navigators with Black men living with HIV to complete six months of intensive support via in-person, video chat, phone, and text conversations. WITH U, an adapted youth case management program¹, was implemented at infectious disease clinics associated with Project ARK (AIDS/HIV Resources and Knowledge), a Ryan White HIV/AIDS Program (RWHAP) Part D recipient of the Washington University School of Medicine in St. Louis, Missouri. Implementation took place from October 2019 to July 2021, with a three-month disruption due to the coronavirus disease 2019 (COVID-19) public health emergency (PHE) from March 2020-June 2020.

The WITH U program provided education, support, and navigation assistance for Black men who have sex with men (BMSM), over the age of 18 and living with HIV.¹ Program encounters were broken into eight weeks of weekly sessions followed by four months of monthly sessions and delivered with an intent-to-treat approach. The activities during these sessions were directed by the self-identified needs of the participant and/or self-directed goals set by the participant. Though the COVID-19 PHE challenged intervention delivery, the WITH U program remained feasible, even when participants faced significant challenges around the social determinants of health (e.g., hunger, unstable housing, poverty, experience of trauma, etc.). During qualitative interviews, participants reported

that the services provided by the health navigators were very important to them.



RATIONALE & NEED

Black youth and young adult men who have sex with men (YBMSM) ages 18-29 experience higher HIV incidence rates and poor health outcomes along the HIV care continuum compared to adults (over age 30) in St. Louis and across the United States.² HIV health disparities among YBMSM are often the result of a complex intersection of racism, discrimination, trauma, psychosocial cofactors, and low health literacy.^{3,4,5} These disparities highlighted a need to adapt current services and provide more direct, intensive services to those at risk of struggling with their care.

¹Specifically, WITH U participants were newly diagnosed, not linked to care, out of care, at risk of falling out of care (including due to behavioral health concerns), or not virally suppressed.



To address these disparities and address the needs of YBMSM, WITH U employed a peer health navigation program that attended to behavioral health needs, health literacy, linkage to services, and psychosocial support through participant goal-setting activities. The peer health navigation services were integrated within Project ARK's existing youth-focused, multi-disciplinary team to provide intensive support to YBMSM along the HIV care continuum. While Project ARK previously has had peer educators that work with clients along the HIV care continuum, the WITH U program enhanced the structure and expanded the services provided by peers. The increased intensity of WITH U included additional formal meetings with the health navigator, more focused action plans, and a closer monitoring of progress than general peer programs. WITH U created formal criteria for referral into the program, delineated the time-period that participants spend in peer health navigation services, and assessed participants' progress within the program. By adding universal screening for peer health navigation services based on specific inclusion criteria (lost to care, new to care, or at risk of falling out of care), the WITH U program directly assisted those with the highest need for support. Additionally, rigorous assessment within the specified timeframe of WITH U allowed meetings and activities to be more directed and added an enhanced level of evaluation.

IMPLEMENTATION

WITH U was a six-month, peer-based, health navigation program centered around 12 one-on-one sessions between a health navigator and a participant. Sessions took place in-person, or by phone call, text message, in app messaging, and/or video conferencing. The activities during these sessions were centered around education, navigation, and support, as directed by the participant's needs and goals.

For successful implementation of a peer health navigation program like WITH U, the Washington University team identified the following activities as crucial during pre-implementation:



- Assess organizational commitment and capacity for integrating and supervising peer HNs
- Establish organization-wide understanding of the roles and collaborative relationships of members of multi-disciplinary teams
- Thoroughly train staff
- Develop a system of referral to meet participants' identified psychosocial needs

Elements essential to the successful implementation of WITH U include:

- Use screening tools: Implement tools that provide comprehensive information on what factors impact the participant's ability to achieve improved clinical outcomes.
- Deliver health navigation core functions:

Education - Assist in applying disease management or prevention plans in daily life (e.g., goal setting, skill building, practice and rehearsal of behaviors, troubleshooting, and problem solving);

Support - Provide emotional and social support (e.g., encouragement in use of skills, dealing with stress, and simply being available to talk with participants troubled by negative emotions);

Navigation/Linkage - Act as a liaison to clinical care and support participant activation to communicate and assert



themselves to obtain regular and quality care; provide linkage to behavioral health services and offer referrals to mitigate social determinants of health (e.g., food, housing, utilities, etc.).

- Assist participants with goals: Establish a system for goal setting and analyzing goal attainment.
- Integrate mental wellness: Regularly check in on participant's mental wellness, including readiness and/or utilization of formal behavioral health services. Also, have the health navigator encourage and model positive behaviors in mental wellness, such as disclosing their own behavioral health utilization, destigmatizing asking for help, modeling positive self-affirmations, or practicing meditation.
- Conduct case conferencing: Create time and space to consistently bring all members of the multi-disciplinary team together to focus on the participants' needs.
- Enhance contact with participants: Maintain an open channel for communication with participants as they move through the program.
- Enhance support for peer health navigators with a clinical supervisor.

FINDINGS

DEMOGRAPHICS AND PSYCHOSOCIAL RISK FACTORS

A total of 65 young Black men who have sex with men (YBMSM) enrolled in the WITH U program. Program participants attended an average of 5 to 6 of 12 possible sessions (Mean=5.69; Standard Deviation=3.05) with their health navigator, or approximately half of the available sessions.

Approximately one quarter of participants scored at or above clinical cutoffs for depression or anxiety symptoms, and over 40 percent reported being bothered by past traumatic stressors in the last month. Approximately two-thirds of participants reported using marijuana or another non-prescribed drug in the past year, and the same number reported engaging in binge drinking in the last year. More than half of WITH U participants

reported either worrying about or experiencing food insecurity in the last three months, over a third were concerned about losing their housing, and a quarter were unable to pay their utilities when due in the last three months.

During WITH U sessions, the health navigators provided important elements of support, including encouragement, stress management, emotional support, empowerment, and disclosure support. The figure below demonstrates how frequently and the various types of support provided. Health navigators provided support during 73 percent (225/308) of all completed sessions during the intervention period (10/15/19 – 7/21/21). Of the 55 participants that completed at least one session with their Health Navigator, 100 percent received at least one support element.

OUTCOMES

Quantitative Evaluation Results

Overall, participants reported high satisfaction with WITH U and attended an average of 5-6 of 12 possible sessions with HNs (M=5.69, SD=3.05). Attending a greater number of sessions was significantly associated with being virally suppressed at enrollment ($r(50)=.36, p<.05$) and six month-follow-up ($r(38)=.34, p<.05$), as well as greater concern about losing housing ($r(54)=.29, p<.05$) and experiencing unemployment for at least three months in the last year ($r(54)=.29, p<.05$). This aligns with qualitative findings that navigator support around instrumental needs was critical to participants. However, though participants identified mental health support from navigators as equally important, experiencing more depressive symptoms was significantly associated with attending fewer sessions ($r(54)= -.32, p<.05$). Moreover, a switch to virtual sessions due to the COVID-19 pandemic was a barrier to engagement for some participants.

Behavioral health needs were assessed during the baseline, 6-month, and 12-month patient surveys using the PHQ-8⁶, GAD-7⁷, PCL-C-2⁸, and CRAFFT⁹ screening instruments. Psychosocial findings from the screening instrument at baseline are shown in the table on the next page (Figure 1.).



Figure 1. Psychosocial Risk Factors

PSYCHOSOCIAL RISK FACTORS	N=
Depression (PHQ-8 ≥ 10; last 2 weeks)	17 (26.2)
Anxiety (GAD-7 > 10; last 2 weeks)	17 (26.2)
Bothered by re-experiencing past stress (moderately or higher)	30 (46.2)
Bothered by feeling upset when remembering past stress (moderately or higher)	28 (43.1)
Possible Substance Use Problems (CRAFFT > 2)	49 (75.4)
Used marijuana or other recreational drug in last 12 months	45 (69.2)
Engaged in binge drinking in last 12 months	45 (69.2)
Felt like alcohol or drugs are causing problems in life	12 (18.5)

Mental Wellness Services (MWS), which are behavioral health services provided by an in-house licensed clinician, were offered to all participants that screened positive on any of the screening instruments. The WITH U program effectively referred and connected participants with MWS while in the 6-month intervention. However, only 44 percent of those referred to MWS received therapeutic services (i.e., had at least one completed therapeutic encounter while in the intervention) and even fewer (16 percent) remained engaged in MWS (i.e. had at least four or more completed therapeutic encounters).

MAIN TAKEAWAYS

1 Intensive, long-term services are a challenge for this population and overly structured health navigation programs may inhibit participation when not allowing for participant-directed timeframes and activities.

- Facilitator/Best Practice: Some participants prefer to receive health navigation support as an “on-call” service to attempt to quickly resolve of identified problems. Be flexible and consider a tiered approach to better meet participant’s needs.

“It takes a lot of energy and time. You have to really want to do it... to be committed to it.” – Participant

2 Standard therapy may not to be a good fit for many of the participants targeted by this intervention or BMSM in general.

- Facilitator/Best Practice: Peer HNs provide critical emotional support in the absence of mental wellness engagement. HNs should regularly communicate their professional limitations and remind participants of the availability of mental wellness resources.

“So one thing that a lot of clients... most of the clients, if not all of them...really just needed support. And by support, it’s not even support about anything specific. They just needed somebody to talk to. And sometimes we would have sessions and not have conversations about HIV or medication. They just really wanted somebody to listen.” – Health Navigator

3 Some participants are not ready to set goals and actively work on their care and treatment.

- Facilitator/Best Practice: Assess and address participant readiness to change for meaningful engagement.



“I think one of the things that I found out were that they just weren’t ready. I think that for some of them, even talking about their status was an uncomfortable conversation. A lot of them were still having a lot of anxiety about how they got...how they were infected. Some people were just not ready for medications. And so we’ve had conversations about that...it turned them off. Some people dealt with some drug issues and when that came up, that turned them off. So I think it was specific issues that they just weren’t ready to kind of, face yet.” – Health Navigator

4 Peer-based HNs are intimately impacted by the work that they do and have a high potential for re-traumatization and burnout.

- Facilitator/Best Practice: Peer professionals need structured supervision and support (both professional and emotional), similar to any other professional working with this population (e.g., doctors, therapists, and MCMs).

“Other team members that don’t necessarily operate with clients in the way that we do may not understand. And they may not understand the very high potential for burnout that we have of doing this job with multiple clients, day in and day out. You’re giving yourself and talking

about your past traumas. You’re talking about your HIV diagnosis. You’re talking about how you have some of the same problems that they have.” – Health Navigator

5 Participants were heavily impacted by the COVID-19 pandemic. Participants reported that the pandemic negatively affected their wellbeing, employment and financial status, ability to manage difficult emotions, and life circumstances.

- Facilitator/Best Practice: Participants suffering the effects of the COVID-19 pandemic (e.g., escalating mental health concerns, employment loss, food insecurity, loss of loved ones) attended to basic needs—food, housing, employment, etc. These social determinants of health were powerful.

“I have definitely been referred to [the housing program] a couple of times. When I was going through a couple financial crises and especially when COVID-19 started...I lost my job and things like that, just due



to the pandemic. So the [HN] were very present throughout the whole... COVID-19 pandemic.... They have really been present, just want to ensure that I’m okay. Like, “Hey, are you eating? Do you have a place that’s warm? Are you safe?” And things like that.” – Participant

MENTAL HEALTH TAKEAWAY

This work has led to considerations for how we structure our mental wellness program and provide mental wellness services to YBMSM. Trained peer HNs offering wellness support has been shown to

be well received and accepted. When describing the WITH U program in general terms, most participants emphasized their HNs’ availability and personalities as being vital to their positive experiences. The majority of participants explained that working with a HN ensured they had someone “that’s always there.”

Additionally, standard therapy may not to be a good fit for many of the participants targeted by this intervention or BMSM in general. Despite having a dedicated process for successfully screening and referring participants to behavioral health care, on a whole, participants did not choose to engage in standard therapy sessions to meet their needs. Perhaps a new model of mental wellness consists of well-trained and supported HNs.

Figure 2. Health Navigator Support Provided per Session and Participant

Non-traditional mental wellness provided by Health Navigators:

SUPPORT					
ENCOURAGEMENT	EMOTIONAL	BUILD RAPPORT	EMPOWERMENT	STRESS MANAGEMENT	DISCLOSURE
46% of all sessions	44% of all sessions	43% of all sessions	26% of all sessions	25% of all sessions	8% of all sessions
84% of all clients	73% of all clients	75% of all clients	60% of all clients	62% of all clients	27% of all clients



REFERENCES

- 01** Wohl, A. R., Garland, W. H., Wu, J., Au, C., Boger, A., Dierst-Davies, R., Carter, J., Carpio, F., & Jordan, W. (2011). A youth-focused case management intervention to engage and retain young gay men of color in HIV care. *AIDS Care*, 23(8), 988-997. <http://www.tandfonline.com/doi/abs/10.1080/09540121.2010.542125>
- 02** Sullivan, P. S., Rosenberg, E. S., Sanchez, T. H., Kelley, C. F., Luisi, N., Cooper, H. L., Diclemente, R. J., Wingood, G. M., Frew, P. M., Salazar, L. F., Del Rio, C., Mulligan, M. J., & Peterson, J. L. (2015). Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: a prospective observational cohort study. *Annals of Epidemiology*, 25(6), 445-454. <https://doi.org/10.1016/j.annepidem.2015.03.006>
- 03** Quinn, K. (2019). Applying an intersectional framework to understand syndemic conditions among young Black gay, bisexual, and other men who have sex with men. *Social Science & Medicine*, 112779. Advance online publication. <https://doi.org/10.1016/j.socscimed.2019.112779>
- 04** Wyatt, G. E., Gomez, C. A., Hamilton, A. B., Valencia-Garcia, D., Gant, L. M., & Graham, C. E. (2013). The intersection of gender and ethnicity in HIV risk, interventions, and prevention new frontiers for psychology. *The American Psychologist*, 68(4), 247-260. <https://doi.org/10.1037/a0032744>
- 05** Beer L., Mattson C. L., Bradley H., Skarbinski J., & Medical Monitoring Project. (2016). Understanding Cross-Sectional Racial, Ethnic, and Gender Disparities in Antiretroviral Use and Viral Suppression Among HIV Patients in the United States. *Medicine (Baltimore)*, 95(13), e3171. <https://doi.org/10.1097/MD.00000000000003171>
- 06** <https://www.mdcalc.com/phq-9-patient-health-questionnaire-9> (using the 8 item version)
- 07** <https://www.mdcalc.com/gad-7-general-anxiety-disorder-7>
- 08** https://www.integration.samhsa.gov/clinical-practice/Abbreviated_PCL.pdf (using the 2 item version)
- 09** https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf





ERASE

EAST BAY ADVANCED CARE - SUTTER BAY HOSPITALS (SUTTER BAY)



Eradicating Racism and Striving
for Excellence in HIV Care

LOCATION

Oakland, California

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

You can also visit the following websites:

- EBAC website: <https://www.ebac510.org/>
- Alameda County HIV Care website: <https://acphd.org/hiv/>
- California Department of Public Health-
California Planning Group (CPG) website:
[www.cdph.ca.gov/Programs/CID/DOA/Pages/
OA_CPG.aspx](http://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_CPG.aspx)

CONTACT INFORMATION

Tony Sillemmon, Psy.D, MSW

EBAC Administrative Manager

Email: Sillemt@sutterhealth.org

Phone: (510) 869-8485





INTERVENTION SUMMARY

East Bay Advanced Care (EBAC) implemented ERASE (Eradicating Racism and Striving for Excellence in HIV Care), an adaptation of an evidence-based model of care known as the Youth-Focused Case Management Intervention,¹ for Black men who have sex with men (BMSM) living with HIV from August 2019 to December 2021.

Based at Sutter Health's Alta Bates Summit Medical Center in Oakland, California, EBAC has been providing HIV services for more than 30 years. EBAC is the only full-time hospital-based primary care center in Alameda County – and the only HIV-focused program in the East Bay region (Alameda and Contra Costa Counties) that directly integrates HIV specialty care with primary care by the same provider. It is one of only three organizations in the region that provides treatment adherence support, and the only one that provides long-term HIV navigation services. As such, EBAC is able to provide comprehensive services to people living with HIV and those at-risk for contracting the virus all under one roof.

Implemented at the EBAC clinic in Oakland and in the community, ERASE provided a stigma-free, BMSM-specific space at EBAC, reduced structural barriers for BMSM to access care, provided 24/7 support, and directly linked clients to on-site, integrated care including primary and specialty medical care. ERASE's target population was BMSM living with HIV ages 13+ who fit into one of these categories: newly-diagnosed/new to care; never entered into care; fallen out of care; at risk of

falling out of care, and/or not virally suppressed. BMSM living with HIV were recruited from within EBAC's existing client base of over 1,700 individuals living with HIV, and via referrals from out-side organizations, medical providers, or existing clients. Individual clients were seen for periods of 6-18 months, depending on their enrollment date.

RATIONALE & NEED

BMSM in EBAC's geographic area are dramatically and disproportionately impacted by HIV. African Americans in the region are three to six times over-represented among persons living with HIV² and have consistently lower rates of linkage to care, retention in care, and viral suppression than whites.³ These disparities have led to four times higher HIV-related mortality rates among African-Americans in California.⁴

The causes of these disparities are complex. Nationally, the literature identifies higher rates of sexually transmitted infections, later HIV diagnosis, fear of stigma and discrimination, and racism in health care settings as major contributors to disparities in HIV outcomes for BMSM.⁵ In addition, local needs assessment data show unmet mental health, substance use, and housing needs as primary barriers to care for individuals living with HIV. According to East Bay HIV providers, mental health needs are the greatest barrier for clients living with HIV in the region, followed closely by substance use. These are often connected, as lack of access to culturally-responsive and affordable mental health services, especially when



combined with unstable housing, employment, food, education, or family circumstances, can lead individuals to self-medicate.⁶

To address barriers to care and respond to the needs of BMSM, ERASE provided weekly case management visits for clients for two months, followed by monthly visits for their remaining time in the program, up to 18 months. ERASE drew on strategies and best practices learned from EBAC's 30 years of experience providing HIV care to highly vulnerable populations. These included: (1) using peer case management staff with lived experience who invested in long-term relationships with clients; (2) creating a BMSM-specific space within EBAC; (3) linking clients to on-site, integrated, wraparound services, (4) and addressing structural barriers to accessing care through a "clinic with-out walls" approach.

IMPLEMENTATION

After an initial HIV-positive diagnosis, the first 24-48 hours are critical to linking clients to care. EBAC has a long-held practice of linking new clients to HIV medical care on the spot, while simultaneously providing warm, welcoming, and affirming messages and connections with staff to minimize the fear or anxiety that can accompany an HIV diagnosis. For ERASE, clients were immediately given a warm handoff to one of two case managers. The case managers were peers with lived experiences and/or strong cultural competency; this provided the foundation for offering responsive case management that created a safe and trusting relationship between the client and the program.

“Isolation is real especially for an African American HIV + man in his 60s. This program really helped me socially.” – A. M.

To create a stigma-free BMSM-specific space in which to serve clients, ERASE utilized a dedicated

safe space in EBAC's facility, designed by and for BMSM. This space operated as the ERASE program office, hang out space, and waiting room for clients. It was complete with a mini-fridge, couches, snacks, music, and decorated with culturally-relevant and affirming items created by and for BMSM youth. EBAC has found that this intentional approach of de-medicalizing the physical care space can transform client relationships with the care system, helping clients feel safe, shifting perceived power relationships, and decreasing barriers to accessing needed services. It can also decrease the sense of social isolation that can contribute to clients falling out of care. Use of this BMSM-centered space supported EBAC's use of the "stay connected" strategy. Clients could drop in at any time, were greeted warmly and in culturally competent ways by all staff, saw messages that reinforce the importance of staying in care, and accessed auxiliary resources, all under one roof.

“The case management services was excellent and made us feel connected in a time where COVID has us all feeling disconnected.” – N.D.



To reduce structural barriers for BMSM to access care, ERASE was designed to function as "a clinic without walls." Because of EBAC's unique ability to offer a wide array of services in-house, the peer case managers were able to schedule HIV care, primary care, and other specialty health appointments (including behavioral health) while talking to the client, drastically reducing barriers often involved with scheduling regular care (e.g.,

appointments only available weeks out, traveling to multiple locations). Clients could literally walk across the hall with their peer case manager to get labs, pick up prescriptions, and be seen by medical and behavioral health care providers in same-day appointments. They could also receive assistance with benefits enrollment, and access housing vouchers, social work, and other support services on site. Clients were able to drop-in to the BMSM space anytime, visit with their case managers, and receive integrated wraparound support services. In addition to case management visits in the ERASE office, some visits took place in client homes, at other locations in the community based on clients' needs, or virtually through telecommunications, particularly during the COVID-19 pandemic. Peer case managers shared coverage of a 24/7 pager/cell phone, enabling BMSM clients' access to support anytime they needed it.

The peer case managers provided ongoing education; supported client engagement and retention through regular text messages, phone calls, and group and individual support; scheduled and supported medical appointments, including sending appointment reminders, providing bus/Bay Area Rapid Transit passes to clients needing transportation assistance, accompanying clients to appointments, and helping reschedule missed appointments; and helped clients navigate medical or ancillary support services. They provided clients with warm handoffs to a variety of resources, most commonly housing and food assistance, and substance abuse and mental health services.



After Shelter-in-Place was enacted during the COVID-19 pandemic, clients were not easily able to go to EBAC's offices due to logistical restrictions and/or preferred, for their safety, to meet with their peer case manager at home. Home visits

by case managers increased from 20% to 90% of in-person case management contacts. In addition, the case managers used home visits to deliver food, medication, and other essential resources to clients. Clients could also access both case management visits and medical appointments virtually. Monthly ERASE support groups, facilitated by the Program Co-Director and Social Worker, were shifted from in-person to virtual meetings during the pandemic.

Over the first 22 months of ERASE implementation, 160 clients were enrolled, completing a total of 2,722 case management visits (17.01 visits on average), of which 144 completed the full intervention (defined as immediate linkage to HIV medical care and ongoing case management and service referral/navigation assistance, for 12 or 18 months, depending on the cohort to which they were assigned).

FINDINGS

SATISFACTION AND CONNECTION

Based on data from brief assessments completed by clients each month (1,854 of which were collected, averaging 11.59 per each of the 160 clients), ERASE clients rated program services highly, with notable improvements over time. For instance, on a 0-5 scale:

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

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

NEEDS FOR BEHAVIORAL HEALTH AND SUPPORTIVE SERVICES

ERASE clients reported decreased needs for certain services and increased needs for others, as shown in the table below.

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

NEEDS	N=	BASELINE	END OF PROGRAM
Currently need HIV medical care	153	88.4%	76.25%
Been unemployed for at least 3 of the past 12 months	153	82.5%	75.00%
Currently need help for emotional issues like stress, anxiety, or depression	153	50.4%	31.25%
Not had stable housing at some point in the past 12 months	153	40.0%	30.00%
Feel like drugs or alcohol are currently causing issues in their life	153	34.0%	21.88%
Been released from jail or prison within the past 12 months	153	20.0%	0.00%
Have severe or moderately severe depression (based on score from PHQ8)	153	18.9%	13.75%
Had bad experience with HIV health care provider within past 12 months	153	18.6%	24.38%
Don’t currently have health insurance	153	4.8%	9.38%



HIV CARE AND HIV-RELATED HEALTH

In addition to improvements in linkage to HIV care, ERASE clients demonstrated improved HIV-related health outcomes as well. Changes in viral load were harder to measure given the program’s short time frame; however, small changes can be seen in the data below. Beyond what can be seen through the quantitative data on the program’s services and impact, ERASE case managers have observed a widespread acceptance of and engagement in the intervention among clients. Clients have welcomed the case management meetings and other support as they progress and over time participate more in the program.

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

LESSONS LEARNED/RECOMMENDATIONS

Some key lessons learned in ERASE that contribute to effective care should be highlighted. For one, staff observed that human connection builds better relationships with clients and creates better communication between staff members and clients. These relationships help to ERASE staff to understand the issues clients face, provide informative feedback and relevant support, which create greater trust and healthier bonds, and in turn clients’ deeper engagement in the program. Secondly, strong community collaboration and communication between program personnel, community partners, clients, and their natural support systems adds other vehicles through which to effectively address clients’ needs and promote their retention in the program. Active collaboration achieves a bidirectional system that enhances proponents’ chances of successfully serving ERASE clients.

This program saved my life. I was on my death bed, now I’m stably housed – T.W.

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



REFERENCES

- 01** Wohl, A. R., Garland, W. H., Wu, J., Au, C., Boger, A., Dierst-Davies, R., Carter, J., Carpio, F., & Jordan, W. (2011). A youth-focused case management intervention to engage and retain young gay men of color in HIV care. *AIDS Care*, 23(8), 988-997. <http://www.tandfonline.com/doi/abs/10.1080/09540121.2010.542125>
- 02** Office of AIDS, California Department of Public Health. (2021). California HIV Surveillance Report -- 2019. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California_HIV_Surveillance_Report2019_ADA.pdf; 2017 - 2021 Alameda & Contra Costa County Integrated HIV Prevention & Care Plan. 2016; HIV Surveillance Brief. Contra Costa Health Services. August 1, 20
- 03** HIV in Alameda County, 2013-2015. Alameda County Public Health Department. February 2017; HIV Surveillance Brief. Contra Costa Health Services. 2016.
- 04** Office of AIDS, California Department of Public Health. (2021).
- 05** HIV Surveillance Brief. Contra Costa Health Services. 2016.
- 06** 2017 - 2021 Alameda & Contra Costa County Integrated HIV Prevention & Care Plan. 2016.





Care Engagement Project

CHRISTIAN COMMUNITY HEALTH CENTER



Care
Engagement
Project

A PROGRAM OF
CHRISTIAN COMMUNITY
HEALTH CENTER

FUNDING STATEMENT

This intervention was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$300,000 with 100 percent funded by HRSA/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

LOCATION

Chicago, IL

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

For more information about the services that CCHC offers to the community, visit:

<https://cchc-online.org>

To learn more about Roseland, CCHC's community, please visit: <http://archive.lisc-chicago.org/news/category/199>

CONTACT INFORMATION

Dr. Obianuju Okoye

Program Director

Email: ookoye@cchc1.org





INTERVENTION SUMMARY

Christian Community Health Center (CCHC) is a Federally Qualified Health Center (FQHC) that has provided high-quality health care and social services to underserved African American and Hispanic communities for 28 years. CCHC is the only African American-led FQHC on the far South Side of Chicago and in South Suburban Cook County that offers comprehensive housing and supportive services and integrated primary care delivered by a culturally appropriate multi-disciplinary team of licensed and credentialed African American and Hispanic providers.

CCHC also provides integrated care to individuals living with HIV/AIDS as well as an array of wraparound HIV/AIDS services, including HIV outreach, counseling, and testing; intensive medical and housing case management; treatment adherence counseling; primary care; oral health care; 340b pharmacy services; behavioral health services; subsidized Permanent Supportive Housing (PSH); employment services; transportation; partner support services; partner counseling and referrals (PCRS); support groups; referrals to home health; legal assistance; and nutrition/food services.

For the SPNS BMSM Initiative, CCHC implemented the Care Engagement Project (CEP), a case management-based intervention which sought to increase rates of engagement and retention in HIV care for Black men who have sex with men (BMSM) living with HIV, with the goal of stabilizing hard

to reach clients and retaining them in consistent care for improved viral loads and overall positive health outcomes. CCHC's proposed catchment area included low income, underserved, predominantly African American communities on the far South Side of Chicago and the surrounding south suburbs.

Implementation of CEP at CCHC took place from August 2019 to August 2021. CEP recruited 89 clients through December 2020 who were:

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



The CCHC CEP model of care was adapted from an evidence-informed youth-focused case management intervention.¹ For CEP, clients were assigned to a peer case manager (PCM), and referred to behavioral health and medical services, as needed. The PCMs met with the clients, on average weekly, to assess progress on their treatment plan and see if any other social services were needed.

RATIONALE & NEED

CCHC is located in the Roseland neighborhood and in the Washington Heights community area on the far south side of Chicago. According to Local Initiatives Sport Chicago (LISC), this area is low income, 96 percent African American, has a high unemployment rate, and has a large subset receiving Medicaid.² Many community residents are plagued with socio-economic determinants/risk factors like un- or under-employment, which lead to insufficient housing, lack of financial resources, exposure to violence, lack of adequate mental health assistance, substance abuse, and some degree of illiteracy. CCHC also experiences non-compliance in follow-up and returning for care and treatment.

Challenges also include access to low-cost specialty care appointments, or specialists that accept public insurance plans or otherwise uninsured Ryan White HIV/AIDS Program (RWHAP) patients. This has been an ongoing barrier at CCHC due to financial constraints and the cost of specialty care appointments for areas of psychiatry. In addition,



stigma regarding the need for mental health services and accessing mental health services is still pervasive in communities of color. African Americans tend to rely on family, religious, and social communities for emotional support rather than turning to health care professionals, even though this may at times be necessary. According to the website of McLean Hospital, a Harvard Medical School affiliate, “[t]he Black community adopted and passed on from generation to generation...such nuanced descriptions for depression and other mental illnesses...[it] led to underestimating the effects and impact of mental health conditions. Also, it strengthened beliefs that a psychiatric disorder is a personal weakness.”³ Many believe symptoms of poor mental health, like depression, are “just the blues.”

Issues of distrust in the health care system and mental health stigma frequently lead African Americans to initially seek mental health support from non-medical sources.

CCHC CEP aimed to address these barriers to care by taking advantage of the cultural competence and appropriateness of its staff. To increase interaction between the PCMs and the clients, CCHC CEP shifted from requiring a bachelor’s degree as an education requirement for the PCMs. Instead, CCHC opened the positions to individuals who had extensive experience and were driven, knowledgeable, and compassionate towards the target population. To eliminate transportation as a barrier to accessing care, CCHC engaged the services of Kaizen, which allowed the clients to get back and forth to appointments. In addition, one licensed clinician also offered counseling services in Spanish and was a Certified Addiction Specialist.

IMPLEMENTATION

The initial stage of CCHC CEP consisted of enrollment of the recruited clients by a PCM. A brief assessment was given to identify each client's challenges and barriers. These included, but were not limited to, linkage to care, mental health issues, food needs, behavioral health, substance use, and housing. During that initial phone call, the PCM asked clients questions about their behavioral/mental health. Given the stigma associated with behavioral health, PCMs provided information to clients regarding the benefits of behavioral health services. At CCHC, particularly during the coronavirus disease 2019 (COVID-19) public health emergency (PHE), clients also had the option of in-person behavioral health visits and telehealth behavioral health visits.

Following enrollment, the PCMs contacted each client weekly to biweekly to discuss their issues, services, and possible referrals. As a result of the COVID-19 PHE, PCMs stopped meeting with clients face-to-face and instead restricted the follow-ups to phone calls. During these calls, the PCMs updated clients on HIV education, medication adherence, and treatment adherence, and addressed transportation needs using the Kaizen app. The clients were tracked, and services monitored, using Client Encounter Logs which were updated weekly for all enrolled clients. This allowed CEP staff to know the status of the referrals, as well as appointment attendance. All notes, dates, and encounter types were manually recorded within the logs.



The behavioral health component was key to this program. During implementation of CEP, CCHC initiated a bi-weekly meeting between the PCMs, the Behavioral Health Director (BH Director), and the Program Director. Prior to the meeting, the BH Director was provided the list of CEP clients that had been scheduled for behavioral health appointments. During the meeting, the team conducted a detailed follow-up on referred clients, noting clients who cancelled their appointments, or were a no-show, so that the PCMs could follow up with them. The BH Director also provided more details collected from the BH team, including the providers' case notes for each client, which allowed the PCMs to follow up more effectively. The PCMs also used CCHC's Electronic Health Record (Athena) to confirm whether clients showed up for their appointments. The standard CCHC automated appointment reminders were sent to the clients. These consisted of phone calls, as well as text message reminders one week and two days prior to the appointment. The PCMs also reminded the clients about appointments during their regular check-ins.

The following internal services were provided to the client through CEP:



- Peer case management



- In-person or telehealth behavioral health and medical appointments



- Transportation (to and from appointments through Kaizen)



- Housing services



- Access to food pantries and/or other needed resources

FINDINGS

A total of 89 clients were enrolled in CCHC CEP.

- Active clients monthly: 29
(i.e., the number of clients who the PCMs were still able to reach virtually)
- Behavioral Health Referrals: 29
- Behavioral Health Brief Interventions: 52
- Medical Services Referrals: 39
- Housing Referrals: 12
- Transportation Assistance: 22.
(Of the rides scheduled for those 22 clients, six were missed/cancelled, 11 were for medical appointments, and 11 were for non-medical appointments.)

CCHC CEP experienced challenges with data collection and management. Medical records release forms were not initially collected at the start of the program, which made it challenging to access the medical records of clients who received

medical care outside of CCHC to collect data for the evaluation. This led to some missing data on HIV care continuum outcomes, which would have been helpful to analyze to determine client medical progress. At the close of the Initiative, none of the initial staff remained and turnover in the Data Manager role led to multiple individuals contributing to data collection and management and, as a result, monitoring challenges ensued.

In addition, to support the collection of data in a virtual world, it is important to have updated, correct contact information for clients. The CCHC CEP client population, particularly during the COVID-19 PHE, had phone numbers that changed frequently and/or were disconnected temporarily or permanently. This made it challenging for the PCMs to reach clients, particularly when face-to-face visits were not allowed. Between this real communication barrier and challenges filling and training the Data Manager and other positions, administrative challenges and sharp learning curves contributed to ongoing challenges during implementation.



REFERENCES

- 01** Wohl, A. R., Garland, W. H., Wu, J., Au, C., Boger, A., Dierst-Davies, R., Carter, J., Carpio, F., & Jordan, W. (2011). A youth-focused case management intervention to engage and retain young gay men of color in HIV care. *AIDS Care*, 23(8), 988-997. <http://www.tandfonline.com/doi/abs/10.1080/09540121.2010.542125>
- 02** Local Initiatives Support Corporation. (2011, October 17). Roseland — LISC Chicago. <http://archive.lisc-chicago.org/mobile/news/category/199>
- 03** McLean Hospital (2021, July 20). How Can We Break Mental Health Barriers in Communities of Color? Retrieved November 23, 2021 from <https://www.mcleanhospital.org/essential/how-can-we-break-mental-health-barriers-communities-color>



BROTHERS UNITED/THE DAMIEN CENTER LINKAGE TO CARE INTERVENTION



+LOVE

New Orleans Aids Task Force (Crescent Care)



FUNDING STATEMENT

CrescentCare is a Federally Qualified Health Center (FQHC) which provides comprehensive primary care services as well as an array of support services. The agency has a 37-year history of providing prevention and outreach services and currently provides HIV care to 35 percent of individuals living with HIV in New Orleans. This intervention was housed in the Prevention Department and was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$975,000 with 100 percent funded by HRSA/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

LOCATION

New Orleans, LA





INTERVENTION SUMMARY

The +LOVE Program was an intervention implemented by CrescentCare, a Federally Qualified Health Center (FQHC) in New Orleans, Louisiana, which provides comprehensive primary care services as well as an array of support services. The agency has a 37-year history of providing prevention and outreach services and currently provides HIV care to 35 percent of individuals living with HIV (LWH) in New Orleans. The +LOVE Program was overseen by and housed in the agency's Prevention Department. It was a six-pronged intervention to enhance and improve HIV care and outcomes for Black gay, bisexual, and other men who have sex with men (BMSM) LWH, who reside in the New Orleans metropolitan statistical area (MSA). The program provided participants, both existing clients at CrescentCare and clients from other health facilities, with the following: 1) a dedicated case manager (CM); 2) a dedicated behavioral health therapist (BHT); 3) text-based mHealth digital support (CareSignal) that tracked participants' basic needs and levels of anxiety and depression, and provided ART medication reminders; 4) a dedicated triage crisis coordinator (TC), a social worker who responded to crisis alerts generated by participants' answers in the text program and offered immediate crisis assistance; 5) free Lyft rides to HIV and related care appointments; and 6) referrals to peer support.

+LOVE Program staff operated as a team to provide the above interventions, using data

from CareSignal to track and analyze participants' experiences and needs in order to tailor their services in real-time and on a weekly basis. Daily, weekly, and monthly assessments administered through the text messaging program coupled with longer surveys administered to participants at baseline, four, six, eight, and 12 month intervals were used to assess satisfaction with program interventions and improvement in HIV care experience, as well as to determine ways to increase efficacy of the program. Enrollment for the 12 month intervention ran from October 3, 2019 through December 31, 2021.

RATIONALE & NEED

In New Orleans and in Louisiana, BMSM LWH face disparities in linkage and retention to HIV care and in viral suppression. Among persons LWH, BMSM are less likely to be consistently engaged in HIV care than other groups LWH and suffer from higher HIV/AIDS-related morbidity. In 2014, 49 percent of men who have sex with men (MSM) of color were virally suppressed, compared to 63 percent of White MSM (WMSM) LWH. Between 2017 and 2021, 70 percent of newly diagnosed AIDS cases were among Blacks in Louisiana. In 2018, among those in HIV medical care, 98 percent of 13-24 year-old WMSM were virally suppressed compared to only 81 percent of 13-24 year-old BMSM. According to state findings, young WMSM have better outcomes on every measure of the HIV continuum as compared to all persons LWH in Louisiana. The disparity is also reflected in CrescentCare's own continuum of care data. In



2017, only 62 percent of BMSM clients were retained in care compared to 73 percent of WMSM clients. Similarly, viral suppression occurred in only 78 percent of BMSM clients compared to 86 percent of WMSM clients.

Lower rates of viral suppression among BMSM LWH are linked to poor Social Determinants of Health (SDoH) indicators. BMSM are more likely to experience discrimination, housing instability, poverty, low education, unemployment, and food insecurity because of societal marginalization and are more likely to have experienced incidents of health care maltreatment because of systemic racism, in comparison to their White counterparts—all factors that affect access and adherence to HIV treatment. The +LOVE Program designers hypothesized that because of these factors, improving HIV care and medication adherence among BMSM necessitated addressing BMSM LWH's lack of access to support systems and resources, beyond just access to doctors and medicine.



The aim of the +LOVE Program was to provide a culturally appropriate intervention that took into account the challenges that prevent BMSM LWH from thriving in the context of HIV care by providing BMSM LWH with more integrated HIV care, navigation support, and specialized resources, including crisis support they need to keep up with their medication, make their HIV care appointments, link them to behavioral health resources, promote health care empowerment to overcome medical mistrust and fears related

to prior mistreatment in medical systems, and address SDoH that present barriers to sustained viral suppression. The overarching goals were: 1) to increase the ease with which services offered at CrescentCare, including medical services, case management, behavioral health services, and peer support services, could be accessed by BMSM LWH clients; 2) to increase capacity to assess and address the real-time social, psychological, and basic needs of individual BMSM LWH clients; and 3) to facilitate the integration of services and communication among providers and support staff who are working with BMSM LWH in order to meet the social, psychological, and basic needs of BMSM LWH clients.

By providing participants with a dedicated CM who was familiar with the specific needs of BMSM LWH and who was a member of the BMSM community himself, +LOVE was able to secure the trust of BMSM LWH and increase access to services and resources that they needed to improve their social and economic stability. By providing participants with a dedicated BHT, who offered “sex positive therapy” with a focus on building self-esteem and had extensive experience with LGBT clients and persons of color (POC) as well as clients LWH, the program provided enhanced psychological support to participants, addressed mental health needs that could act as barriers to HIV care and medication adherence, and helped diminish the effects of social stigma. By providing a TC, a social worker familiar with the needs of the BMSM LWH population who could offer immediate help to participants in crisis, the program ensured that resources and support were provided in a timely manner to prevent crises from interrupting HIV care. In addition, the work of the CM, BHT, and TC was supported and enhanced with the information provided by the mHealth text messaging system. Routine CareSignal assessments made it possible for the +LOVE team to track participants' needs, mood states, and crises in real-time so that no participant's situation could escalate to the point of interrupting their regular HIV care appointments and medication regimen. By providing free rides to HIV care and related appointments, the program reduced transportation barriers that prevented BMSM LWH from engaging in HIV care and accessing medications. Finally, the CM, BHT, and



TC referred and encouraged participants to take part in the Movement, another program offered by CrescentCare, which provided BMSM with online and in-person peer support, social activities, and linkage to STI testing, to assist participants in building their social support network.

IMPLEMENTATION

Key components of the +Love Program are described below.

DEDICATED CASE MANAGER

Participants were provided with a dedicated CM who worked with them throughout their participation in the program. He conducted screenings with participants to assess their basic needs, provided referrals to resources and assistance with insurance and housing, and functioned as a liaison with the participants' medical case manager and HIV care providers. The CM's interactions with participants were conducted through in-person appointments, phone calls, and text messaging directly to participants' phones. During the height of the COVID-19 pandemic, most communication was conducted remotely, although the CM did conduct in-person delivery of food to participants.

DEDICATED BEHAVIORAL HEALTH THERAPIST

Participants were provided with a dedicated BHT whose training and therapeutic expertise were particularly fitting for the population served by the program. It incorporated a social justice lens amplified with tools from eye movement desensitization and reprocessing (EMDR) and other trauma-informed techniques. The therapy was sex positive, with a focus on building self-esteem and harm reduction strategies. The BHT also conducted and taught mindfulness-based stress reduction and provided guided meditation. All participants were offered free therapy upon enrollment and could access the free therapy at any time during the course of their participation in the program. The BHT was trained to work with clients who are not in traditional monogamous relationships. An important part of the initial enrollment discussion with potential participants was psychoeducation,



during which +LOVE staff described the variety of therapeutic techniques offered in order to lessen stigma surrounding therapy that had been identified during formative qualitative research in the community. Psychoeducation was also incorporated into other aspects of the program, including case management and crisis management.

CARE SIGNAL MHEALTH TEXT MESSAGING SERVICE

The text-based messaging program provided various types of tracking depending on individual participants' needs and comfort, to which they consented to upon enrollment. Mood, depression, and anxiety tracking included periodic questions via texts asking about mood changes and questions that comprise the PHQ-9 scale for depression and the GAD-7 scale for anxiety, including questions regarding suicidal ideation and suicidality. Medication tracking provided reminders to take medications at times pre-designated by the participants during enrollment and tracked adherence. Basic needs tracking, which included pre-determined SDoH indicators, inquired about participants' basic needs, such as food, housing, and employment. Based on tracking parameters set by the +LOVE team, the text messaging service used text responses to classify participants according to their risk. For example, high numbers on mental health assessments, lack of response



to medication alerts, and urgent basic needs triggered alerts that were sent directly to the TC, so that she could assess who needed immediate or more intensive attention. Depending on the alert category, alerts were also sent to the participants' BHT and/or CM.

TRIAGE CRISIS COORDINATION

The TC, a licensed social worker, addressed and investigated all of the alerts that came through the text messaging system and determined what form of immediate linkage and support the client needed. Basic needs and medication alerts, such as housing instability, inability to obtain medication, and food insecurity were dealt with by both the TC and the CM together. The TC conducted crisis management and wellness checks via phone calls and direct text messages to participants. For participants in behavioral health crises whom she assessed as needing behavioral health therapy, she provided psychoeducation as a means of encouraging them to make an appointment with the program's dedicated BHT. The TC was able to provide a different form of behavioral health support to participants, in particular to those who were less likely to engage in traditional therapy. In addition to mediating crisis alerts generated by the text-message program, the TC also assisted clients with crisis needs for which they contacted her directly and conducted wellness checks with all clients after Hurricane Ida in fall of 2021.

FREE LYFT RIDES

The program coordinator, CM, BHT, and TC coordinated free Lyft rides for participants to all of their HIV and related appointments, including lab appointments and behavioral health appointments.

MOVEMENT REFERRALS

The CM, BHT, and TC provided participants with information on events held by the Movement, a BMSM peer support program offered by CrescentCare that provided social support and additional navigation support for services, such as STI testing and treatment.

Figure 1. Frequency of Care Signal Crisis Alert Topics

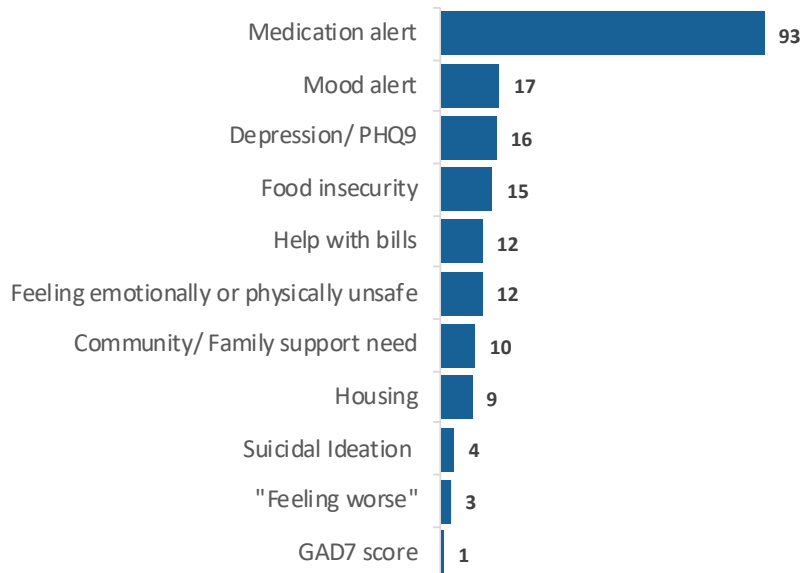
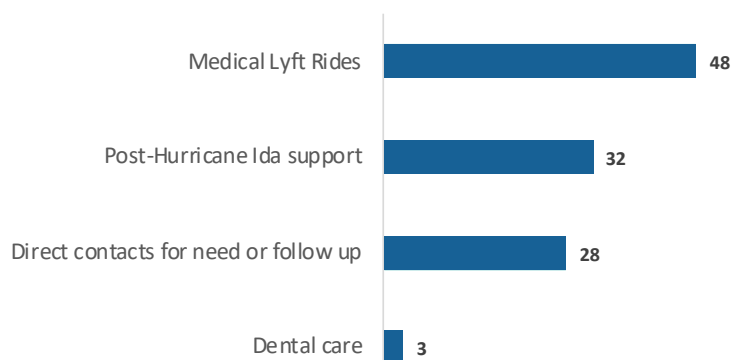


Figure 2. Frequency of Non-Care Signal Client Crisis Needs

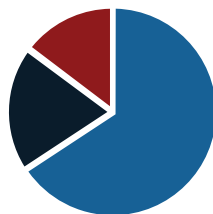


FINDINGS

146 BMSM LWH enrolled in the +LOVE Program, with an average age of 34. Upon enrollment, 55 percent reported being unemployed for at least three months in the past twelve months and 22 percent reported housing instability in the prior twelve months. Only 25 out of 146 (17%) of participants had received behavioral health therapy prior to their enrollment. At the conclusion of the program 55 (38%) participants had received behavioral health therapy through +Love. This increase is statistically significant with a p-value of <.01. Out of the 55 participants who received behavioral health services through +Love, 42 (76%) had not received behavioral health services at baseline. Participants received a total of 312 therapy appointments from the BHT. The TC addressed 192 alerts through CareSignal and completed 303 crisis coordination encounters with participants.

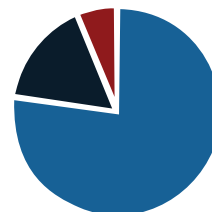
Program assessment surveys revealed that participants perceived substantial improvements to their HIV care and their medication adherence because of the +LOVE Program. At 12 months following enrollment in the program, 81 percent of respondents reported that they were more likely to attend all of their HIV care appointments and 78 percent reported that the +LOVE Program had increased their trust in the health care system. Participants' self-assessment of the utility of specific interventions provided by the program also indicated improvement in their HIV care. For example, 79 percent of participants reported that CareSignal helped them to stay on top of their medication more effectively than before the program. In comparing viral load levels at baseline versus at 12 months post-enrollment in the program, 66 percent of participants showed improvements in viral load suppression. Comparing end of involvement in the program to baseline, 89 percent of participants who were not undetectable at baseline experienced a decrease in viral load. Among participants who were undetectable at baseline, 92 percent maintained their undetectable viral load by the end of their involvement in the program.

Distribution of viral suppression status at baseline



- Undetectable
- Suppressed
- Neither Undetectable nor Suppressed

Distribution of viral suppression status at 12-months



- Undetectable
- Suppressed
- Neither Undetectable nor Suppressed





A cohort analysis of outcomes differences between participants who accessed crisis intervention and/or behavioral health services in addition to case management and those who just access case management, shows that the behavioral health services component developed in the program, played a key role in **retention in care, viral suppression, and ART adherence.**

RETENTION IN CARE

- Participants accessing services beyond case management had 2.67 [95% CI: 1.21-5.88] times the odds of having a routine HIV medical care visit within the last 6 months than those who used case management alone.
- Participants accessing services beyond case management had 3.13 [95% CI: 1.36-7.19] times the odds of having had 2 or more HIV care visits within the past year than those who used case management alone.

VIRAL SUPPRESSION

- Participants accessing services beyond case management had 7.44 [95% CI: .99-55.71] times the odds of having achieved viral suppression in the last 12 months than those who used case management alone.
- Baseline PHQ Score was a significant confounder ($p=.042$).

ART ADHERENCE

- Participants accessing services beyond case management had 3.39 [95% CI: .98-11.67] times the odd of having been prescribed ART within the last 12 months than those who used case management alone.

In other words, the integration of traditional behavioral health therapy with mHealth tracking and crisis support was key to the success of the intervention.

STRENGTH THROUGH YOUTH LIVIN' EMPOWERED (STYLE) INTERVENTION



STYLE 2.0

DUKE UNIVERSITY



FUNDING STATEMENT

This intervention was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$974,923 with 100 percent funded by HRSA/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

LOCATION

Durham, NC

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

CONTACT INFORMATION

Heather Parnell

Research Manager

Email: style@duke.edu

Phone Number: (919) 613-5432

Website: www.stylenc.org





INTERVENTION SUMMARY

STYLE 2.0 was an adaptation of an existing innovative model of care (MOC), Strength Through Youth Livin' Empowered (STYLE),¹ designed to engage and retain Black and Latino young men who have sex with men (MSM) living with HIV in medical care and behavioral health services. STYLE 2.0 focused specifically on young Black MSM and added innovative virtual programming to target this hard-to-reach population. Virtual programming included health care navigation, support groups, motivational interviewing, and the STYLE 2.0 healthMpowerment (HMP) app, which provided information and resources, fostered social support, and contained game-based motivational elements.

STYLE 2.0 included cisgender Black MSM ages 18-35 living with HIV in the Research Triangle region (i.e., Durham, Orange, and Wake counties) of North Carolina and the Columbia, South Carolina area. STYLE 2.0 participants include those who were newly diagnosed/new to care, at risk of falling out of care, or not virally suppressed. The intervention period ran for a total of 12 months for each participant. The first six months of STYLE 2.0 focused on the Health Care Navigators (HCN) utilizing an adapted Centers for Disease Control and Prevention (CDC)-created CLEAR: Choosing Life: Empowerment! Action! Results!² protocol to meet the unique needs of participants. During this time, participants worked closely with the HCN to set personal goals for behavioral change and problem-solving. During the final six months of STYLE 2.0, the HCN worked less directly

with each participant, shifting their focus to providing referrals to resources and maintaining support groups, as well as acting as a safety net for participants. STYLE 2.0 enrolled its first participants in November 2019 and enrollment of new participants ended in December 2020. The intervention ran through December 2021.

STYLE 2.0 was conducted by the Center for Health Policy & Inequalities Research (CHPIR) within Duke University's Global Health Institute in Durham, North Carolina, an urban area in the Research Triangle region. CHPIR is a mobilizer and facilitator of a broad range of health policy and health disparities research that address policy relevant issues. Its activities focus on population-based health research, health systems research, and intervention and evaluation research. As a non-clinical site, the STYLE 2.0 team partnered with the following local organizations to recruit participants for the intervention and connect them to needed services:

- Duke Infectious Diseases Clinic (Durham, NC)
- University of North Carolina Division of Infectious Disease (Chapel Hill, NC)
- University of South Carolina Medical Group, Infectious Disease Division (Columbia, SC)
- Lincoln Community Health Center – Early Intervention Clinic (Durham, NC)
- Wake County Human Services (Raleigh, NC)



RATIONALE & NEED

Racial disparities in the HIV care continuum prevent linkage and retention in HIV care, antiretroviral therapy uptake and adherence, and viral suppression. Thirty-eight percent of Black men are estimated to be consistently retained in care, compared to 49 percent of white and 50 percent of Hispanic men. Black MSM accounted for 26 percent of the 37,968 new HIV diagnoses in 2018.³ Only 70.8 percent of Black MSM ages 25-34 were linked to care within one month of HIV diagnosis, compared to 77.6 percent of white MSM.⁴

Compared to white MSM, Black MSM experience lower rates of viral suppression and overall poorer health outcomes. In addition, Black MSM are at high risk for poor adherence due in part to psychosocial stressors, high rates of substance abuse and mental health disorders leading to poor health outcomes, persistence of risk behaviors, and

onward HIV transmission. Decreased adherence has been associated with both alcohol and drug use in samples of HIV-infected MSM, including young Black MSM.⁵⁻⁸

To address these disparities and respond to the needs of Black MSM, STYLE 2.0 adapted the original MOC by adding remote and/or virtual components to the work of the HCN and Behavioral Health Providers (BHP). Providing these services in virtual settings (e.g., the STYLE 2.0 HMP app, phone calls, text messages, and Zoom) alleviated various barriers to care, such as transportation or taking additional time off of work or school. In addition, the STYLE 2.0 HMP app offered an opportunity to build community and provide information focused on the issues that are most important to the Black MSM population. The app was designed to increase safer sex behaviors, promote health and wellness, build community, and create positive norms around HIV, and enabled the intervention to reach geographically or socially-isolated clients.

“This is the first type of group thing I’ve ever done... They’re Black. They’re men. It’s just more appealing because I can relate...”

- STYLE 2.0 Support Group Participant



IMPLEMENTATION

STYLE 2.0 utilized the following activities to address barriers to HIV and behavioral health care engagement. Participants were able to choose to participate in any or all components of the intervention.

OUTREACH:

The HCN were actively engaged in the community (e.g., present at community events) and managed the referral network, which included both active and passive referrals to STYLE 2.0 from a variety of sources

MEDICAL-SOCIAL SUPPORT NETWORK:

STYLE 2.0 was supported by a network of board-certified infectious disease physicians, who also represented the clinical partners.

HCN CLEAR SESSIONS:

As noted above, STYLE 2.0 used a CDC-adapted program, CLEAR, through which the HCN worked with participants to create skills to help them make healthy life choices. Participants met with the HCN to determine which key skills were the most important work on, and then met with them every 1-2 weeks to work through the adapted CLEAR protocol to gain and/or improve upon these skills. Sessions included “Creating a Vision for the Future,” “Communication,” “Problem Solving,” and “Adherence.”

ANCILLARY SUPPORT SERVICES:

The HCN linked participants to supportive services (e.g., housing, education, employment, etc.) and additional clinical and behavioral health care, as needed.

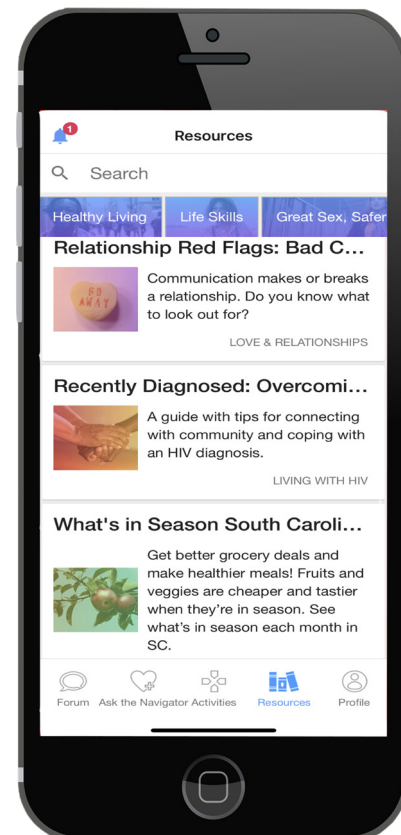
VIRTUAL COMPONENTS (STYLE 2.0 HMP APP):

After enrollment, the HCN helped the participants download and set up the STYLE 2.0 smartphone app and explained the community-building and educational features. Features of the app included:

- **Forum** for discussion on current events, health topics, general conversation, praises

for reaching milestones (e.g., graduations), and small competitions.

- Private, one-on-one **Health CareNavigator Messaging** where participants communicated individually with the HCN.
- **Knowledge Center** with health empowerment articles, interactive quizzes, and goal-setting activities. The STYLE 2.0 app included articles in categories such as *Healthy Living*, *Living with HIV*, *Love & Relationships*, *Great Sex Safer Sex*, and *Life Skills*.
- **Ask the Navigator** forum, where participants anonymously asked questions to be answered by the Navigator team and displayed (as appropriate) for all app users to respond to or offer support.
- **User Profile** with virtual badge awards for app engagement and a custom avatar feature. Users were awarded badges for posting in the forums, reading articles, completing activities such as quizzes and goal-setting exercises, and leaving likes or comments.



BEHAVIORAL HEALTH:

STYLE 2.0 behavioral health components included the use of the SAMISS screener⁹⁻¹⁰ at intake and six months, HCN referrals to the BHP for motivational interviewing sessions (see below), referrals to additional behavioral health services, and mental health/substance use-focused content, social support networks, and health empowerment through the STYLE 2.0 HMP app. In addition, support groups took place over Zoom and focused on topics such as identity and spirituality, disability justice, LGBT+ trailblazers, and general wellness check-ins.

- After the HCN met with the participants for CLEAR sessions, they aimed to meet with the BHP regularly for a debriefing. This was to ensure participants were not showing mental/behavioral health concerns (symptoms of depression, anxiety, suicidal ideation, substance misuse, etc.) while in the presence of the HCN. If there were concerns, the BHP made a referral to other resources to help the participants.

- The HCN also provided a warm handoff to the BHP for participants who screened positive for behavioral health services, using a three-way video conference or phone call to introduce the BHP, who provided four virtual motivational interviewing sessions. During these sessions, the BHP helped the participant find the inner confidence and motivation necessary to make specific, positive life changes. General goals included increasing readiness to enter or regularly engage in HIV care and identifying and addressing the key barriers that prevent such engagement.

SOCIAL MARKETING CAMPAIGN AND OUTREACH:

While pared down from the original plan, STYLE 2.0 used targeted social media campaigns for recruitment and to bring awareness to the program.

FINDINGS

Out of the 128 potential participants who were referred, 66 enrolled in STYLE 2.0 with an average age of 27.7. Data collected over the course of the intervention included surveys at baseline, 6-months, and 12-months, in-depth interviews, medical chart reviews, and app paradata, which contributed to a robust data set describing the participants and their changes throughout the 12-month STYLE 2.0 program. Findings from these data will be reported on by the STYLE 2.0 project team in the future.



Early qualitative interviews described the importance of working with HCN “that look like me” (i.e., were of the same race and gender identity) and the creation of a virtual community to share common experiences, advice, opinions, and discussions about current events.

“Without the Health Care Navigator, I could say there’s a lot of times since I’ve been home that I almost gave up and wanted to go back to prison and do the rest of my time so I could get out of parole because of how hard it was. The Health Care Navigator was one of the people who helped me talk myself out of it. I gained too much to try to give up like that.”

- STYLE 2.0 participant

Lessons learned/best practices:

Throughout the entire program, Young Adult Advisory Board (YAB) oversight helped ensure community weigh-in on STYLE 2.0 components including recruitment materials, support group structure, and STYLE 2.0 app content. Creating a community was an important aspect of the program for both the YAB participants and the program participants.

Word-of-mouth community campaigns were critical for program enrollment, and HCN exposure to clinic staff led to strong program support from the entire clinic. In addition, in-person clinic recruitment with a warm handoff yielded the highest chance of enrollment in the program. Virtual warm handoffs proved effective as well, especially between the HCN and the BHP.

While STYLE 2.0 was designed to include virtual components, the coronavirus disease 2019 (COVID-19) public health emergency forced all

aspects of the program completely virtual. In response, STYLE 2.0 project staff created virtual protocols for recruitment, enrollment, and support groups that will be disseminated to allow other organizations to replicate the project for individuals who are unable to attend in-person activities.



REFERENCES

- 01** Hightow-Weidman, L. B., Smith, J. C., Valera, E., Matthews, D. D., & Lyons, P. (2011). Keeping them in “STYLE”: finding, linking, and retaining young HIV-positive black and Latino men who have sex with men in care. *AIDS patient care and STDs*, 25(1), 37-45.
- 02** Rotheram-Borus, M. J., Swendeman, D., Comulada, W. S., Weiss, R. E., Lee, M., & Lightfoot, M. (2004). Prevention for substance-using HIV-positive young people: telephone and in-person delivery. *Journal of acquired immune deficiency syndromes (1999)*, 37(Suppl 2), S68-S77.
- 03** Dasgupta, S., Oster, A. M., Li, J., & Hall, H. I. (2016). Disparities in consistent retention in HIV care — 11 states and the District of Columbia, 2011-2013. *MMWR morbidity and mortality weekly report*, 65, 77-82.
- 04** Jeffries, W. L., IV, Dailey, A. F., Jin, C., Carter, J. W. Jr., & Scales, L. (2020). Trends in diagnosis of HIV infection, linkage to medical care, and viral suppression among men who have sex with men, by race/ethnicity and age — 33 jurisdictions, United States, 2014–2018. *MMWR morbidity and mortality weekly report*, 69, 1337–1342. DOI: <http://dx.doi.org/10.15585/mmwr.mm6938a1>
- 05** Halkitis, P. N., Parsons, J. T., Wolitski, R. J., & Remien, R. H. (2003). Characteristics of HIV antiretroviral treatments, access and adherence in an ethnically diverse sample of men who have sex with men. *AIDS care*, 15(1), 89-102.
- 06** Rotheram-Borus, M. J., Swendeman, D., Comulada, W. S., Weiss, R. E., Lee, M., & Lightfoot, M. (2004). Prevention for substance-using HIV-positive young people: telephone and in-person delivery. *Journal of acquired immune deficiency syndromes (1999)*, 37(Suppl 2), S68-S77.
- 07** Parsons, J. T., Rosof, E., & Mustanski, B. (2008). Medication adherence mediates the relationship between adherence self-efficacy and biological assessments of HIV health among those with alcohol use disorders. *AIDS and behavior*, 12(1), 95-103.
- 08** Parsons, J. T., Rosof, E., & Mustanski, B. (2007). Patient-related factors predicting HIV medication adherence among men and women with alcohol problems. *Journal of health psychology*, 12(2), 357-370.
- 09** Whetten, K., Reif, S., Swartz, M., Stevens, R., Osterman, J., Hanisch, L., & Enron, J. J., Jr. (2005). A brief mental health and substance abuse screener for persons with HIV. *AIDS patient care and STDs*, 19(2), 89-99.
- 10** Pence, B. W., Gaynes, B. N., Whetten, K., Eron, J. J., Jr., Ryder, R. W., & Miller, W. C. (2005). Validation of a brief screening instrument for substance abuse and mental illness in HIV-positive patients. *Journal of acquired immune deficiency syndromes (1999)*, 40(4), 434-444.



PROJECT SILK INTERVENTION



PROJECT VOGUE

GAY MEN'S HEALTH CRISIS, INC.



FUNDING STATEMENT

This intervention was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$975,000 with 100 percent funded by HRSA/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

LOCATION

New York, NY

RESOURCES

To learn more about the intervention and how to replicate it, visit <https://targethiv.org/BlackMSM>

CONTACT INFORMATION

Armstrong Tingwane, M.Phil.

GMHC, Principal Investigator

307 West 38th Street, New York, NY 10018

Email: armstrongT@gmhc.org

Phone Number: (212) 367-1521





INTERVENTION SUMMARY

GMHC was founded in 1982 as the world's first response to the disease ravaging gay communities in New York City (NYC). Since then, the agency has grown into a robust and nationally recognized AIDS and HIV service organization that serves more than 12,000 clients annually. The agency adapted and implemented Project Vogue, a three-year program in NYC that ran from August 2019 through November 2021. Enrollment of new clients ended in December 2020. This program served individuals who identify as Black men who have sex with other men (BMSM) ages 18-45, living with HIV, who were newly diagnosed/new to care, not in care, not virally suppressed, and/or at risk of falling out of care. BMSM is inclusive of transgender males/gender non-conforming individuals who have sex with men. Project Vogue served clients in two groups: those clients from the House and Ball (H&B) community and those who were non-H&B community members.

GMHC adapted the Project Vogue intervention from Project Silk, a recreation-based intervention that provides sexual health-related services in a stigma-free space for Black LGBT individuals. Similarly, GMHC's Project Vogue adaptation provided intensive, community-based care coordination services and integrated HIV medical care and behavioral health care for BMSM. Project Vogue aimed to increase viral load suppression and improve the longevity, quality of life, and other health outcomes for BMSM. The intervention also worked to mitigate the effects of

behavioral health conditions on health outcomes and improve clients' retention in HIV care and medication adherence.

As an active and leading member of NYC's social service community, GMHC supplemented its onsite services through partnerships with dozens of other agencies, enabling clients to receive specialized care where it helped them most. For Project Vogue, GMHC created specific formal linkage agreements with four main community partners to meet program goals: Mount Sinai Hospital System, Callen-Lorde Community Health Center, Ryan Community Health Center (Ryan Health), and Housing Works. However, clients also received care from more than 24 other medical, behavioral health, and social services providers in NYC.



RATIONALE & NEED

GMHC has a long history of working with BMSM in the community through a variety of culturally and contextually relevant programs. Through this work, GMHC recognized that while BMSM need GMHC's services – especially HIV/STI care, behavioral health services, basic benefits, and housing assistance – it is challenging to formally engage them in such services. In part, this may be from past experiences of discrimination due to behavioral health issues, homophobia and racism, lack of trust in mainstream medical providers, and perceived lack of need for services.

“I think men of color need more representation...and I don't want to feel like when I go to a regular hospital. I feel different than when I go to an HIV clinic that is predominantly for people of color.”

-Project Vogue Client

Through its more than 35 years of experience in service provision, GMHC also found that many clients struggle to enter a high-intensity service environment and require a low-threshold experience that enables them to adjust to accessing such care, and benefit from peer-led support.



As such, GMHC launched Project Vogue to specifically address the unique needs of BMSM clients through a peer-based, low-threshold model of care coordination which worked with clients at varying levels of readiness to engage in care, or “met clients where they are at,” and used evidence-based techniques—e.g., peer support, motivational interviewing, and counseling—to reduce fear and improve client self-efficacy. Project Vogue also provided enhanced outreach and screening to BMSM and fostered improved health outcomes by augmenting the agency's existing services with a suite of social work-informed support services to address emotional, practical, and clinical factors that impact clients' ability to engage and maintain treatment.

Project Vogue's model posited that by combining these service elements of community-based care coordination described above, together with a strong peer-based support, there was a higher chance of mitigating the structural, clinical, and individual level factors that prevent effective engagement in HIV and behavioral health care for BMSM. The model was not prescriptive and was tailored for each unique client's needs, which

IMPLEMENTATION

helped it stand out from more traditional intensive case management models.

Project Vogue was a 12-month intervention that used a Program Coordinator (PC) and Peer Navigation Ambassadors (PNAs) to provide HIV navigation and support services. Each client was exposed to five core and optional non-core elements which are described below:

Intake and Enrollment: During intake and program enrollment, clients completed the GMHC comprehensive behavioral risk assessment (CBRA), which profiled the status of the client's need for HIV treatment and medical care, behavioral health and substance use services, and supportive services. **The assessment also contained following tools: PHQ2, GAD2, and CAGE-AID.**



Individual Counseling Session #1: Following the intake assessment, the PNA or designee initiated a relationship with the client and created an individualized action plan based on the outcome of the assessments and an analysis of the client's unmet needs. If appropriate, this included making referrals to behavioral health care or substance use services.

Individual Counseling Session #2 (month 6) and #3 (month 12): The two other Individual Counseling Sessions followed a similar format to the first with slight variations; these included reviewing client medical records, assessing progress of the client's action plan, and making updates where applicable. PNAs also conducted re-assessments, including of the clients' HIV Primary Care Status Measures (PCSM) every six months. The final Individual Counseling Session also included wrap-up and the development of an exit strategy to discharge the client from the intervention.

HIV Navigation Services: The heart/core service of the model of care (MOC) involved continuous provision of HIV navigation services (HNS). HNS were initiated during completion of the individualized action plan in the first Individual Counseling Session. Through HNS, the PNA/PC helped clients address emotional, cultural, and other sources of hesitance to attaining optimal care, support, and remaining stable as identified during the initial assessments. This support was provided through regular check-ins in-person or virtually. **At a minimum, the PNA conducted four one-on-one check-ins with the client every six months via secure text messaging, direct messaging, phone, or in person.**

GMHC integrated a HIPAA-compliant mobile app called GET! to support HNS. It was acquired through GMHC's partnership with New York State's AIDS Institute. The app was chosen to primarily enhance staff-to-client engagement, facilitate secure conversations about medically sensitive data, track key milestones, and generate appointment reminders for medical and behavioral health services. Some of the core components of the app include medication adherence messages and tracking, appointment scheduling, educational materials, and secure personal messaging between program staff and the app users (clients). Non-core elements of the intervention included weekly H&B sessions, voguing classes, arts and wellness classes/activities, and a bi-weekly empowerment group. Project Vogue staff strongly encouraged clients to take part in these activities to promote artistic and self-expression.

FINDINGS

Project Vogue had

- **80** clients enrolled
- **3,336** encounters in all GMHC associated services
- an average of **41.7** encounters per client

Clients often concurrently received services through different programs at the agency due to the design of this MOC, and how it fit into the agency's mission to assist clients holistically with a range of wrap-around services.



The coronavirus disease 2019 (COVID-19) public health emergency significantly altered the way all GMHC programs were implemented. GMHC remained in lock-down and all staff worked from home for more than half of the program period. This made contacting clients difficult because clients could no longer utilize the “drop-in” space at GMHC, and many clients no longer had reliable access to internet. Clients also changed their phone numbers or other methods of contact more frequently, due to financial hardship or other instabilities in their lives. This caused delays in staff engaging with clients, required multiple efforts, creativity, and “hope” that a client would respond back to help them remain engaged in care.

GMHC also learned that traditional work hours do not always work for engaging clients, so the program had to be flexible with staff hours to accommodate this situation.

GMHC also observed how HIV, homosexuality, and mental health stigma negatively affected participation in traditional, clinical behavioral health services. Clients were more responsive to the low threshold services, such as support/empowerment groups and supportive counseling which incorporated motivational interviewing techniques.

To enhance collaboration with community partners, GMHC also learned that fostering client-facing and peer-to-peer relationships with external partners was a sustainable process. Implementing partners should not only rely on formal memoranda of understanding (MOUs), but also strive to ensure client-facing staff receive adequate support for effective client engagement across the continuum of care when collaborating with peers based at partner agencies.

The success of Project Vogue relied on long term support of clients by their PNAs. However, the agency experienced high turnover of these peers. To mitigate this, the agency created a

tangible support process of professional growth opportunities for peers. This included getting more resources to increase their work hours or become full time staff so they could enjoy more benefits and growth. This brought some stability and reduced stress into their lives (housing, finances, etc.), so they could perform better without being distracted by many other challenges outside of work.



REFERENCES

- 01** His Health. Project Silk. NASTAD. <https://www.hishealth.org/models-of-care/project-silk>
- 02** National HIV Curriculum. Patient Health Questionnaire-2 (PHQ-2). University of Washington. <https://www.hiv.uw.edu/page/mental-health-screening/phq-2>
- 03** National HIV Curriculum. Generalized Anxiety Disorder 2-item (GAD-2). University of Washington. <https://www.hiv.uw.edu/page/mental-health-screening/gad-2>
- 04** National HIV Curriculum. CAGE-AID Questionnaire. University of Washington. <https://www.hiv.uw.edu/page/substance-use/cage-aid>

