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

Implementation Manual

Authors

Friends Research Institute

***Building Brothers Up* (*2BU*) Team**

Kimberly A. Kisler, PhD, MPH
Research Scientist
Principal Investigator
Cathy J. Reback, PhD
Senior Research Scientist
Co-Investigator
Jesse B. Fletcher, PhD
Research Scientist
Evaluator & Data Manager

Bill Le
Program Coordinator
Peer Case Manager
Eric Scott
Peer Case Manager
Prudence Mendiola
Research Assistant
Cur'Shauna Wyatt, MPH
Intern

Acknowledgements

The *Building Brothers Up* (*2BU*) team wishes to thank our Community Advisory Board (CAB) members for giving their time and input, and our participants for remaining committed to this program in the midst of the coronavirus disease 2019 (COVID-19) pandemic and overarching civil unrest. We would also like to thank our collaborating partners, particularly AIDS Healthcare Foundation, APLA Health, Charles R. Drew University/OASIS Clinic, and the Los Angeles LGBT Center, who forged strong relationships with our team allowing for the seamless hand-off of our *2BU* participants to much-needed HIV clinical, behavioral health, and other support services. Finally, we would like to dedicate this project to Shelton Spencer, a tireless advocate, important community gatekeeper, and fierce warrior for the communities we serve. In his memory, we vow to continue his work with the same spirit, passion, and empathy that he embodied.

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 authors and do not necessarily represent the official views of, nor an endorsement by, HRSA/HHS, or the U.S. Government.

Suggested Citation

Friends Research Institute. Implementation Manual. Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who have Sex with Men Initiative. 2022. Available at: https://targethiv.org/

Table of Contents

Background 5
Introduction 5
Intervention Overview 6
  Demonstration Site Background 6
    Needs Assessment 6
  Adapted Model of Care 8
    Original MOC 8
    Adaptations 9
  Population Served 9
    Initiative Eligibility Criteria 9
    Friends Research Institute-Specific Eligibility Criteria 10
Pre-Implementation Activities 11
  Organizational and Community Resources 11
  Partnerships 12
    Internal Partnerships 12
    External Partnerships 12
  Staffing and Supervision Model 13
    Staffing Roles 13
    Recruitment and Hiring 15
    Staff Training and Continuing Education 15
    Clinical Supervision 15
  Marketing and Promotion 15
Local Evaluation 16
  Local Evaluation Overview 16
    Local Brief Assessment 16
    Local Evaluation Assessment 17
  Logic Model 18
Implementation Activities 19
  Outreach and Recruitment 19
  Core Components 19

Behavioral Health Integration 21
Additional Adaptations 22
COVID-19 Adaptations 22
Costs 24
Intervention Outputs and Outcomes 24
Intervention Outputs 24
Intervention Outcomes 25
Lessons Learned and Best Practices 26
Implementation 26
Evaluation 28
Dissemination Activities 29
To Learn More 29
Contact Information 30

Background

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

The intervention outlined in this Implementation Manual was part of the *Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who have Sex with Men (BMSM)* Initiative (otherwise known as the "BMSM Initiative"). This HRSA Special Projects of National Significance (SPNS) Initiative was funded by the HRSA RWHAP Part F. The *Building Brothers Up* (*2BU*) intervention was implemented by Friends Research Institute based in Los Angeles, California, and the intervention was conducted and evaluated as part of a RWHAP SPNS-funded site. SPNS supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by the RWHAP. SPNS advances knowledge and skills in the delivery of health care and support services to underserved populations with HIV. Through its demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

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

Introduction

This Implementation Manual provides guidance on how to adapt and implement Friends Research Institute's *Building Brothers Up* (*2BU*) in order to facilitate future replication. Among other things, this Manual describes the selected MOC and adaptations, pre-implementation activities, local evaluation, intervention components and implementation experiences, and intervention outputs and outcomes. This Manual also shares lessons learned and best practices to support successful replication of intervention components.

This Manual is designed to provide a broad, concise overview of *2BU* to a diverse audience of clinical leadership, HIV service providers, and other stakeholders interested in identifying and implementing new, innovative strategies for improving care for BMSM with HIV and other populations in their communities. More detailed information, including resources and tools for future replicators, can be found in the Implementation Toolkit (see the appendices).

Intervention Overview

Demonstration Site Background

Friends Research Institute, Inc. (FRI) is a 501(c)(3), private, non-profit corporation established in 1955. Friends Community Center (FCC), a division of Friends Research Institute, is the community research center, located on the border of Hollywood and West Hollywood in Los Angeles County (LAC), where *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, and transgender women, all of whom are experiencing multiple health disparities. The goal of FCC is to reduce HIV transmission and acquisition as well as the risks that can result from substance use.

For this proposed project, FRI established Memoranda of Understanding (MOUs) with the following four community clinics to provide HIV medical care, behavioral health, and support services: AIDS Healthcare Foundation (AHF), APLA Health, Charles R. Drew University/OASIS Clinic, and the Los Angeles LGBT Center.

Needs Assessment

The Centers for Disease Control and Prevention (CDC)[1,2] reports that relative to men who have sex with men (MSM) from other racial/ethnic backgrounds, Black men who have sex with men (BMSM) in the U.S. have higher HIV prevalence, incidence, lower rates of linkage to and retention in HIV care, and are less likely to have achieved full viral suppression. The CDC further estimates that 20 percent of BMSM with HIV are not yet aware that they are infected, a higher rate than is observed among non-BMSM. Explicit efforts to curb these trends have evidenced limited success; BMSM still account for more HIV diagnoses than any other group in the U.S., and HIV incidence rates have remained stable among BMSM since 2010.

---

[1] Centers for Disease Control and Prevention. HIV and African American Gay and Bisexual Men. National Center for HIV, Viral Hepatitis, STD, and TB Prevention—Division of HIV Prevention. Atlanta, GA; 2022. Available from: https://www.cdc.gov/hiv/group/msm/bmsm.html [Last accessed: 4/10/2022].

[2] Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection – Medical Monitoring Project, United States, 2019 Cycle (June 2019-May 2020). HIV Surveillance Special Report 28. Atlanta, GA; 2021. Available from: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html [Last accessed: 4/10/2022].

As revealed by the Los Angeles County Comprehensive HIV Plan 2017-2021,[3] disparities between BMSM and MSM from other racial/ethnic backgrounds are accentuated in Los Angeles County (LAC), where BMSM comprise less than 1 percent of the general population but 15 percent of all annual HIV infections. Evidence demonstrates 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).

However, explicit efforts to improve health outcomes among BMSM have yielded limited results and significant deficits persist. In LAC, BMSM fare poorer than other MSM for HIV Care Continuum outcomes - only 65 percent of BMSM 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 (compared to 59 percent among MSM overall), and only 48 percent have achieved full viral suppression (compared to 61 percent among MSM overall).[4] These data have led LAC to identify BMSM as a priority population in the plan for Ending the HIV Epidemic in Los Angeles County.[5] Therefore, *2BU* aimed to address the disparities among BMSM in LAC by providing a peer case management intervention to assist this target population in advancing across the HIV Care Continuum.

---

[3] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021). Los Angeles, CA 2016. Available from: http://publichealth.lacounty.gov/dhsp/Reports/Publications/LAC-Comprehensive-HIV-Plan2017-2021.pdf [Last accessed: 4/10/2022].

[4] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021). Los Angeles, CA 2016. Available from: http://publichealth.lacounty.gov/dhsp/Reports/Publications/LAC-Comprehensive-HIV-Plan2017-2021.pdf [Last accessed: 4/10/2022].

[5] Los Angeles County Department of Public Health, Division of HIV and STD Programs. Ending the HIV Epidemic in Los Angeles County: 2020-2025. Los Angeles, CA; 2019. Available from: https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf [Last accessed: 4/10/2022].

Adapted Model of Care

Original MOC

As noted above, each recipient adapted and implemented one of four evidence-informed MOCs expected to improve linkage to care, engagement in care, retention in care, and HIV health outcomes and address the comprehensive needs of BMSM with HIV. All of the MOCs were originally developed to improve HIV care and treatment and/or HIV health outcomes for youth and/or adult men of color. FRI adapted a ***youth-focused case management*** intervention.[6] Key components of the original MOC include: two Bachelors-level case managers; clinic- and venue-based outreach; a 24-month intervention; and provision of psychosocial case management services. The following table briefly describes the implementation process of *Youth-focused case management*.

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

[6] Wohl AR, Garland WH, Wu J, et al. A youth-focused case management intervention to engage and retain young gay men of color in HIV care. AIDS Care 2011;23(8):988-97; doi: 10.1080/09540121.2010.542125.

Adaptations

To meet the current needs of BMSM in LAC, adaptations were made to the original MOC, *Youth-focused case management*. Adaptations were proposed, workshopped, and finalized in concert with the Community Advisory Board (CAB). Engaging a CAB comprised of BMSM with HIV, *2BU* participants, respected community gatekeepers, and service providers working with the community was important for the adaptation process. The CAB met twice during the formative phase and then twice a year for the remainder of the project. The CAB was instrumental in refining the adaptations, choosing a name for the intervention, designing the logo and promotional materials, refining outreach and recruitment strategies, identifying candidates for staffing, and promoting *2BU* within the larger community. For future replication of this MOC, it is important that a CAB be actively engaged in the adaptation process as well as the implementation of the intervention.

Please see Table 1 for an overview of adaptations made.

Table 1: Adaptations made to MOC

Adaptation	***Youth-focused case management***	***Building Brothers Up (2BU)***
Target population	Latino and Black MSM	Black MSM
Age	13-23 years	18-65 years
Intervention staff	Bachelors-level case managers	Peer case managers
Intervention location	Clinical site	Community research site
Intervention design	Implemented over a 24-month span	Implemented over a 3-month span

Population Served

Initiative Eligibility Criteria

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

- HIV positive;
- Aged 13 and older;
- Identify as a BMSM (including cisgender men, transgender men, and gender non-conforming individuals assigned male at birth); and

- Fit into one of the following categories:
  - Newly-diagnosed/new to care;
  - Never entered into care;
  - Fallen out of care;
  - At risk of falling out of care; and/or
  - Not virally suppressed.

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

Friends Research Institute-Specific Eligibility Criteria

- BMSM (self-identified);
- Aged 18-65 years;
- HIV-positive serostatus that could be verified*;
- Not engaged in care (had not had two or more HIV medical care appointments at least 90 days apart in the past 12 months, and/or had not had an undetectable viral load in the past 12 months);
- Engaged in care (had two or more HIV medical care appointments at least 90 days apart in the past 12 months and had an undetectable viral load in the past 12 months) but is at risk for falling out of care defined as:
  - Had been incarcerated within the last 12 months, and/or
  - Had been unemployed for at least three months within the last 12 months, and/or
  - Had experienced housing instability [in the past 12 months, had spent at least one night in a homeless shelter or transitional shelter, and/or on the street or other outdoor public place, and/or in an abandoned building, and/or in a car or other vehicle, and/or at a friend's or family member's on a temporary basis, and/or in a sober living or recovery program or drug treatment program, and/or in a jail or prison], and/or
  - Had been diagnosed with a STI in the past 12 months, and/or
  - Had little interest or pleasure in doing things and/or had felt down, depressed, or hopeless within the past two weeks, and/or
  - Had five or more drinks in a day at least once within the past 12 months, and/or
  - Had used marijuana, another street drug, and/or prescription medication "recreationally" at least once in the past 12 months, and/or
  - Had a negative experience with an HIV healthcare provider or clinic staff in the past 12 months;

- Resided in LAC;
- Willing and able to provide informed consent; and
- Willing and able to comply with project requirements.

*To verify that a potential participant was HIV-positive, he had to provide a diagnosis form or other medical documentation such as laboratory results or an ART prescription.

Pre-Implementation Activities

Organizational and Community Resources

FCC is the only community-oriented agency in LAC that has continually focused on addressing the behavioral health needs of MSM, including BMSM, in a highly impacted region of LAC with the goal of reducing HIV transmission rates and improving HIV treatment outcomes. Further, FCC is the only high tolerance behavioral center in the region; when other agencies refuse to see a participant who exhibits poor hygiene often due to housing instability, and is disruptive or otherwise difficult to provide services to, often due to mental health co-morbidities and/or substance use, FCC is always there to address the behavioral needs that are a barrier to accessing services. As many FCC participants have said, "[FCC is] the last shop on the block." Overall, a combined history of consistent, targeted service delivery and a "higher tolerance" organizational environment significantly enhanced participant enrollment and retention in *2BU*.

Additionally, a CAB comprised of MSM, both HIV-positive and HIV-negative, has been actively involved in the program design, implementation, and quality management for all FCC programs, including *2BU*. This has resulted in programming that is appropriately tailored to the wants and needs of the community and has established community "buy-in" for current and proposed programs.

Partnerships

Internal partnerships as well as external partnerships are paramount to the successful implementation of *2BU*.

Internal Partnerships

As a community research site, FCC implements both research studies – funded through various federal, state, and local mechanisms – and non-clinical service programs. Having programs on-site that deliver much-needed services to participants such as health education and risk reduction, HIV testing, outpatient substance use treatment, and programming that offers hot meals and hygiene supplies, provides an opportunity for participants to take advantage of several co-located programs that may benefit their overall health and well-being. To ensure referrals from other service programs at FCC, the *2BU* team introduced the project to all staff prior to implementation, and then consistently updated all organizational staff about project progress and opportunities for participation. Further, the *2BU* team communicated often with staff in other FCC programming that work with BMSM to help facilitate "warm hand-offs" between programs.

External Partnerships

As FCC is a non-clinical site, formal partnerships with four medical clinics that provide HIV primary care and behavioral health services were essential to the success of the project. MOUs were established prior to implementation with each clinic to determine a process for seamless entry into HIV care and behavioral health services (e.g., simple and timely process ["red carpet treatment"] for making an appointment, facilitating a "warm hand-off" to clinical staff, connecting participants to resources through the partnering clinic to facilitate access to care, such as transportation vouchers, etc.). Partnering HIV clinics also assisted with promotion of and referral to *2BU* for existing BMSM patients who could benefit from the peer case management intervention. Please see the Implementation Toolkit for a sample of an MOU established with an HIV medical care clinic.

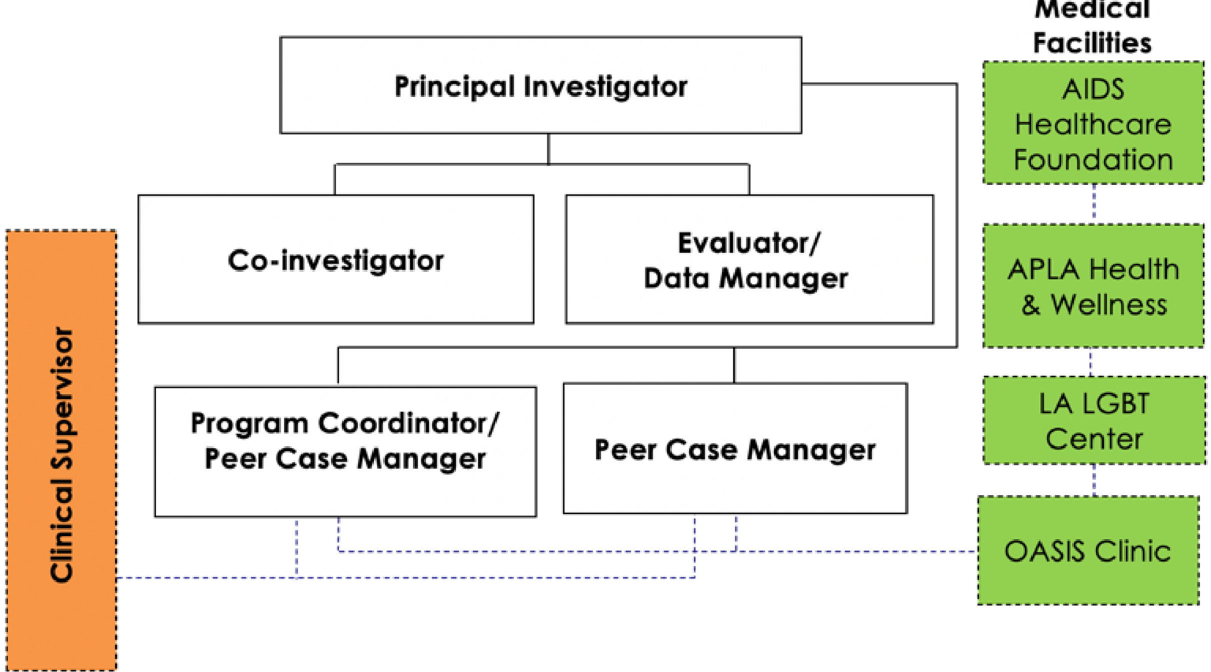
In order to remain knowledgeable about culturally appropriate agencies and services, and to maintain personal relationships with our community partners, including partnering HIV clinics, *2BU* staff made site visits to agencies, in pairs of two, on an ongoing basis throughout the implementation of *2BU* to promote the project as well as build and maintain strong relationships with community partners. This also allowed for *2BU* staff to build a robust resource list to which *2BU* participants could be referred for behavioral health and other support service needs.

Staffing and Supervision Model

Staffing Roles

Please see Figure 1 for an overview of *2BU* staffing.

Figure 1: 2BU Staffing Overview



The responsibilities of core intervention staff are described below.

Principal Investigator (PI): The PI was responsible for the overall management of the project; project implementation; participant safety; overseeing all program management tasks; assisting with staff hiring and training; facilitating CAB meetings; working with the Co-Investigator (Co-I), Project Coordinator, Evaluator/Data Manager, and CAB in the interpretation of findings; working with the Co-I and Evaluator/Data Manager in preparation of conference presentations and manuscript development.

Co-Investigator (Co-I): The Co-I shared many of the PI responsibilities. Please see the above description for PI for an overview of Co-I responsibilities.

Project Coordinator: The Project Coordinator was responsible for the day-to-day operations of the project; assisting with staff hiring and training; supervising and coordinating all project activities; overseeing program monitoring activities including program performance indicators; reviewing participant files for quality assurance; conducting in-service trainings at local CBOs and networking with community gatekeepers to enhance community awareness of *2BU*; substituting for absent Peer Case Manager; maintaining all program and intervention supplies; working with the CAB and project staff on the development and implementation of project materials; participating in CAB meetings; working with the PI, Co-I, Evaluator/Data Manager, and CAB in the interpretation of findings.

Peer Case Manager: The Peer Case Manager was responsible for recruiting and screening potential participants for the project; opening consent; administering assessments; providing peer case management to BMSM with HIV through the six-session *2BU* intervention; linking all BMSM with HIV who are not currently in HIV care to HIV care; linking BMSM with HIV to up-to-date and culturally appropriate behavioral health and other support services; maintaining fidelity to the *2BU* intervention protocol; maintaining accurate and complete participant files; maintaining accurate written reports and logging all program activities; maintaining accurate and complete up-to-date, culturally appropriate referral list; attending CAB meetings.

Evaluator: The Evaluator was responsible for overseeing all aspects of the program evaluation including operationalizing process and outcomes indices analysis, design, and revision; working with the PI, Co-I, Project Coordinator, and CAB in the interpretation of findings; working with the PI, Co-I, and Data Manager in preparation of conference presentations and manuscript development.

Data Manager: The Data Manager was responsible for overseeing all aspects of data management; working with the PI, Co-I, Project Coordinator, and CAB in the interpretation of findings; working with the PI, Co-I, and Evaluator in preparation of conference presentations and manuscript development.

Clinical Supervisor (Consultant): The Clinical Supervisor was responsible for providing clinical supervision and consultation on the project; consulting with Project Coordinator and Peer Case Manager on participants' treatment plans and psychological and behavioral barriers to HIV care; answering questions and addressing concerns regarding participants' treatment experiences and/or mental health and/or issues related to their behavioral barriers; reviewing, discussing, and problem-solving with the Project Coordinator and Peer Case Manager regarding current caseloads.

Recruitment and Hiring

Hiring a Peer Case Manager with a lived experience that is similar to the participants is an important part of the pre-implementation process. To cast a wide net to identify qualified candidates, we advertised on a number of job search websites, attended local CABs that included and/or targeted BMSM to promote the job openings, promoted within our own MSM CAB, advertised on local listservs that catered to members of and service providers to the larger BMSM community, and conducted targeted outreach to local service providers who work with BMSM.

Staff Training and Continuing Education

Upon hire, all staff received a six-to-eight week multi-tier training consisting of: (1) in-house trainings by senior staff followed by quality assurance checks through field observations, role plays, and mock assessments (e.g., Outreach Safety & Strategies, *2BU* enrollment procedures, peer case management sessions, assessment delivery); and (2) outside presentations and webinars provided by community professionals such as the local AIDS Education and Training Center and the California STD/HIV Prevention Training Center (e.g., Human Research Ethics, HIPAA, Good Research Practices, Data Quality Assurance, HIV/AIDS 101, ABCs of Hepatitis, STD 101, Motivational Interviewing, Dealing with Difficult Clients).

Clinical Supervision

The knowledge and ability to adequately support and case manage BMSM with HIV, especially for peer staff, can be challenging. To reduce burnout and provide the resources necessary to support peer staff so they can best serve the *2BU* participants, clinical supervision was provided by a PhD-level professional to the Project Coordinator and Peer Case Manager on a bi-weekly basis.

Marketing and Promotion

To identify a name for the intervention that embodied the spirit of the community, the CAB was utilized to generate ideas and then select and refine a project name. Through an iterative process, the members of the CAB decided on the name "*Building Brothers Up*" and specifically suggested that the project be called "*2BU*."

Once the name was created, a logo needed to be designed that felt authentic and genuine to the community served by *2BU*. To generate ideas, the website www.ZillionDesigns.com was used, whereby we described the project and target audience and then graphic designers from across the globe submitted ideas for a logo. The *2BU* team then selected five designs and brought those designs to the CAB to select the best design and solicit suggestions on ways to improve the design (i.e., color, font). After we had selected the graphic designer from the website with whom we wanted to work, we utilized iterative feedback from the CAB to refine a final logo.

Once the name and logo were finalized, the *2BU* team worked with a local graphic designer who was familiar with the BMSM community to design three recruitment materials: a recruitment flyer; a postcard; and a business card. Marketing materials were refined over a few months using feedback from the *2BU* team, and then the near-final materials were presented to the CAB for further feedback. To view these three recruitment materials, please see the Implementation Toolkit. Recruitment materials were shared both in-person and electronically with local service providers, advertised on FCC social media, placed in outreach kits for FCC staff who conduct street- and venue-based outreach, placed in print and electronic media, and posted in local spaces that cater to BMSM (e.g., bars, food lines, barbers).

Local Evaluation

Local Evaluation Overview

The local evaluation consisted of two separate components: 1) a Local Brief Assessment that occurred at each of the six peer case management sessions; and 2) a Local Evaluation Assessment, which occurred only at baseline, 6-, and 12-months post-enrollment.

Multisite Evaluation

The MSE assessed implementation processes, intervention services and client-level outcomes, and intervention costs. Self-reported client survey data, encounter data, and clinical outcomes data collected for the MSE were available for analysis in local evaluations.

Local Brief Assessment

The Local Brief Assessment included the Needs and Barriers Assessment (NBA- please see the Implementation Toolkit for a copy of this tool), the Patient Health Questionnaire depression scale (PHQ-8), and the Syndemic Health Index, which were administered at each peer case management session (i.e., weekly for the first month, and monthly for months two and three), for a total of six assessments per participant. The NBA was adapted by the Co-I in 2012 from a CDC-funded risk counseling program to be used in an earlier HRSA-funded SPNS demonstration project, and has since been utilized in several case management programs at FCC. Collected via a tablet, the Local Brief Assessment was designed to assess immediate changes in needs and barriers associated with linkage and retention in HIV care as well as HIV medication adherence to reach and sustain full viral suppression. Many of the needs and barriers assessed were representative of the sundry health disparities facing BMSM which serve as obstacles to proper

HIV primary care including: food scarcity, unstable housing, lack of transportation, etc. Additionally, the Local Brief Assessment included the PHQ-8, allowing for collection of the same depression data reported at baseline, 6- and 12-months for the MSE. Depression is known to be associated with increased HIV transmission risk behaviors among BMSM, and is additionally associated with HIV primary care non-adherence among MSM generally. Such factors serve as syndemic health disparities which are critical in understanding HIV primary care outcomes among BMSM, and were thus necessary targets of assessment for *2BU*. At the completion of each Local Brief Assessment, the participant received a $20 gift card to thank them for their information and time.

Local Evaluation Assessment

The Local Evaluation was an assessment explicitly designed to make meaningful comparisons between the original primary outcomes of the *Youth-focused case management* MOC and *2BU*, and to fill any gaps in variables of interest not otherwise assessed in the MSE. Variables within the Local Evaluation included psychosocial characteristics (e.g., general and HIV-specific self-efficacy), sexual risk behaviors (including condomless anal intercourse), substance use (drug and alcohol), and HIV testing and care history. Further, the Local Evaluation Assessment was self-administered by the participant via tablet/laptop in the same manner in which the MSE was administered and at the same time points (baseline, 6-, and 12-months post-implementation). Upon completion of each Local Evaluation Assessment, which was combined into a single questionnaire with the MSE, a participant received a $50 gift card to thank them for their information and time.

Logic Model

The Logic Model for *2BU* can be found in the figure below.

Building Brothers Up (2BU) Logic Model

Resources	Activities	Outputs	Outcomes	Impact
• ETAP • HRSA Funding & Program Officer • HIV collaborating agencies • Space & infrastructure • Community Advisory Board (CAB) • 1 Full-time Program Coordinator/Peer Case Manager • 1 Full-time Peer Case Manager • 1 Part-time PI • 1 Part-time Co-I • 1 Part-time Evaluator • 1 Part-time Data Manager • 1 Consultant (Clinical Supervisor)	***Formative Stage*** • Collaborate with ETAP to develop MSE materials • Develop protocols & procedures • Obtain IRB and other regulatory approvals • Conduct 2 annual CAB meetings ***Intervention Stage*** • Recruit BMSM with HIV • Screen 335 BMSM for eligibility • Consent and enroll 120 BMSM with HIV • Conduct the *2BU* case management intervention • Conduct baseline, 6-, and 12-month follow-up assessments as well as local brief assessments at each peer case management session • Compile, clean, & analyze data • Prepare Program Implementation Manual, Toolkit, Monograph, & other dissemination materials, manuscripts, presentations, & reports • Disseminate preliminary & outcome findings	***Formative Stage*** • Advertising materials (including print and digital geo-localized ads) • Outreach materials • Intervention adapted with CAB • Intervention refined through CAB oversight ***Intervention Stage*** • 120 enrolled BMSM with HIV • Minimum 85% (~102) follow-up rate at 6- and 12-month assessments and local brief assessments • ~20% (~24) BMSM will be newly diagnosed; of those, ~90% (~22) will be linked to HIV care within 3 months of diagnosis • ~20% (~24) will be BMSM diagnosed but not linked to HIV care; of those, ~90% (~22) will be linked to HIV care • ~60% (~72) BMSM with HIV already in HIV care will be retained in HIV care through 12-month follow-up • ~90% (~108) BMSM with HIV will be prescribed or retained on ART at the 12-month follow-up • ~90% (~108) BMSM with HIV will achieve a viral load <200 copies/mL at last test at the 12-month follow-up • 2 annual CAB meetings to disseminate preliminary results to the community	• ↓Behavioral health barriers to HIV primary care among BMSM • ↑ Linkage to HIV care among newly diagnosed BMSM with HIV • ↑ Re-engagement in HIV care among previously diagnosed BMSM with HIV who have dropped out of care • ↑ Initiation & adherence to ART among BMSM with HIV • ↑ Viral load monitoring among BMSM with HIV	• ↓ Behavioral health sequelae among BMSM with HIV • ↑ Sustained virological suppression among BMSM with HIV • ↓ HIV transmission among BMSM with HIV & their partners • ↑ Improved HIV care outcomes among BMSM with HIV • ↓HIV morbidity & mortality among BMSM with HIV in LAC • ↓ Health disparities between BMSM and other populations in LAC

Implementation Activities

Outreach and Recruitment

To ensure enrollment targets were met and a diversity of participants were enrolled, we utilized five proven recruitment strategies.

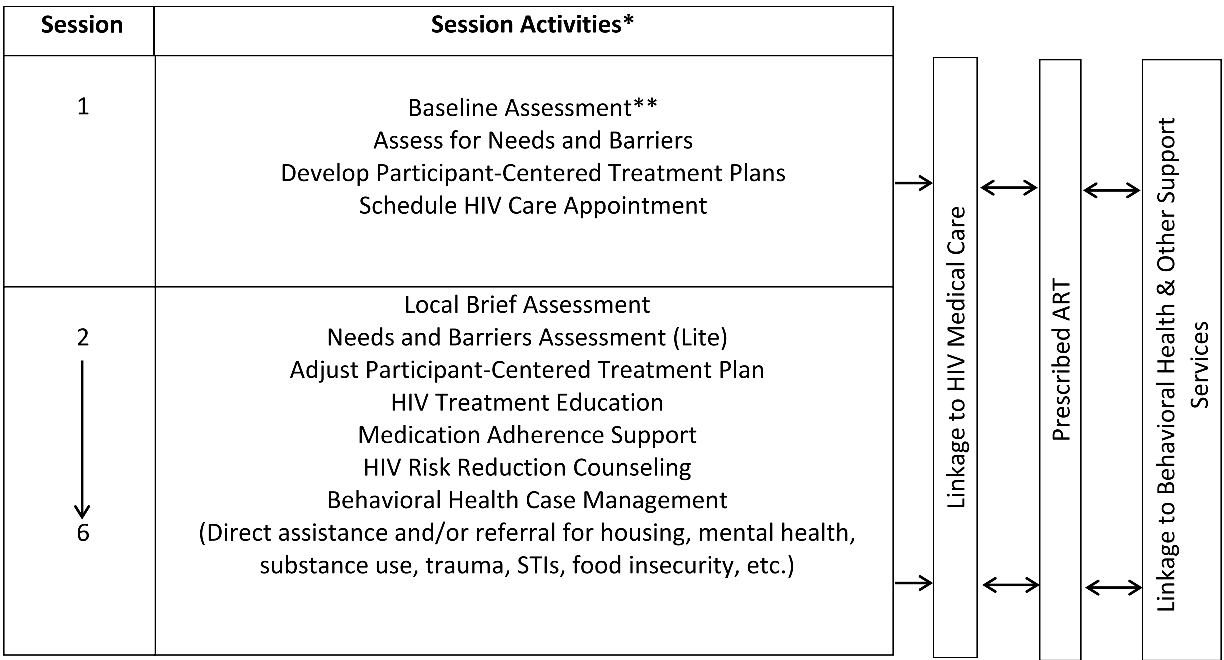
These recruitment strategies included:

1) **Online recruitment:** Online banner ads and digital flyers were placed through geo-mapping on websites and social media that target BMSM, and through local digital spaces;
2) Our logo and flyer were placed in **print media** for BMSM or that BMSM read (e.g., a program for a local LGBT chorus, local 'zine targeting BMSM);
3) **Street- and venue-based outreach:** *2BU* staff conducted street- and venue-based outreach identified through the CAB and ongoing community mapping at locations where BMSM congregate such as bars, clubs, food lines, and public libraries. Outreach was utilized to build and maintain ongoing trust and rapport with the population and, thereby, recruit into the project;
4) **Poster/Flyer Advertisement:** Project posters/flyers were posted at collaborating community-based organizations and other venues (which contained details about how to contact the Peer Case Manager for further information regarding the project);
5) **Participant-incentivized snowball recruitment:** Current participants were incentivized to recruit a maximum of three potential new participants from their social, sexual, and/or drug-using networks.

Core Components

2BU is administered across three months and includes a total of six sessions. The first four sessions are delivered weekly in month one, and sessions five and six are delivered monthly in months two and three, respectively. *2BU* is delivered by a Peer Case Manager. Please see Figure 2 below for an overview of the intervention delivery system.

Figure 2: Overview of Intervention Delivery System



*Sessions occurred weekly in the first month (Sessions 1-4), and monthly in the second and third months (Sessions 5-6).
**Baseline assessment included Patient Survey, Local Evaluation, and Local Brief Evaluation.

The initial session includes a detailed assessment of the participant's needs and barriers using the NBA (please see the Implementation Toolkit for a copy of this tool). The NBA was designed to be participant-centered, meaning the needs and barriers reviewed may focus on support and other services and may or may not be directly connected to HIV care. 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 are identified, the Peer Case Manager works with the participant to develop a Participant-centered Treatment Plan, which includes both short-term and long-term goals (please see the Implementation Toolkit for a copy of the Participant-centered Treatment Plan). The Participant-centered Treatment Plan identifies both long-term goals and short-term actions that must 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. For example, a participant may agree to attend a scheduled appointment while the Peer Case Manager may agree to research additional support services on behalf of the participant. Once the Participant-centered Treatment Plan is created, both the participant and Peer Case Manager sign the agreement to show commitment to the plan. A priority of the first session is to schedule an HIV care appointment for the participant if this is identified as a need.

During Sessions 2-6, the participant's needs and barriers are reviewed and re-assessed using a reduced version of the NBA called the NBA-Lite, and both parties once again agree to short-term action steps for the subsequent session. Additionally, the long-term goals identified in the Participant-centered Treatment Plan are revised, as needed. An integral component of all six sessions is 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 must be accessed at a partnering organization, the Peer Case Manager spends considerable time assisting the participant with making appointments, arranging for transportation, ensuring all documentation and required forms are in place, and facilitating a "warm hand-off" to an actual person at the partnering agency. Building strong, personal relationships with staff at partnering organizations and having protocols in place for "red carpet treatment" at a partnering organization are vital for the success of an intervention like *2BU* that is delivered at a non-clinical site.

Behavioral Health Integration

As a non-clinical community research site, FCC does not provide clinical or behavioral health services on-site. Therefore, *2BU* was designed to integrate behavioral health within *2BU* to ensure behavioral health needs are identified, participants are referred to needed services, and that services are accessed upon referral.

When behavioral health needs are identified through the NBA and at the peer case management sessions, the Peer Case Manager reaches out to partnering organizations to ensure "red carpet treatment" is given to the participant in terms of the ability to secure an appointment in a timely manner. To ensure a "warm hand-off" is made to a partnering organization for behavioral health services, the Peer Case Manager focuses a considerable amount of effort on cultivating relationships with behavioral health service providers that are well-liked and well-respected by members of the community. Relationships are often formalized with partnering organizations by establishing MOUs that detail procedures for making appointments, naming points of contact for seamless communication, and identifying additional support services and incentives available to participants to facilitate accessing behavioral health care at each organization. For *2BU*, four MOUs were established with local HIV care clinics that also provide behavioral health and other support services.

We also developed a thorough system of tracking behavioral health screening conducted via the NBA, and referrals made in order to ensure behavioral health appointments are accessed. Progress notes within each participant file help the Peer Case Manager keep track of referrals and appointments made and serve as a reminder to follow up with the participant at subsequent peer case management sessions about the referral or appointment. The efficient tracking of referrals and appointments made helps to ensure participants link and retain in needed services.

Additional Adaptations

COVID-19 Adaptations

Implementation of *2BU* began in October 2019 and continued uninterrupted with no further adaptations until the COVID-19 pandemic hit LAC. The original adapted intervention and all evaluation procedures were delivered completely in-person at the FCC site. However, once "safer-at-home" directives required all FCC staff to transition to remote work and the site closed, we worked to pivot *2BU* and the associated evaluation procedures to a fully remote/online (e.g., over the phone, on Zoom) modality of delivery. Once the FCC site opened back up, *2BU* was pivoted once again to a hybrid design which allowed participants to participate in intervention and evaluation activities either in-person, remote/online, and/or a combination of the two delivery modalities.

Please see Table 2 for details on the adaptations made to *2BU* in the wake of the COVID-19 pandemic.

Table 2: Overview of Adaptations Made to *2BU* Due to COVID-19

COVID-19 Impact		
Recruitment	Program Delivery	Evaluation & Data Collection
• Slight adjustments made to most of the original recruitment strategies to allow for full online/remote delivery: ○ Online recruitment: No adjustments made ○ Print media: Transitioned to online media since print media was less accessible ○ Poster/flyer advertisement: Shared digitally instead of as hard copies ○ Participant-incentivized snowball recruitment: Referrals were made remotely and incentives were delivered electronically • Street- and venue-based outreach ceased for several months due to "safer at home" orders. However, once in-person work was safe, outreach protocols were modified and safety measures were put in place to allow staff to safely conduct street- and venue-based outreach. • The screener for eligibility was originally delivered in-person or over the phone using a tablet. The flexibility in offering screening both in-person and remotely allowed for smooth transitions during interruptions caused by the pandemic.	• All elements of *2BU* originally delivered exclusively in-person (i.e., enrollment, peer case management). • During the period of remote work, *2BU* was adapted to be delivered exclusively over the phone or via Zoom. This included the enrollment procedures, such as opening consent (converted to DocuSign that relied on access to an email), and delivery of the peer case management sessions. ○ Most of the existing and potential *2BU* participants did not adapt well to the fully remote delivery; several existing participants refused to participate in peer case management sessions remotely and most potential participants who screened eligible declined participation because of the remote delivery. • When "safer-at-home" restrictions were lifted, all elements of *2BU* were then transitioned into a "hybrid" delivery whereby a participant could choose to participate in the modality of his choice (i.e., fully remote, fully in-person, or a combination). • All *2BU* documents and files (e.g., NBA, participant progress notes, tracking forms) were originally paper. During the "safer-at-home" directive, all program documents and files were converted to secure electronic formats.	• All elements of *2BU* evaluation and data collection originally administered exclusively in-person. ○ Assessments were originally self-administered by the participant on a tablet or laptop. • During the "safer-at-home" directive, all evaluation and data collection procedures transitioned to remote/online delivery. ○ All assessments were either staff-administered over the phone or participants were sent a link via email and the assessment was done on a personal cell phone/tablet/computer. Participants were encouraged to take the assessment independently but while on the phone or on Zoom with the Peer Case Manager in case questions or issues arose. • Originally, gift cards were signed out in-person after assessment completion. Once *2BU* transitioned to remote delivery, gift cards were delivered electronically.

Costs

The annual cost for operating *2BU*, excluding staffing and office space, was approximately $17,181. This includes the cost for printing materials (approximately $800), office supplies (approximately $3,700), and risk reduction supplies (approximately $600). For scalability purposes, a site might also require a graphic artist to design recruitment materials and incur advertising costs. Ongoing staffing would include a Principal Investigator at 25 percent effort, a Project Coordinator at 100 percent effort, and at least one Peer Case Manager at 100 percent effort. Additionally, each site and geographic location would have a different cost for operating supplies, salaries, fringe benefits, indirect costs, and rent.

Intervention Outputs and Outcomes

Intervention Outputs

Table 3 highlights intervention outputs:

	Participants Enrolled	**69**
	Average Age	**44.7 years**
	Annual Income of $5,000 or Less	**46.4%**
	At Least a High School Education	**75%**

A total of 91 potential participants screened, 87 screened eligible, and 69 participants enrolled in *2BU*. Total participant follow-up rates were 54 percent at 6-months and 68 percent at 12-months.

Participants' sociodemographic characteristics were an average of 44.7 years of age (range = 18 thru 65), all self-identified as Black and a minority, and one-fifth also identified as Latinx (13.8 percent). Nearly three-quarters (72.5 percent) self-identified as "gay." At baseline, nearly half (46.4 percent) reported an annual income of $5,000 or less, the majority had at least a high school education or GED (36.8 percent high school graduate/GED, 38.2 percent more than a high school degree), and nearly three-quarters (72.5 percent) reported having Medicaid as their primary health insurance.

Intervention Outcomes

Observed HIV Care Continuum outcomes at each study time point demonstrated that participants both significantly increased retention in HIV primary care and achievement of viral suppression at the 6-month timepoint, but no other longitudinal improvements were observed. Further, increased attendance of the *2BU* peer case management sessions was associated with significant increases in the odds that the participant would be retained in HIV care (adjusted odds ratio [aOR] = 2.73; 95% Confidence Interval [CI] = 1.12-6.66). Increased attendance of the peer case management sessions also significantly increased the odds of achieving full viral suppression (aOR = 1.68; CI = 1.00-2.81).

Lessons Learned and Best Practices

Implementation

IMPLEMENTATION	
Challenges/Lessons Learned	Facilitators/Best Practices
Challenge: Although a participant may benefit from traditional behavioral health services (i.e., therapy), many either did not want to access behavioral health services with the same service providers or they felt that more informal behavioral health support was more valuable. **Lesson Learned:** The informal structure of the *2BU* intervention may provide the desired behavioral health support BMSM need. Service providers are encouraged to recognize that behavioral health care may look different to different populations. Further, service providers should be willing to provide behavioral health services that meet the needs identified by the participant (not what service providers think the participant needs).	Peer staff, such as Peer Case Managers, can provide immeasurable value to interventions like *2BU*. However, peer staff may relate to the personal lived experiences of the participants which can be stressful and draining. Therefore, employing support, such as hiring a licensed clinician to provide regular clinical supervision to peer staff, can help reduce burnout. Additionally, peer staff should be provided with opportunities for professional development and growth. Providing opportunities to develop new skills can keep peer staff motivated and contribute to enhancing their professional cache so they can eventually access greater opportunities within the organization and/or field.
Challenge: When offering *2BU* at a non-clinical site, partnering organizations are vital for the successful referral to HIV, behavioral health, and other support services. However, the everchanging landscape of service provision in the community and high turnover at many agencies can make it challenging to maintain robust relationships that facilitate "warm hand-offs." **Lesson Learned:** Continuous involvement in community events, consistent engagement with partnering organizations, and ongoing conversations with key gatekeepers within the community are paramount for staying up-to-date on the service provider's landscape. Active, ongoing engagement and simply "showing up" cultivates and maintains relationships at partnering organizations to ensure referrals to services can be met with the "red carpet treatment" and that "warm hand-offs" result in successful engagement in services.	There should be a heavy emphasis on maintaining a participant-centered approach. For example, the needs identified within a peer case management session may seemingly be unrelated to advancement along the HIV Care Continuum (e.g., participant needs assistance getting dog food or other pet supplies). However, the identified needs may be what are most important to the participant at the time, and addressing these specific needs may allow the participant to eventually be amenable to addressing HIV-specific needs.

IMPLEMENTATION CONT.	
Challenges/Lessons Learned	**Facilitators/Best Practices**
Challenge: The COVID-19 pandemic interrupted implementation, forcing a transition from in-person delivery of services to remote/online delivery. **Lesson Learned:** Although the *2BU* team thought remote/online delivery of intervention elements would facilitate easier attendance and completion of *2BU* activities, participants did not like or adapt to the new delivery modality. Many participants were older, had technology but were unfamiliar with how to use it (e.g., Zoom, accessing email), or lacked access to reliable Wi-Fi; all of which made remote/online delivery less desirable for many. Since COVID-19, there has been a push for telehealth and the transition of many services to remote/online delivery; it is important to note that some populations will fall out of care if they are less comfortable with technology or prefer in-person services. Technology literacy, such as helping a participant download required apps (e.g., Zoom), access free "hot spots" or Wi-Fi, and/or increase font size of text, may be a necessary component to intervention activities delivered remotely/online.	It can take time for participants to disclose their needs and barriers to the Peer Case Manager. The first few sessions of *2BU* may be dedicated to building trust and rapport. Therefore, the peer case management sessions are guided by the participants' ability and desire to disclose. By engaging in active listening and demonstrating respect for the participant, trust and rapport usually develops and behavioral health care can ensue.
	Engaging a CAB, which includes strong representation by members of the community served, is important to the successful design, adaptation, and implementation of *2BU*. Community feedback ensures the intervention continually meets the needs of the target population that results in community engagement.

Evaluation

EVALUATION	
Challenges/Lessons Learned	Facilitators/Best Practices
Challenge: The COVID-19 pandemic interrupted implementation, forcing a transition from in-person delivery of enrollment procedures (i.e., opening consent) and assessments to remote/online delivery. **Lesson Learned:** Although the *2BU* team thought remote/online delivery of enrollment procedures and assessments would facilitate easier participation, participants did not like or adapt to the new delivery modality. Many participants were older, had technology but were unfamiliar with how to use it (e.g., Zoom, accessing email), or lacked access to reliable Wi-Fi; all of which made it harder to complete enrollment procedures or administer assessments remotely/online. Since COVID-19, there has been a push for the transition of many services to remote/online delivery; it is important to note that some populations will fall out of care if they are less comfortable with technology or do not have the capacity for basic technology use (e.g., access to a working email). Technology literacy, such as helping a participant create an email account, download required apps (e.g., Zoom), and/or increase font size of text, may be a necessary component to evaluation activities delivered remotely/online. Further, use of remote/online delivery of assessments rather than in-person delivery of assessments may reduce follow-up rates.	Participants from marginalized and heavily impacted communities, like BMSM, should be fairly compensated for their opinions, experiences, and time. Therefore, participants who complete assessments should always be provided with a gift card or cash to thank them for their information and time.

Dissemination Activities

To Learn More

Please see Table 4 for an overview of professional conference presentations and posters as well as manuscripts featuring *2BU*.

Table 4: Manuscripts, Professional Conference Presentations, and Posters Featuring *2BU*

Authors	Title	Type	Conference & Location or Journal	Date
Le, B., Scott, E., & Kisler, K.A.	"Clinical and Behavioral Health Integration for BMSM Living with HIV"	Poster	2020 National Ryan White Conference on HIV Care and Treatment Washington, D.C. (virtual)	8/2020
Kisler, K.A.	"Adapting and Implementing the Youth-focused Case Management Model of Care for the SPNS BMSM Initiative: *Building Brothers Up* (*2BU*)"	Oral Presentation	2020 National Ryan White Conference on HIV Care and Treatment Washington, D.C. (virtual)	8/2020
Le, B., Scott, E., Fletcher, J.B., Reback, C.J., & Kisler, K.A.	"'Ah-ha!' Moments from Adapting an Evidence-informed Model of Care to Improve HIV and Behavioral Health Outcomes among Black Men who Have Sex with Men"	Poster	American Public Health Association, San Francisco, CA (virtual)	10/2020
Kisler, K.A., Fletcher, J.B., & Reback, C.J.	Peer Case Management Improves HIV Care Continuum Outcomes among Black Men Who Have Sex With Men Living With HIV: Building Brothers Up (2BU)	Manuscript	AIDS Patient Care & STDs	9/2022

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