Christian Community Health Center: Care Engagement Program (CEP)

Implementation Manual

SPNS BMSM Initiative

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Care Engagement Program (CEP)

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Table of Contents

Background 5
Introduction 5
Intervention Overview 6
Demonstration Site Background 6
Needs Assessment 7
Adapted Model of Care 7
Original MOC 7
Adaptations 8
Population Served 9
Initiative Eligibility Criteria 9
Pre-Implementation Activities 9
Organizational and Community Resources 9
Partnerships 11
Internal Partnerships 11
External Partnerships 11
Staffing and Supervision Model 12
Community Advisory Board (CAB) 14
Marketing and Promotion 14
Local Evaluation 16
Local Evaluation Overview 16
Implementation Activities 17
Core Components 17
Behavioral Health Integration 19
Additional Adaptations 19
COVID-19 Adaptations 19
Intervention Outputs 22
Lessons Learned and Best Practices 22
Implementation 22
Challenges and Lessons Learned 22

Facilitators and Best Practices 23
Evaluation 23
Challenges and Lessons Learned 23
Facilitators and Best Practices 24
Dissemination Activities 25
To Learn More 25
Contact Information 25

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 living with HIV (PLWH) 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, and the intervention was conducted and evaluated within a RWHAP-funded site. The **Care Engagement Program (CEP)** intervention was implemented by **Christian Community Health Center (CCHC)**, a RWHAP Part C and Part F recipient based in Chicago, Illinois. 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 living 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 living 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 living 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 living with HIV in their respective communities.

Introduction

This Implementation Manual provides guidance on how to adapt and implement CCHC's CEP 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 CEP to a diverse audience of clinical leadership, HIV service providers, and program implementers interested in identifying

and implementing new, innovative strategies for improving care for BMSM living with HIV and other populations in their communities. More detailed information for future replicators can be found in the Implementation Toolkit (see the appendices).

Intervention Overview

Demonstration Site Background

CCHC is a Federally Qualified Health Center (FQHC) that has been providing high-quality health care and social services to underserved African American and Hispanic communities for 28 years. Recognized by the National Committee for Quality Assurance (NCQA) as a Level 3 Patient Centered Medical Home at each health center access point, CCHC has been a pioneer in integrated health care, recognizing social determinants of health and linking housing and health care long before it was popularly recognized as best practice. Incorporated as a 501(c)3 non-profit organization since 1991, CCHC uniquely offers primary care, behavioral health, and oral health as well as wrap-around social services including supportive housing. CCHC is the only African American-led FQHC on the far South Side of Chicago and South Suburban Cook County that offers comprehensive housing and supportive services and comprehensive integrated primary care delivered by a culturally appropriate multi-disciplinary team of licensed and credentialed African American and Hispanic providers. CCHC's mission is to provide high-quality primary health care and related services to the community regardless of the patient's ability to pay, in a manner which demonstrates in word and deed the love of Jesus Christ. CCHC's three medical health centers located in Chicago, South Holland, and Calumet City provide primary and oral health care to more than 16,000 patients annually. CCHC serves predominately African American neighborhoods and communities of the far South Side of Chicago and the southern suburbs within Cook County, including South Holland, Riverdale, Dolton, Harvey, Phoenix, Chicago Heights, and Ford Heights.

CCHC provides integrated care to individuals living with HIV/AIDS as well as an array of wrap-around 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.

CCHC receives support from the HRSA Minority AIDS Initiative Fund, HRSA Part C to provide primary care, oral health, behavioral health and substance use disorder services, and contractual psychiatry to underserved PLWH (including 332 individuals in 2021). CCHC also receives AIDS Foundation of Chicago Part B funding to provide medical and non-medical case management to RWHAP patients. Through the Public Health Institute of Metropolitan Chicago

(PHIMC), CCHC also provides annual risk-based HIV testing and linkage to care to BMSM and Black high-risk heterosexuals.

Needs Assessment

BMSM are disproportionately affected by HIV/AIDS. According to the Centers for Disease Control and Prevention (CDC), BMSM make up the highest number of new HIV diagnoses in the US and dependent areas.[i] Out of the 37,968 new HIV diagnoses in 2018, BMSM accounted for 9,712, or 26 percent.

There are several factors that result in increased HIV rates among BMSM and affect their receipt of HIV care. According to a study published in the *Journal of AIDS and Behavior* in 2014, BMSM experience inadequate access to culturally competent services, stigma, and discrimination that impede access to health care services.[ii] In addition, further research indicates that the stigma and discrimination experienced by BMSM can result in negative mental health outcomes, including depression and lower self-esteem. Thus, there is a glaring need for behavioral health interventions to improve care for BMSM living with HIV.

Most of Chicago's African American residents live in low income, underserved communities on the city's South, Far South, and West Sides that lack adequate services necessary for early HIV diagnosis and linkage to early vital care, for viral suppression, for reduced risk of transmission, and to live longer, healthier lives. CCHC has provided services to this population for over 25 years and has developed culturally appropriate programs to effectively engage and serve these underserved communities.

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 living with HIV. All the MOCs were originally developed to improve HIV care and treatment and/or HIV health outcomes for youth and/or adult men of color. For CEP, CCHC adapted a **youth-focused case management** intervention.[iii] Key components of the original MOC include: two Bachelors-level case managers; clinic- and venue-based outreach; a 24-month intervention; and provision of psychosocial case management services. The following table briefly describes the implementation process of the original MOC.

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

Adaptations

To improve interaction between the CMs and the clients, CEP shifted from requiring a bachelor's degree as an education requirement of the CM positions. Instead, CCHC opened the positions to individuals who had extensive experience with the BMSM community, and were driven, knowledgeable, and compassionate towards the target population.

See the *Additional Adaptations* section below for information on adaptations that occurred during CEP implementation, including those related to the coronavirus disease 2019 (COVID-19) public health emergency (PHE).

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) of this Initiative, 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, or a history of negative experiences in a health care setting.

CCHC did not have any additional, site-specific eligibility criteria for CEP.

Pre-Implementation Activities

Organizational and Community Resources

As noted above, CCHC has the privilege of being the largest African American-led FQHC on the Far South Side and surrounding suburbs, providing comprehensive HIV/AIDS primary care services to African American and Latino men, women, and LGBTQ populations. According to 2016 RWHAP Services Report (RSR) data, 97 percent of CCHC's RWHAP clients are African American, and 71 percent are male, of whom 63 percent self-identify as men who have sex with men (MSM). The organization's reputation in the community, the community's understanding of the quality of clinical services available at CCHC, and CCHC's prior experience serving BMSM facilitated recruitment for and implementation of CEP, as CCHC's clinical providers already had the cultural exposure and understanding to provide the needed services in CEP.

Additionally, CCHC has more than 26 years of experience in providing RWHAP services, having first received RWHAP Title I funding from the City of Chicago to provide primary health care

services for PLWH in 1994. Experience providing these services proved helpful to the implementation of CEP, as CCHC had an extensive list of previous clients from other RWHAP programs who were eligible to participate in CEP.

It was also helpful that CCHC's medical and behavioral health services are provided in-house, which made it easy for the CMs to facilitate and coordinate services. CEP clients were scheduled for medical appointments with providers who saw RWHAP patients from other programs. Also, communicating with the Chief Medical Officer (CMO) and Behavioral Health Director (BH Director) at the initial grant award about CEP needs, as well as throughout the grant, helped ensure that providers knew what was expected for CEP.

CCHC also had contracts to connect patients to transportation services for the other RWHAP programs, through Kaizen. CCHC likewise used Kaizen for CEP to transport clients to and from medical and behavioral health appointments. CCHC also has official CCHC cars, which are available for emergency use by CCHC, including CEP.

CEP leveraged CCHC's existing, comprehensive system of in-house, on-site care. CCHC provides sexually transmitted infection (STI) services on-site at the community health centers. Those who test positive are immediately linked to care by working with the Patient Health Navigator, who will schedule an appointment for the patient and introduce them to CCHC's health system. This introduction includes an orientation packet and a needs assessment of the individual. As a federally-funded community health center, CCHC provides a wide range of primary health care and related services including family practice, internal medicine, pediatric care, hospital care, OBGYN care, adult and child immunizations, disease management, physical exams, minor office surgery, heart disease risk screening, cancer screening, discount prescription drug programs, dental care, a mobile van, and podiatry. Mental health and substance abuse services are also provided in-house by clinically licensed staff. This system made it easier for CEP clients, who sometimes needed extensive medical services, to access care.

CCHC offers comprehensive care for PLWH that includes primary health and medical care for HIV/AIDS, behavioral health and substance abuse counseling, dental care, nursing and/or case management, an on-site pharmacy, insurance enrollment, pharmaceutical assistance programs, transportation, and housing assistance. During the new patient encounter, these patients are assessed by Health Advocates as new clients and offered or scheduled for these services as appropriate. Patients are evaluated and cared for continuously by a multi-disciplinary team that includes an Infectious Disease M.D., a P.A., A.P.N.s, and other M.D.s as providers of care, and assisted by an R.N., an M.A. care coordinator, a patient health advocate, and Medical Case Managers.

Partnerships

Ensuring the collaborative efforts of key stakeholders both internally and externally was vital to the success of CEP. Internally, this involved CCHC's Behavioral Health team, Case Management team headed by the Health Administrator (HA), and the Medical team. Externally, CCHC established other important partnerships discussed below.

Internal Partnerships

Given CCHC is a full-service health center, there are extensive internal stakeholders. Notably, the Behavioral Health team, led by the BH Director, was a key internal partner. CEP collaborated with the Behavioral Health team to connect clients to in-person and telehealth visits. The CCHC BH Director was a key member of the CEP project team, championing the behavioral health referrals and ensuring that the CEP clients received timely behavioral health appointments. The BH Director was also responsible for gathering client notes from the Behavioral Health team, and addressing the details of the notes with the CMs during bi-weekly meetings, particularly any critical issues.

In the initial year of CEP implementation, the CMs worked directly with the CCHC HA who oversaw CCHC's Case Management Department. The HA provided direct supervision to the CEP CMs. This supervision continued until there was a vacancy in the HA position, after which the CMs started reporting directly to the CEP Program Director (PD). Additionally, CCHC's clinical providers were important partners, providing in-house medical care to the clients, and the CCHC Executive team and Administration helped ensure clinical staff prioritized CEP clients. CCHC's Part B, C, and Outreach Teams, clinics, Case Management Department, and housing programs supported the CEP team by identifying potential clients. Finally, like all of CCHC's care teams, CEP was able to CCHC-insured vehicles to transport patients directly to care themselves and sit with them to help them navigate their first appointment as well as manage the emotions and information overload that can be overwhelming upon initial diagnosis.

External Partnerships

In addition to leveraging internal partners, CCHC has partnerships with local hospitals and community-based agencies that provide counseling, testing, and referral (CTR), PrEP, PEP, and other outreach services. These local non-profits make referrals to CCHC for primary, oral, and behavioral health care services for PLWH, and follow up on their linkages to care. This is also how some clients from CEP's internal recruitment list became CCHC patients. CCHC outreach teams are trained in the medical scheduling systems and can immediately, electronically schedule same-day, or within-seven day appointments, for newly-diagnosed patients where a primary care provider together with a care team member will complete an intake, start labs and confirmatory testing, provide education, and link the patient to supportive services based on need.

As mentioned above, CCHC used Kaizen to connect CEP clients to transportation services. Kaizen is an external organizational resource that CCHC also uses with the other RWHAP programs. The CMs made appointments for CEP clients on the Kaizen website for transportation to and from appointments, which helped remove a barrier to care.

To conduct external outreach and recruitment, CEP initially set up an external partnership with Project Vida, which was later transitioned to Lorde, Rustin & Bates Inc. (LRB). Both of these partnerships assisted CCHC with outreaching and recruiting clients to participate in CEP. CCHC switched from Project Vida to LRB midway through implementation, as the latter had more peer experience and could better target clients for CEP.

Finally, an external partnership was set up with Katalyst Consulting to assist with CCHC's local evaluation of CEP. Katalyst Consulting came highly recommended, and the evaluation was run by an experienced consultant.

Staffing and Supervision Model

The CEP team consisted of the following positions:

- 1 Project Investigator (PI)
- 1 FTE 60% PD
- 2 FTE 100% CMs
- 1 FTE 80% Data Manager (DM)
- 1 Recruitment/Outreach Consultant (ROC)
- 1 Local Evaluation Consultant (LEC)

The CEP team was led by the PI, who was in charge of the overall running of CEP in conjunction with the PD. The PD provided direct project oversight and overall staff supervision. The PD also represented CCHC and CEP at various HIV-related conferences, events, partner meetings, and local HIV community planning groups. The PD supported the dissemination of best practices and project outcomes and gave presentations about new and emerging HIV trends and resources at staff meetings, community events, and conferences.

The CMs were responsible for managing and supporting clients, and ensuring they were receiving services. They were the first point of contact for CEP clients. For replication, this role requires flexibility and easy access for the clients. A stable line of communication is needed, and the CMs should be open to working outside of business hours, supported by the organization. The CMs should also have experience with case management and the BMSM population, as well as strong communication skills, to be able to coordinate client care and services.

The DM was in charge of managing and cleaning the data sets for the evaluation.

The ROC recruited CEP clients not already receiving care from CCHC. As indicated above, this position was created through an external partnership. That external partnership was needed for the first two years of the Initiative during the recruitment phase. While CCHC contracted externally for this role, an external partner is not needed. Ideally, this individual should be actively involved with the target population in the local BMSM community, and have experience working with clients in the community. CCHC did not have an internal candidate that fit these criteria, so opted to go with an external contractor instead.

The LEC was in charge of the local evaluation and survey administration. As indicated above, this position was created through an external partnership. The CEP LEC also had a strong background in research, and stepped in to assist CEP leadership, as well as with data management, during vacancies in the PD and DM positions during implementation.

In the initial staffing model, CEP also included the HA, who was in charge of CCHC's Case Management Department. Under this model, the CMs reported directly to the HA. Over the course of the Initiative, CEP leadership determined that due to a staffing vacancy in the HA position that arose during the COVID-19 PHE, it was easier for the CMs to be supervised directly by the PD. The CMs met with the PD individually once a week, and again during a weekly internal team meeting. During the individual meeting, the CMs were able to discuss personal concerns as it related to their individual roles. In the CEP team meeting, all members of the team provided a summary of their efforts so everyone was well informed about what was happening across the team.

CCHC used the Relias Training Platform and also partnered with the Midwest AIDS Education and Training Center (MATEC) to provide HIV/AIDS-related training for clinical and support staff.

Staff Trainings	
Referral mapping	CMs received CCHC Case Management Trainings during Orientation.
Trauma-informed practice	CCHC provided this through the Relias Training Platform.
Competency assessment and development plans	CMs received CCHC Case Management Trainings during Orientation.
Other	CCHC used the Relias Training Platforms to offer CEP staff training on working with the BMSM population and cultural sensitivity.

Community Advisory Board (CAB)

CCHC had an existing CAB that was leveraged during CEP planning and implementation. Both CCHC staff and CAB members participate in the Chicago Area HIV Integrated Services Council (CAHISC) and CCHC's Executive Committee. Members of the CAB also hold consumer advocacy offices/positions on CAHISC, Adherence, MSM, and Transgender Committees, AIDS Foundation of Chicago (AFC), AFC Part B/Contract Administrators Meetings, CDC Jurisdictional Collaborative, Part C Greater Chicago Metropolitan Group, Chicago Department of Public Health (CDPH) Learning Collaborative, South Side HIV/AIDS Resource Providers Group, South Suburban HIV/AIDS Regional Coalition (SSHARC), Health Consortium of Illinois, and Illinois Primary Health Care Association. These connections within the community were beneficial, as CAB members were able to help spread the word about CEP.

There were no CAB meetings between February-September 2020 as a result of the COVID-19 PHE. Afterwards, the PD worked with Case Management Department to keep the CAB members informed about the happenings of CEP and CEP services. The CAB members also supported dissemination by helping promote of the program.

Marketing and Promotion

As discussed above, for external recruitment, CCHC partnered with outreach community organizations. Initially, CCHC engaged the services of Project Vida to assist with external recruitment. Project Vida used their local community influence to get clients enrolled. In February 2020, in a bid to increase recruitment numbers, CCHC contracted with LRB, a

community-based organization that provides organizational development services to various institutions across Chicago. LRB increases the capacity of organizations that provide services to LGBTQ communities of color and people of color living with HIV to assess structural and systemic-level challenges and provides technical assistance, training, and coaching to address barriers. LRB was familiar with the CEP target population, and knew how to find potential CEP clients, particularly using social media platforms. Other recruitment components included self-referral, a social networking strategy, and referrals from other CCHC RWHAP programs.

- **Self-referrals** were clients who directly learned about CEP through marketing. Flyers (see the Participant Recruitment Flyer) inviting individuals to participate were posted at venues (e.g., bars, coffee shops, health clinics, support groups) frequented by BMSM. Advertisements and targeted messages were also posted on websites, including Craigslist, relevant Facebook groups, Adam 4 Adam, Jack'd, and Grindr. The flyers contained a brief description of the intervention, eligibility criteria, and instructions for contacting intervention staff.
    - To aid in the identification of BMSM and create connections to and with the CEP program, a CEP-specific logo was created to brand materials. This logo was placed alongside the CCHC logo.

- CCHC's **social networking strategy** utilized BMSM clients living with HIV to recruit other BMSM living with HIV. CCHC encouraged them to spread the word about the free services the clients would receive through CEP.
- BMSM living with HIV were also identified through **referrals from other CCHC programs**, such as the prevention team, clinics, case management programs, and housing programs. These internal recruitment strategies proved to be the most successful. During the final month of recruitment in December 2020, CCHC enrolled 21 clients in under a month from a list of over 50 verified eligible individuals. This list also did not include all eligible individuals from CCHC programs. In retrospect, CCHC would focus on recruiting clients from these internal lists initially.

Local Evaluation

Local Evaluation Overview

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.

In addition to participating in data collection for the Initiative-wide MSE, CCHC conducted a local evaluation. The local evaluation included a process and outcomes evaluation of the implementation of CEP.

Process Evaluation: Throughout the course of the program, CCHC planned to survey clients and staff every four months to assess the perceived strengths and weaknesses of the program, which would assist with modifying the program to better serve the clients and improve outcomes.

Outcomes Evaluation: At baseline, clients were given the initial Initiative-wide BMSM-Patient Survey (BMSM-PS) along with a local survey assessing their current health and wellness status as well as their perception of their overall mental health and knowledge related to HIV. Among other things, the survey assessed anxiety, mistrust, self-efficacy, HIV stigma and knowledge, and social support. Throughout the program, the clients were offered behavioral health therapies and case management services. The local evaluation plan also included recompletion of the survey at the conclusion of the program to assess if there were any changes to their overall perception of their health and wellness and how they cope with their HIV status, which would allow CCHC to analyze if the program significantly impacted the health and coping status of the clients.

Care Engagement Program: Local Evaluation Plan			
Local Evaluation Tool	What is Measured?	When Is It Measured?	Quality Assurance Significance
Client Satisfaction Survey	Perceived strengths and weaknesses of program and program staff	Every 4 months	- Allowed for a more comprehensive evaluation with clients' perspectives. - Provided quantitative data that were shared with program staff in the QA feedback loop.
Staff Survey	Qualitative data from CMs and behavioral health specialists on services implemented	Every 4 months	- Allowed for a more comprehensive program evaluation with staffs' perspectives. - Provided qualitative data that were shared with program staff in the QA feedback loop.

Implementation Activities

Core Components

The core components of CEP included intake, bi-weekly case management sessions, referrals to needed services, and behavioral health case conferences, which are described below:

- **INTAKE**
  - Following enrollment, the ROC sent the client's name, contact email, and phone number to the CMs.
  - The CMs aimed to contact clients within 72 hours of enrollment by the recruitment team to evaluate their needs. Intake was typically done over the phone. The CMs used a brief assessment to identify the challenges and barriers face by each client. This included, but was not limited to, linkage to care, mental health issues, food needs, behavioral health, substance use, and housing.
  - The CMs asked clients questions about their behavioral/mental health needs during intake and, with their consent, scheduled clients for an intensive behavioral health assessment from the Behavioral Health Department if they screened positive.
  - Using the information from intake, the CMs developed Individual Service Plans (ISPs) for clients.

- **BI-WEEKLY CASE MANAGEMENT SESSIONS**
  - The CMs contacted each client bi-weekly to discuss their needs, services, and possible referrals that might be useful. These sessions were completed in-person or over the phone. The CMs also used this time to update clients on HIV education, medication adherence, and treatment adherence, and addressed transportation needs using the Kaizen app.
  - The CMs tracked client contact and services through the use of Client Encounter Logs, which were updated weekly. Session notes, dates, and encounter types were recorded in the Client Encounter Logs for all enrolled clients.
- **REFERRALS**
  - As noted above, the CMs regularly reached out to each client after the initial intake to schedule them for behavioral health, medical services, or support services, if needed.
  - Enrolled clients who did not screen positive for behavioral health or did not want to participate in behavioral health services, could still choose to receive other services that CCHC offered, ranging from medical, transportation, dental, and/or housing services.
  - The general wait time for clients to receive behavioral health care was approximately 1-2 weeks, based on staff availability. Clients were scheduled for an appointment within two weeks.
- **BEHAVIORAL HEALTH CASE CONFERENCES**
  - The CMs met bi-weekly with the behavioral health team to see if clients attended their scheduled appointments with the behavioral health care providers. Additionally, the behavioral health team went over concerns identified by the therapists for the CMs to follow up on. For more information, see the *Behavioral Health Integration* section below.
  - The CMs used Athena, CCHC's electronic medical record (EMR), to verify whether clients showed up for their appointments. If clients did not show for their appointment, the CMs reached out to clients via phone or email to reschedule their behavioral health appointments.
- **OTHER ACTIVITIES**
  - The CMs met weekly with the PD, who also served as the Case Management Supervisor, to discuss client enrollment, program implementation tactics, and clinic policies, including COVID-19 precautions and telehealth implementation that were needed for the best interest of the clients.
  - The CMs also consistently communicated with the ROC, Behavioral Health team, and DM/LEC. Prior to COVID-19, team meetings were held in-person. During COVID-19, per CCHC organizational policy, the team communicated via the Go-To meeting platform, phone, and e-mail.
  - Following the end of the intervention, CEP clients were integrated into CCHC's existing case management services and able to continue receiving care.

Behavioral Health Integration

After the initial assessment by the CMs during intake, the clients were scheduled for behavioral health appointments, as needed. The CMs spent time talking to the clients about the benefits of behavioral health care and helped ensure that they were able to get to their appointments. For example, for face-to-face appointments, the CMs connected clients to transportation services as needed through Kaizen. Telehealth appointments were also provided, and beneficial for those who preferred that type of appointment, especially during the COVID-19 PHE.

Midway through implementation, CCHC added a standing bi-weekly case conference between the PD, the BH Director, and the CMs. 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 that missed their appointments, or did not show, so that the CMs could follow up with them. The BH Director also provided more details collected from the Behavioral Health team's case notes, which allowed the CMs to follow up more effectively. The CMs were provided a summary of the client's behavioral health visit, which was used when following up with clients during case management sessions.

In the initial stages of CEP, as well as with the pandemic, CCHC found it challenging to schedule behavioral health appointments. Setting up the bi-weekly meetings with the BH Director facilitated this process, as she was able to help with scheduling clients. For example, in some cases, there were last-minute therapist cancellations. When this happened, the CMs were able to report the issue to the BH Director, who followed up with a timely rescheduling.

Additional Adaptations

As previously mentioned, one of the main changes that happened during implementation of CEP was adjusting the supervisory oversight of the CMs from the HA to the PD. This happened primarily because the HA position became vacant. From a replication standpoint, it would be best for the CMs to report directly to the HA, as the HA at CCHC was already in charge of all case management in other RWHAP programs, or the BH Director, to support behavioral health integration.

COVID-19 Adaptations

The COVID-19 PHE also brought about extensive changes to program delivery and implementation, including to client recruitment, enrollment, case management, and how clients received services. The table at the end of the section provides a summary of the impact of COVID-19 on CEP.

RECRUITMENT

CCHC took the necessary steps to minimize exposure and decrease the risk of any employee, consultant, or eligible client's potential exposure to COVID-19. In the early stages of the COVID-19 city and statewide stay-at-home order, working with the ROC, CCHC temporarily suspended recruitment and enrollment activities and took time to consider how to adjust and revamp efforts. Starting April 13, 2020, CCHC began officially recruiting clients via social media outlets such as FaceBook, Adam4Adam, Jack'd, and Grindr. CCHC also began recruiting clients through referral networks, asking clients and other contacts to inform and refer other individuals to the program. These word-of-mouth promotions yielded strong positive results. Furthermore, in the latter part of 2020, CCHC reached out to internal clients in other RWHAP programs who met the eligibility criteria.

ENROLLMENT AND INTAKE

Individuals that agreed to participate in CEP were provided appointments for enrollment. These appointments were conducted via Zoom. After being verbally consented to participate, clients were provided a link to the baseline survey and their unique identifier. The ROC was available to answer questions as they took the survey. Upon completion, the clients took a screenshot of the survey completion screen and sent it to the ROC who then provided them with a digital gift card. For the recruitment of internal clients from other CCHC programs, the LEC took on a similar role as the ROC.

After the enrollment was completed, the clients were forwarded on to the CMs for intake. During intake, clients were reached via phone and a needs assessment and ISP were completed remotely and saved to a secure, password-protected shared drive, which the behavioral health personnel could access and provide the interventions. In addition, as intake was conducted over the phone during the COVID-19 PHE, the CMs developed an abbreviated intake model/assessment, which was composed of fewer questions that the CMs deemed essential. This was done to accommodate clients who were not eager to spend long times on the phone. This abbreviated version can be found in the Implementation Toolkit.

CASE MANAGEMENT

As a result of the COVID-19 PHE, and corresponding state guidelines for the lockdown and social distancing, the CMs shifted to managing clients mostly remotely in March 2020. This ensured there was enough in-office space to maintain social distancing. Clients were consistently monitored to ensure they were receiving the best care, and had the needed transportation and services for their medical and behavioral health appointments. The CMs continued to monitor clients by contacting them via phone 1-2 times every two weeks. Clients were contacted more frequently when they had a medical or behavioral health appointment scheduled in order to give reminders, or provide assistance with transportation to the appointments. When the CMs were unable to reach the client via phone, they left voicemail messages requesting a call back. For clients with non-functioning phone numbers, or lines that

were disconnected, whose email addresses were available, the CMs sent emails to them asking for a suitable number to reach them, or requesting that they call the CMs. Throughout the pandemic, the CMs continued to ensure that the clients received regular communication from CCHC, and provided and connected them as best as possible with the services that they needed. They also started to track and make commentary with the Client Encounter Log.

DATA COLLECTION

Adjustments to survey administration in response to COVID-19 were as follows:

1) Clients were consented to participate before beginning their survey via email using a consent document on file.
2) Clients continued to take the survey in Qualtrics. Hard copies of the survey were not provided to clients due to in-person restrictions.
3) Clients were able to choose a location that best suited them to complete the survey. Clients no longer came in-person to meet with the DM to complete the survey.

In addition to affecting program delivery, clients' limited access to WiFi/internet service also affected data collection. Some clients had to rely on their phone service, and had issues connecting to the internet when there was poor network coverage. This affected Zoom calls and also delayed survey completion.

COVID-19 Impact		
 Recruitment	 Program Delivery	 Evaluation & Data Collection
• Recruitment was initially paused. • Once restarted, CCHC began recruiting clients via social media outlets such as Facebook, Adam4Adam, Jack'd, and Grindr, before later turning to internal lists.	• Intake and case management services shifted to virtual delivery, including monitoring clients via phone. • Behavioral health and medical appointments also became available via telehealth.	• Clients no longer had the option of coming in-person to meet with the LEC to complete the evaluation surveys, including the baseline survey during enrollment, so this was done remotely.

Intervention Outputs

	Participants Recruited	**89**
	Average Age	**27**
	Unemployed	**10%**
	Receiving Behavioral Health Services	**64%**
	Receiving Social Support Services	**52%**
	Receiving Transportation and Other Services	**30%**
	Receiving Outpatient/Ambulatory Services	**52%**

Lessons Learned and Best Practices

Implementation

Challenges and Lessons Learned

CEP implementation encountered the following challenges:

1) One of the initial challenges the CMs faced stemmed from the stigma around mental health and behavioral health care in the Black community. To overcome this, the CMs discussed the benefits of behavioral health care with clients, particularly during the COVID-19 PHE, where many clients experienced loneliness and losses.

2) A CM experienced a situation with a client, who called him contemplating suicide, and was able to intervene and connect them with the city suicide hotline. Afterwards, they were able to follow up and ensure they were seen by the behavioral health team. This

demonstrated the importance of clients having easy access to the CMs, and training the CMs in what to do in emergency situations.

3) By following up and providing Kaizen transportation services, the CMs were able to increase engagement in behavioral health care. Also, the telehealth option was especially favorable for clients who preferred to receive behavioral health care at home. CEP did experience an issue where the Kaizen platform may have unexpectedly canceled transportation bookings, which the CMs were able to address and rectify.

4) One of the main challenges with virtual program delivery during COVID-19 was clients' limited access to WiFi/internet service. Some clients had to rely on their phone service, and had issues connecting to the internet when there is poor network coverage. This affected the evaluation.

Facilitators and Best Practices

1. The weekly team meeting was important for keeping the momentum going. Additionally, it provided a platform to discuss, and receive input, from other team members.
2. Similarly, the bi-weekly behavioral health case conference provided the CMs with more information and a well-rounded perspective to manage the clients.
3. CCHC successfully recruited 21 clients from internal lists during the final month of recruitment. The total number of enrolled clients would have been higher if CCHC had focused on this recruitment source earlier, as many clients who expressed eagerness to join the program were busy and unable to enroll over the Christmas holidays. CCHC's Case Management Team that oversees RWHAP Part C services, as well as the Housing Department, assisted in providing these lists.

Evaluation

Challenges and Lessons Learned

There were several challenges experienced with CEP, notably the constant turnover of the DM and the lack of medical record release forms. When CEP first launched, clients who were receiving care outside of CCHC did not fill out medical records release forms during intake. Medical records data were used in the MSE. In addition, due to COVID-19 and other institutions being understaffed or closed, it became difficult for the CMs to both obtain signed consents from these clients, and also reach the record departments of those external institutions.

CCHC initially offered $10 gift cards for CEP clients without medical records release forms to come in and sign consents. This worked for only one client, so CCHC increased the incentive amount to $20 and were able to get three additional clients. The CMs faxed the signed consents to the records departments of the other institutions, but were unsuccessful with all but one.

This was despite calling multiple times weekly, and leaving voicemail messages. Also, some CEP clients did not understand why that was not done in the beginning. These challenges show just how important it is for an organization to ensure all consent forms are received and signed during intake, including medical records release forms. Replicators should ensure this is done during the enrollment process.

Additional challenges are included in the table below.

Facilitators and Best Practices

See the table below for a description of best practices for survey administration.

EVALUATION	
Challenges/Lessons Learned	Facilitators/Best Practices
Difficult to collect data virtually > Ensure updated and correct contact information for clients.	Before starting surveys, advise clients of the length. Give clients the option to reschedule.
Inconsistent data collection methods > Have established protocols that all staff are aware of and follow, regardless of the individual responsible for the collection.	Remind clients that there are personal questions on the survey and that they might not want to have other people in the room with them.
Constant turnover in DM > Ensure that 1-2 other staff are fully aware of what is done so that new employees can be trained on the proper protocols for data collection.	Where possible, bring snacks and/or a beverage for the client. Breaks are recommended midway through the survey. If the client requests to take a break at any other point of the interview, ask if he minds waiting until the end of whatever section you are in the process of completing.
Switching of the data collection system mid-program > Invest in a data collection system that is managed/owned and operated by the agency so that data are not lost with staff transitions.	Provide incentives as compensation for completing evaluation surveys. Bring appointment cards to give the client a reminder of when the next follow-up survey will be.
Lack of medical records release forms > Obtain client signatures during intake.	Some participants may have trouble remembering dates or time frames. Use a calendar and/or prompt the participant by referring to times of the year or events (e.g., “Was it around the new year?” or “Was it before Barack Obama was elected president?”)

Dissemination Activities

To Learn More

For more information about CEP, CCHC will disseminate program results through several methods, including on the organization's website (http://cchc-online.org), and through posters and presentations at conferences.

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