AIDS PATIENT CARE and STDs
Volume 36, Supplement 1, 2022
Mary Ann Liebert, Inc.
DOI: 10.1089/apc.2022.0094

Open camera or QR reader and scan code to access this article and other resources online.

Prioritizing Flexibility, Human Connection, and Representation: Findings from the Qualitative Process Evaluation of the Special Projects of National Significance Black Men Who Have Sex with Men Initiative

Sarah E. Hodge, MPH, Meredith Passero, BA, Deja Robinson, BA, Savyasachi Shah, BDS, MPH, Tamia Anthony, MPH, and Chandria D. Jones, PhD, MPH

Abstract

Previous research has identified significant unmet need for behavioral health care services for Black men who have sex with men (Black MSM); this challenge has been linked to poorer overall health and well-being. Health Resources and Services Administration (HRSA) funded a Special Projects of National Significance (SPNS) Initiative, *Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who have Sex with Men*, with a goal to integrate behavioral health and clinical care services using four different evidence-informed models of care, ultimately improving HIV health outcomes. NORC at the University of Chicago conducted a multisite evaluation to assess the success of this Initiative, including a qualitative process evaluation that examined adaptations, services, integration activities, recruitment methods, and fidelity. The process evaluation described methods and processes used by demonstration sites to achieve their goals. This included challenges or barriers to implementation and the associated adaptations, notably due to the COVID-19 Public Health Emergency. Our study found key themes that indicated successful implementation were flexible service delivery, human connection, and client representation. We recommend future replicators apply these lessons learned in diverse health care and community settings that serve Black MSM. Additional information about the interventions can be found on TargetHIV.

Keywords: HIV, Black, African American, men who have sex with men, LGBTQ, process evaluation

Introduction

Black men in the United States use behavioral health care services at lower rates than their White male counterparts. Although many Black men indicate that they experience depressive symptoms such as socioeconomic and psychological stress commonly attributed to discrimination as a result of their racial and ethnic identities, they are less likely to seek professional behavioral health resources and services.[1] According to a 2020 US Department of Health and Human Services Offices of Minority Health report, in 2019, only 9.8% of Black men older than 18 years used mental health services, compared to 19.8% of Non-Hispanic White men.[2,3] Similarly, prescription medication for mental health services was acquired less among Black men (6.5%) than among White men (16.6%).[2,3]

Black men of sexual and gender minority identities experience the impacts of stigma and discrimination in even more nuanced ways. Black MSM may be more disproportionately impacted by psychological stressors than their heterosexual

Public Health Department, NORC at the University of Chicago, Bethesda, Maryland, USA.

counterparts, and more vulnerable to depressive symptoms, behavioral health issues, and substance abuse.[4] Black MSM with HIV occupy a unique position in the United States. According to a 2020 Centers for Disease Control and Prevention (CDC) report, Black MSM comprise less than 1% of the population, but account for 26% of new HIV infections.[5] This is an issue of particular concern due to the cumulative and perceived burdens of discrimination and stigma that many Black MSM with HIV experience, which can impact Black MSMs' ability and willingness to seek behavioral health care. Given these findings, it is clear there is an unmet need for behavioral health care for this population.

The Health Resources and Services Administration (HRSA), Special Projects of National Significance (SPNS), funded NORC at the University of Chicago to serve as the Evaluation and Technical Assistance Provider to conduct an expedited 3-year multisite evaluation of the *Implementation of Evidence-Informed Behavioral Health Models to Improve HIV Health Outcomes for Black Men who have Sex with Men (Black MSM) Initiative*. The Initiative is a Federal cooperative agreement supporting the implementation and evaluation of evidence-informed models of care (MOCs) to engage, link, and retain Black MSM in HIV medical care and behavioral health/supportive services (Table 1). The MOCs integrated behavioral health services with HIV clinical care to address the needs of Black MSM and to improve health outcomes.[6] HRSA funded eight recipients for 3 years to implement adapted MOCs in their communities and to participate in the multisite evaluation.

The purpose of this study was to examine intervention adaptation, implementation, and facilitators and barriers to implementation of MOC interventions. In addition, we examined the process of incorporating behavioral health treatment into clinical interventions, and whether the Initiative had the capacity to contribute to expected Initiative outcomes related to linking, screening, referring, and retaining Black MSM with HIV in clinical/behavioral support care.

Methods

As part of the culturally responsive, sequential, transformative, mixed-method evaluation to assess the impact of the Black MSM Initiative, we conducted a process study to assess the implementation of evidence-informed interventions, including barriers and facilitators to implementation. The process study questions explore what factors influence adaptation and implementation of interventions; which intervention components are delivered with fidelity; and how clients are recruited to participate.[7] The study was designed using a Culturally Responsive Evaluation framework, which shapes directional research to qualitatively investigate the context for implementation and actual implementation, which then informs sensitivity to collecting quantitative outcome data from (and about) groups that have been marginalized, including Black MSM.[8] Ethical conduct of the study was overseen by the NORC Institutional Review Board, which determined the study to not be human subjects research because the ETAP did not receive any identifying information about participants.

Data collection

Using this Culturally Responsive Evaluation approach, we designed data collection instruments to explore and account for the role of community context, demographics, socioeconomics, sexuality, gender, politics, and culture. The qualitative evaluation used document review, site visits, and key informant interviews as data sources. We conducted a document review to systematically extract relevant data from recipients' applications to inform development of the multisite evaluation and later contribute to answering evaluation questions. We also conducted phone calls with each recipient to augment the document review. Recipient calls led to a deeper understanding of each recipient's intervention, implementation plans, and local evaluation. Further, results from the recipient calls informed development of evaluation questions, data collection instruments, and plans.

Table 1. Models of Care Adapted and Implemented During the Black Men Who Have Sex with Men Initiative

Original model of care	*Model summary*	*Implementation locations*
Youth-focused case management intervention[14]	The goal of this intervention was to improve retention in HIV care for young Latino and African American MSM. Case managers provided supportive services to fill participants' identified needs for housing, nutrition support, substance abuse treatment, or mental health services.	St. Louis, MO Los Angeles, CA Chicago, IL Dallas, TX Oakland, CA
Brothers united/ The Damien Center, linkage 2 care[15]	This program, run by an Indianapolis community-based organization, provided comprehensive wraparound and supportive services to the Black LGBTQ community. The program offered prevention and testing. Those who tested positive were referred to services that help them engage in care.	New Orleans, LA
STYLE[16]	STYLE was designed to improve retention in HIV care through a social marketing campaign, outreach to youth and provision of HIV testing services, and a coordinated medical and social support network for recently diagnosed and lost-to-care youth with HIV.	Durham, NC
Project silk[17]	Project Silk was a youth-led, adult-supported drop-in program for LGBTQa individuals that offered recreation opportunities, food and snacks, health services like HIV/sexually transmitted infection testing, access to mental health counseling, and community resources.	New York City, NY

LGBTQ, lesbian, gay, bisexual, transgender, queer; MSM, men who have sex with men; STYLE, Strength Through Youth Livin' Empowered.

Each year, we conducted key informant interviews with recipient staff. We developed a semistructured interview guide to gather data about adaptation and implementation; implementation context; program implementation and fidelity; and recruitment. We also conducted annual 1.5-day site visits (in-person or virtual) with recipients. During site visits, teams asked questions focused on understanding each recipient's ability to support quality implementation, actual implementation activities, implementation costs, and implementation experiences of recipients. With recipient permission, the discussions were audio-recorded. Table 2 describes process evaluation questions and the data sources.

A sequential, transformative strategy guided data collection and analysis. Transformative research[9,10] focuses on studying the lives and experiences of diverse, often-marginalized groups; requires collaborative inquiry so as not to marginalize clients; and advances an agenda to improve clients' lives.[11] We analyzed collected data using thematic analysis to identify common themes, patterns, and interrelationships in the data relevant to expected outcomes and answer-linked evaluation questions.

Qualitative data were imported into NVivo (Version 12). Due to multiple researchers' involvement in data analysis, we incorporated several activities such as codebook development and the calculation of intercoder agreement into the analysis process to provide the level of analytic rigor and systematization necessary to reduce the effects of subjectivity and selection bias. Codebook development was informed by the evaluation questions and findings from the document review. Coders went through several rounds of training exercises so that inter-coder reliability could be assessed and maximized.

The training achieved Kappa scores that exceeded the established cutoff of >0.61, indicating ''substantial agreement,'' after which coders independently coded the study data.[12] Staff met regularly to discuss code application and general findings to answer evaluation questions. Any change to the codebook or coding process as a result of these discussions was applied to transcripts that were previously coded. Upon coding completion, we used NVivo to search, retrieve, and classify the coded data.

Results

The findings from this study can be organized into themes that address our evaluation questions about *adaptation*, *services integration, fidelity*, and *recruitment*. We also identified additional overarching themes of *flexibility*, *human connection,* and *representation*.

Adaptation

During the first year of the Initiative, sites identified and confirmed implementation partners, established workflows, and operationalized proposed adaptations. At some sites, partners were in-house care coordination teams and behavioral health care providers; the project was an opportunity to further integrate case management and health coaching in clinic life. In other sites, the teams planned to refer out to external partners for behavioral health services.

Primary adaptations to the source MOCs focused on modifying ages served, intervention length, staffing, and inclusion of ancillary services noted to be challenges in the original model of care, for example, offering flexibility in meeting sites or transportation assistance. Community Advisory Boards were critical partners to develop ideas to promote access to and destigmatization of behavioral health care. One site held a dinner with Community Advisory Board members to solicit their input: ''We discussed a lot of culturally competent subjects like, 'Do you prefer to be called African American versus Black? What does it look like in the Black community when you are receiving behavioral health services?' That conversation was very informative to us, giving the staff kind of the cultural competence of this is what [clients] are comfortable hearing… Then we were able to create programming and verbiage around that.''

Health navigators, peer staff, and project coordinators also supported protocol development and identified potential adaptations. These were especially important for intervention components that contributed to the environment and participant experiences. For example, navigators helped determine what type and level of technology might be appropriate.

Despite this thoughtful planning, the COVID-19 pandemic caused significant interruptions to projects and the lives of both

Table 2. Process Evaluation Questions and Qualitative Data Collection Methods

Sub-questions	*Document review*	*Recipient calls*	*Interviews*	*Site visits*
(1) What factors influence adaptation and implementation of Initiative interventions?				
(a) What infrastructure supports were in place to facilitate implementation of interventions?	•	•	•	
(b) What infrastructure or system changes needed to be made to facilitate implementation?	•	•		•
(c) How was behavioral health care/supportive service integrated with HIV medical care?	•		•	•
(2) What components of the Initiative interventions are implemented for delivery (with fidelity)?				
(a) How are the interventions adapted for implementation?	•	•	•	•
(b) What types of innovations through adaptation were implemented for patients?	•		•	•
(c) How were interventions implemented?			•	•
(d) Were the interventions implemented as planned?			•	•
(e) What barriers and facilitators to implementation were identified?			•	•
(3) How are clients recruited to participate in the Initiative interventions?				

staff and clients. Sites recruited for 2–5 months before the March 2020 stay-at-home orders. At that time, they were forced to make rapid adaptations like switching to FaceTime, texting, telehealth, and cold calls to reach clients who would normally have interacted with staff at drop-in centers and in-person events.

Services shifted out of the clinic and into clients' homes and other community spaces; offering flexibility made it easier for some clients to participate, but so many were struggling with basic needs that they could not engage with a behavioral health care provider. Particularly for newer clients, the loss of in-person time made it difficult to build trust, check-in informally, or complete warm hand-offs to other services. Despite these challenges, staff were determined to provide support, such as referrals to housing and food assistance.

Services integration

The primary goal of this Initiative was to provide integrated clinical and behavioral health care services. Sites generally adapted their proposed interventions to fit existing physical and administrative infrastructure. This was valuable both to facilitating smooth start-up and looking ahead toward sustaining the project long term.

One team described how overwhelmed their existing clients were at the prospect of seeking out behavioral health services and thought this model might offer low-barrier access to care: ''The challenges of accessing services like behavioral health and case management could be very daunting. And so we felt like if we could integrate what we're already doing, and bring these services in a very integrated fashion to it, it could maybe really reduce the barriers, make it more acceptable.'' It was also a high priority to establish clear, consistent, and actionable workflows used to manage the project. This included supervision structures for team members in peer, health navigator, and case manager roles, to ensure they received needed support during the intervention.

Internally, sites implemented case conferencing with all key players to discuss how individual clients were doing, and whether a client could use additional support. This was particularly helpful to identify needs that came up during a behavioral health appointment, but were not known to the health navigator, and vice versa.

Techniques to present services as accessible and aligned with existing programming were valuable to help clients consider engaging in behavioral health services. This included having the therapist drop into clinical appointments to say hello, using text-based automated screening services, and facilitating on-site support groups to discuss behavioral health—which could be framed as ''mental wellness'' or ''well-being''—and any other issue that was top of mind.

Externally, sites focused on warm handoffs between intervention staff and behavioral health care providers, including in-person introductions or three-way phone calls. Partnerships with transportation providers like Lyft or Kaizen also improved access to in-person appointments. Finally, regular meetings with partner organizations were used to strengthen relationships between staff and refine referral processes and protocols.

Fidelity

The COVID-19 Public Health Emergency was an overwhelming challenge to implement interventions as originally planned. Restrictions on in-person interactions limited teams' ability to build rapport with their clients and to maintain the personal relationships that promote sustained engagement with the program and the broader health care team. At the same time, clients were experiencing increased levels of instability and anxiety. Clients reported isolation, decreased social support, and loss of employment in service industry jobs that were often public-facing and higher risk. Staff reported working much harder than in previous projects to keep clients connected and in care. At the same time, staff were not considered ''essential workers,'' which they indicated was demoralizing and made their ability to work contingent on institutional policies: ''Although we're essential to the guys we serve, the clients, we're not considered an essential worker necessarily in the medical setting.''

The service landscape for laboratories, behavioral health care, and partner organizations shifted dramatically, with organizations closing or laying off staff who were known and trusted contacts. Many social service organizations were overwhelmed with requests and unable to fulfill their original functions proposed for the Initiative. This made it difficult to use existing referral networks. As one staff person said, ''How do you refer to something that doesn't exist anymore?''

In addition, as the Initiative moved online, staff reported challenges for clients who had previously primarily accessed the internet from free Wi-Fi networks in public spaces. Further, many clients with low digital literacy needed assistance using their devices and navigating online spaces like email, DocuSign, and Zoom. This kind of support was not originally expected; several sites felt the shift to primarily virtual services left out their original proposed population and attracted a younger, more tech-savvy clientele.

Despite these challenges, sites identified several innovative practices or solutions to test during the Initiative. Some were technology driven, including a texting service that sent automated medication reminders and screening questions for behavioral health and social support needs. Another site identified a need for an online safe space for clients to connect with because of concerns about stigma and fears their HIV status could be outed. This site modified an existing app to create a virtual supportive space. One site reported having a dedicated call and text line for direct communication was invaluable to clients, who did not always have the time or capacity to navigate complex hospital phone trees.

Recruitment

Sites ultimately recruited over 800 clients. As with other aspects of the Initiative, sites were forced to move into online spaces; they could no longer recruit potential participants who were already physically present in their space, attending medical appointments or socializing at a drop-in center, because foot traffic dropped precipitously. Table 3 describes the most successful recruitment methods used before and during the COVID-19 pandemic.

Several recruitment activities were less successful. Some community partners expressed concern that the Initiative would poach clients or had too many competing priorities to support recruitment. In addition, newly diagnosed men were often very overwhelmed by their diagnosis, and were not generally able to commit to an additional program at that time in their lives.

Table 3. Recruitment Methods

Pre-COVID	*During COVID*
Reviewing clinic rosters and upcoming appointments to identify eligible clients	Advertising on dating apps—although often a high cost per successful recruit
Enrolling immediately upon initial recruitment contact	Word of mouth
Incentivized peer referrals—recognizing some people hesitant to reveal their HIV status to social contacts	Cold calls to existing agency clients—difficult to connect with people
Street- and venue-based outreach	Approaching first in-person for a brief discussion, then completing enrollment virtually later

Flexibility, human connection, and representation

The findings and lessons learned from this qualitative process evaluation can be translated into three overarching themes for future interventions: prioritizing flexibility, human connection, and representation.

While it was not part of the original project plan for any site, being forced into a virtual service delivery model was valuable to learn where and when in-person services were really needed. Ultimately, sites found that flexible MOCs and support benefited many different types of clients.

As described by one team, ''I think our forced virtual approach brought out some things that we [as healthcare professionals] didn't necessarily think could be done well virtually. One is appointments… I do feel like what we found out is that there is value in a one-on-one face-to-face intervention that becomes a connection to care that links people in a more consistent or committed way. They're more committed when they have a person that they know that they're going to be able to see and kind of have a little ''tea tea'' with and all that. But I think on the other hand, what we saw is that virtual medical appointments, case management appointments, and behavioral health appointments were just as important and effective for some as the need to have that interpersonal interaction works for others.''

For some clients, especially those with childcare or home responsibilities, unpredictable schedules, or transportation concerns, attending appointments virtually made it possible to meaningfully participate.

Flexible service delivery was highly valuable to many clients, and sites plan to move forward with additional options for engagement in future programming. However, there was nearly universal sentiment that fully virtual visits could not replicate the meaningful connections brought from in-person engagement. This was true for recruitment, enrollment, and sustaining engagement. No site expressed a desire to do a fully remote intervention in the future, and did not recommend future replicators do the same.

Finally, many Black MSM are rightfully skeptical of seeking care in the US health care system, where they may experience racism, homophobia, stigma, and other forms of discrimination. Having peer and other program staff who were themselves Black MSM and in roles where they could shape program decisions and planning, was critical to providing acceptable, welcoming services.

One program coordinator noted the value of having ''somebody that understands the culture and why someone may not engage, or why someone may not be as open to that doctor and be able to be that go between the doctor and the client or the patient… that piece is what drew a lot of guys to enroll. They said, 'This is awesome because one of *us* is in the seat helping to bridge that gap.' And that I think is the major piece for me that stood out that said, 'Hey, if it wasn't for someone in the community being able to fulfill this role and that gap, that bridge would not happen.'''

Discussion

The evaluation questions for this study sought to answer questions about adaptations, service integration, fidelity, and recruitment.

Adaptations took place both before launching the interventions and during the initial months of the COVID-19 Public Health Emergency. The primary categories of activities included identifying and confirming implementation partners both internal and external, establishing workflows, meeting with members of the population of focus, and operationalizing adaptations. To adapt to the pandemic, sites shifted projects to virtual spaces and offered new ways to connect with the project and with providers.

Service integration was the primary goal for the Initiative, and efforts that were implemented successfully included vertical integration within organizations and investing in deeper relationships with community partners; these activities made it easier for clients to move around within the health care system to access the services they desired and needed.

Fidelity was difficult to measure because of the pandemic, and meant that many aspects of program planning, including how and where to engage with clients and which partners would support project implementation, were not able to be executed as planned. However, sites found value in providing additional support to link clients to digital services, including email, wi-fi, and project-specific phone apps.

Recruitment methods varied depending on the client population and changed during the pandemic to account for the new ways that clients interacted with project spaces. However, over 800 clients were recruited to participate in the Initiative.

The three overarching themes of *flexibility, human connection*, and *representation* illustrate characteristics of implementation that site staff reported they felt were most influential to maintain the project and support clients' physical, mental, and social needs. Flexible service delivery was valuable to meet clients where they were, but could not completely replace the connection derived from in-person engagement. Clients also reported that seeing providers and project staff who looked like them or shared their life experiences was critically important to their sustained engagement in the interventions.

The COVID-19 Public Health Emergency was a massive and unprecedented disruption to the Black MSM Initiative. It is impossible to ascertain each site's success and their fidelity

to the original project plan, had the pandemic not occurred. The pandemic also had notable and heterogeneous effects on data quality and data capture, making it difficult to make cross-program comparisons about both implementation and outcome findings.[13] However, because of the regular contact the research team had with implementing sites, meeting at least monthly throughout the Initiative, we believe that implementation data were captured at a relatively high rate at each site. Outside of the Initiative and these intensive follow-up models, comparability is likely limited.

One key limitation is that the research team was not able to interview clients. As a result, we cannot directly describe their successes, ongoing needs, or individual challenges. However, we interviewed over 20 site staff at three time points, representing a variety of project roles, including project coordinators and peer or health navigators. We believe that many client experiences were thus captured during data collection.

Given the challenges of implementing this Initiative during the COVID-19 pandemic and its associated disruptions, future work in this area should consider opportunities to replicate interventions in diverse health care and social service settings, considering these lessons learned from Initiative demonstration sites. Although the team conducted a rigorous multisite evaluation during the Black MSM Initiative, future evaluations can also help strengthen the evidence base for these interventions and establish precisely which core components are most critical to program and client success, and which can be modified or dropped in future program iterations. We especially advocate for the inclusion of diverse voices, particularly from communities of interest, in program planning and implementation. More information for replicators and Ryan White HIV/AIDS Program (RWHAP) program staff can be found in each site's Implementation Manual and Toolkit at https://targetHIV.org/BlackMSM.

Authors' Contributions

S.E.H.: conceptualization, formal analysis, investigation, writing—original draft, and project administration; M.P.: formal analysis, investigation, and project administration; D.R.: formal analysis and project administration; S.S.: writing—original draft; T.A.: writing—original draft; C.J.: investigation and supervision.

Acknowledgments

The authors would like to thank the staff and clients of the eight Initiative demonstration sites for their expertise, generosity, creativity, and time. The authors would also like to thank the SPNS project officers—Thelma Iheanyichukwu, Melinda Tinsley, Chau Nguyen, John Hannay, Joanne Hsu, Natalie Solomon, and Adan Cajina—for their support of this study.

Author Disclosure Statement

No competing financial interests exist.

Funding Information

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

References

1. Bailey RK, Mokonogho J, Kumar A. Racial and ethnic differences in depression: Current perspectives. Neuropsychiatr Dis Treat 2019;15:603–609; doi: 10.2147/NDT.S128584
2. HHS Office of Minority Health. Mental and Behavioral Health—African Americans. Washington, DC; 2021. Available from: https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24%5D+%5Bhttps%3A%2F%2Fwww.samhsa.gov%2Fdata%2Freport%2F2019-nsduh-detailed-tables [Last accessed: April 25, 2022].
3. U.S. Substance Abuse & Mental Health Services Administration. 2019 NSDUH detailed tables. Washington, DC; 2021. Available from: https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables [Last accessed: April 25, 2022].
4. Buttram ME, Kurtz SP, Surratt HL. Substance use and sexual risk mediated by social support among Black men. J Community Health 2013;38(1):62–69; doi: 10.1007/s10900-012-9582-8
5. U.S. Centers for Disease Control and Prevention. HIV and African American Gay and Bisexual Men: HIV Incidence. Atlanta, GA; 2022. Available from: https://www.cdc.gov/hiv/group/bmsm/incidence.html [Last accessed: April 15, 2022].
6. U.S. Health Resources and Services Administration. Part F: Special Projects of National Significance. Rockville, MD; 2018. Available from: https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program [Last accessed: April 15, 2022].
7. Hodge SE, Johnson-Turbes A, Flemming SSC, et al. Implementation of evidence-informed behavioral health models to improve HIV health outcomes for black men who have sex with men (black MSM initiative): Protocol for program evaluation. JMIR Res Protoc 2022;11(7):e36025; doi: 10.2196/36025
8. Hopson RK. Reclaiming knowledge at the margins: Culturally responsive evaluation in the current evaluation moment. In: The SAGE International Handbook of Educational Evaluation. (Ryan KE, Cousins JB. eds.) Sage Publications, Inc.; Thousand Oaks, CA; 2009; pp. 429–446.
9. Mertens D, Zimmerman HG. A transformative framework for culturally responsive evaluation. In: Continuing the Journey to Reposition Culture and Cultural Context in Evaluation Theory and Practice. (Hood S, Hopson R, Frierson H. eds.) Information Age Publishing: Charlotte, NC; 2014; pp. 275–287.
10. Hood S, Hopson RK, Kirkhart KE. Culturally responsive evaluation. In: Handbook of Practical Program Evaluation. (Newcomer KE, Hatry HP, Wholey, JS. eds.) John Wiley & Sons: Hoboken, NJ, USA; 2015; pp. 281–324.
11. Mertens D. Transformative mixed methods: Addressing inequities. Am Behav Sci 2012;56(6):802–813; doi: 10.1177/0002764211433797
12. McHugh ML. Interrater reliability: The kappa statistic. Biochem Med (Zagreb) 2012;22(3):276–282. PMID: 23092060.
13. Rebeiro PF, Duda SN, Wools-Kaloustian KK, et al. Implication of COVID-19 for HIV research: Data sources,

indicators and longitudinal analyses. J Int AIDS Soc 2020; 23(10):e25627; doi: 10.1002/jia2.25627
14. 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):988–997; doi: 10.1080/09540121.2010.542125
15. Brothers United/The Damien Center. His Health; 2021. Available from: https://www.hishealth.org/models-of-care/brothers-united-damien-center [Last accessed: December 28, 2021].
16. Hightow-Weidman LB, Smith JC, Valera E, et al. Keeping them in ''STYLE'': Finding, linking, and retaining young HIV-positive Black and Latino men who have sex with men in care. AIDS Patient Care STDS 2011;25(1):37–45; doi: 10.1089/apc.2010.0192.
17. Project Silk. His Health; 2021. Available from: https://www.hishealth.org/models-of-care/project-silk [Last accessed: December 28, 2021].

Address correspondence to:
Sarah E. Hodge, MPH
Public Health Department
NORC at the University of Chicago
4350 East-West Highway, 8th Floor
Bethesda, MD 20814
USA

E-mail: hodge-sarah@norc.org