Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

Hannah Fogarty	4/22/2019

Examining HIV Organizational Structures and their Influence on Engagement with Young Black Gay, Bisexual, and other Men who have Sex with Men in Atlanta.

By

Hannah Fogarty
Master of Public Health

Hubert Department of Global Health

____
Sophia Hussen MD, MPH
Committee Chair

Examining HIV Organizational Structures and their Influence on Engagement with Young Black Gay, Bisexual, and other Men who have Sex with Men in Atlanta.

By

Hannah Fogarty

B.A.
Marquette University
2012

Thesis Committee Chair: Sophia Hussen MD, MPH

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in the Hubert Department of Global Health
2019

Abstract

Examining HIV Organizational Structures and their Influence on Engagement with Young Black Gay, Bisexual, and other Men who have Sex with Men in Atlanta.

By: Hannah Fogarty

Background: Young black gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately impacted by HIV. Structural influences on these disparities, including characteristics of the various organizations that serve YB-GBMSM, are understudied to date. To gain insight into quality of services provided by organizations in Atlanta, we drew on Weick's model of organizing, which defines "enactment" as the process by which organizations define problems and determine appropriate solutions.

Methods: We conducted qualitative interviews with 28 HIV service providers (representing 20 healthcare and community-based organizations) in Atlanta. Participants responded to questions regarding their organizations' strategies for meeting the needs of YB-GBMSM. Interview transcripts were coded thematically, grouped by type of enactment, and analyzed using a constant comparison approach.

Results: Organizations' enactment of HIV service provision could be described as following either simplified "rules", or more nuanced "communication behavior cycles" (CBCs). Examples of rules included emphasis on patient quotas, one-time staff trainings, and limited hours of operation. Rules were often viewed as rigid, out-of-touch, and direct inhibitors of engagement with YB-GBMSM. Examples of CBCs included relationship-building, patient-feedback loops and rejection of traditional hierarchical structures. CBCs fostered a broader definition of HIV care, creative insights to combating the epidemic, and increased levels of cultural awareness and community buy-in.

Conclusion: HIV in YB-GBMSM is a multifaceted epidemic that requires an equally complex response**.** Organizations should strive to enact CBCs, to cultivate culturally conscious and innovative definitions of HIV care and foster new approaches to prevention and engagement by YB-GBMSM.

Examining HIV Organizational Structures and their Influence on Engagement with Young Black Gay, Bisexual, and other Men who have Sex with Men in Atlanta

By

Hannah Fogarty

B.A.
Marquette University
2012

Thesis Committee Chair: Sophia Hussen, MD, MPH

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in the Hubert Department of Global Health
2019

Acknowledgements

I would like to thank all of those who provided extraordinary support and whose purposeful and thoughtful feedback made this project possible.

Specifically, Sophia Hussen, the chair of this project, who provided ongoing mentorship and fostered the successful development and actualization of this project.

It is also essential to mention her study team—particularly Marxavian Jones and Shamia Moore who guided conceptualization of this research.

Finally, I would like to acknowledge my social support network that have seen me through this entire process, offered spaces for dialogue, and pushed my thought process further. I’d like to acknowledge Maggie’s and Trackside, which have created physical spaces that facilitate comfort and creativity of thought. Also, Miles.

Table of Contents

Introduction

Background and Rationale

Young black gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately impacted by HIV. The Centers for Disease Control and Prevention report that the likelihood of a Black gay, bisexual or other man who has sex with men (B-GBMSM) in the United States contracting HIV is 1 in 2.[1] Recent studies show that almost two-thirds (63%) of gay, bisexual and other men who have sex with men (GBMSM) living with HIV reside in the southern region of the United States.[2] Factors impacting high incidence among YB-GBMSM are often social in nature; many face socio-contextual barriers such as food insecurity, housing instability, lack of social support, inadequate access to mental health providers, inadequate insurance, and/or stigma. Socio-contextual factors significantly impact the likelihood of YB-GBMSM's engagement in HIV medical care after diagnosis, and social and structural factors are therefore instrumental elements of effective HIV interventions for YB-GBMSM.

Problem statement

Current research has explored social determinants' effect on YB-GBMSM's engagement in medical care. However, structural influences that exist within HIV service organizations themselves are understudied to date. Organizational theories offer key insight into systems of medical care and social service provision; these theories also offer opportunities for patient impact examination. Therefore, utilization of organizational theory presents a unique opportunity to examine the public health impacts of HIV service organizations on the patients they serve.

Weick's Model of Organizing

According to Weick, organizations exist to respond to the complexity of the outside world by "making sense" of complicated problems and responding in ways that creates a sense of order.[3]

Enactment is the process in which organizations define appropriate solutions to complex problems, often involving transition from chaotic problems to action-based response. Examples of enactment are organizationally specific-- they could range from a hospital's hiring policies to address conflicts of interests to establishment of a community advisory board (CAB) to increase patient involvement. These responses guide evolution of intraorganizational landscapes and create worlds where employees exist and respond to consumer needs. This evolution leads to development of abstract structures such as organizational culture, values and norms. Additionally, concrete realities such as official policies, practices and procedures are constructed. Enactment functions within an organization's hierarchy, dictating the experience of employees and the populations they serve. Organizations working on similar problems often interact through collaboration or competition. This creates a shared enactment that operates cross-organizationally, creating an interorganizational landscape that dictates a shared response to complex problems.[4]

Weick describes two methods of enactment: rules and communication behavior cycles (CBCs). Rules are standardized messages used to respond to simple situations. They are concrete in nature and can be referenced quickly to decrease ambiguity. For example, doctors may provide patients with informational pamphlets when diagnosing a new illness. These pamphlets are organizationally accepted as appropriate modes of health education.[5] CBCs are interlocked and dynamic exchanges that exist among organizational members. They are flexible and question the efficacy and purpose of traditional organizational norms. CBCs rely on integrated processes, emphasizing communication and encouraging trial-and-error problem solving. An example of a CBC is a workgroup with multi-level employee representation that creates recommendations to increase workplace satisfaction.

Purpose statement

We will draw on Weick’s model of organizing to gain insight into the nature and impact of enactment by HIV service organizations in Atlanta.

Research question

This exploratory project seeks to examine the following questions:

1. What does enactment look like for HIV service organizations in Atlanta?
2. What are similarities and differences in methods of enactment across different HIV service organizations?
3. How does enactment influence engagement of YB-GBMSM in HIV care?

Significance statement

This project employs organizational theory to provide a nuanced examination of HIV service organizations and their impacts on YB-GBMSM. Utilization of Weick’s model will supply insight into opportunities for HIV service providers to evaluate institutional barriers internally and adjust to fit the unique needs of YB-GBMSM. Ultimately, this will lead decreased barriers to care and increased buy-in for new and innovative engagement strategies. Structural barriers to care within institutions whose missions involve combating the HIV epidemic will be addressed, resulting in greater engagement with YB-GBMSM and increase in positive health outcomes.

Definition of terms

The following terms will embody specific definitions for the sake of this paper:

Gay, Bisexual, Men who have Sex with Men (GBMSM): Individuals assigned male at birth who have sex with other men. This is a commonly used term in public health research.

Young, Black, Gay or Bisexual Men who Have Sex with Men (YB-GBMSM): The target population of this research, an inclusive term that takes the importance of sexual identity into consideration.

HIV Care: Medical, social, and prevention services that contribute to viral suppression and increased quality of live for persons living with HIV. Can also include HIV policies, social support, and community empowerment activities.

Engagement in HIV Care: Active participation by a person living with HIV in their physical, emotional, spiritual and mental health depending on their individual care plan. Includes medication adherence, appointment attendance, and communication with providers.

HIV Service Organizations and Providers: Any medical, community, or social organization that provides services to persons living with HIV. This can also include religious institutions, educational institutions, and social support networks.

Enactment: Process in which organizations define problems and appropriate solutions to equivocality.

Rules: Standardized messages that can be used to respond to simple situations.

Communication Behavior Cycles (CBCs): Interlocked and dynamic exchanges that exist among organizational stakeholders as a response to complex problems

Literature Review

HIV in YB-GBMSM

As previously mentioned, HIV affects Black MSM at an alarming rate. As of 2015, MSM represented 70% of new HIV infections in the United States (US). In 2017, Black MSM accounted for 26% of all new HIV diagnoses in the country. Among MSM, Black persons accounted for 38% of new infections despite accounting for a fraction of the population.[6] The Centers for Disease Control and Prevention report that the likelihood of a black MSM contracting HIV is 1 in 2 over his lifetime.[7] These numbers represent an extreme disparity in HIV incidence.[8] From 2011-2015, HIV incidence among white MSM decreased by 10% while new infections among black MSM remained stable, demonstrating no signs of slowing down.[9] This evidence strongly supports the importance of continued interventions for HIV prevention and medical care that target Black MSM. Research has consistently demonstrated that these disparities are not explained by racial differences in risk behaviors such as engagement in unprotected sex or substance use (specifically injection drug use) during sexual intercourse; if anything, Black MSM generally report lower rates of sexual risk behaviors.[10] These findings support the importance of looking beyond individual behavior and researching structural influences of HIV incidence disparities.

HIV among young populations is also of concern. From 2011-2015, HIV incidence increased among individuals aged 25-29.[11] This cohort had the highest rate of new infections at 34.8%. Persons aged 20-24 had the second highest incidence at 30.3%. [12][13]MSM accounted for 93% of new diagnoses in youth in 2017, highlighting a need for continued focus and intervention among younger MSM. In addition to high rates of infection, current research suggests that young persons living with HIV are less likely to be aware of their HIV status and represent the population with the lowest rates of linkage to HIV care after receiving a positive HIV result.[14] In order to effectively curb the HIV epidemic in the US, younger populations must be tested, engaged and linked to care.

Geographically, HIV is most common in the Southern regions of the US. The area considered to be an epicenter for the HIV epidemic includes Alabama, Georgia, Florida, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.[15] Recent studies show that almost two thirds (63%) of GBMSM living with HIV live in the South. Additionally, GBMSM accounted for 36% of new diagnoses at non-medical testing facilities in the South. Of those diagnosed, only 67% were found to be successfully linked to an HIV medical care provider within 90 days.[16] These linkages are well below the national goals set for 2020, suggesting 85% of newly diagnosed persons linked to medical care within 30 days of diagnosis. [17] Southern states have also been found to have the highest rates of HIV related morbidity and mortality in the country.[18] Early initiation of antiretroviral therapies to treat HIV leads to positive health outcomes, including decreased morbidity, mortality and lower likelihood of onward transmission.[19] Paired with the knowledge that early linkage to care has been shown to lead to a higher likelihood of engagement in medical care and positive health outcomes (including viral suppression)[20] among persons living with HIV, there is an indisputable need to concentrate public health efforts and resources to the Southern areas of the US.

The combination of HIV incidence among black GBMSM, young populations (young GBMSM in particular) and Southern areas of the US make a compelling case that current interventions in these areas are insufficient in combating HIV in the US. Disproportionate rates of infection make the case for examination of socio-contextual factors that directly influence HIV incidence in YB-GBMSM living in Southern regions of the United States.

Socio-contextual Determinants of HIV Incidence Among YB-GBMSM

Current research surrounding HIV has begun to focus on socio-contextual determinants and the impacts they have on engagement in prevention and treatment efforts. These are external influences that are often internalized by YB-GBMSM and materialize as direct barriers to care. Socio-contextual concerns include (but are not limited to) experiences of homelessness, lack of access to health insurance or healthcare, low levels of health literacy, food insecurity, lack of access to mental health or alcohol and other drug treatment, poverty, education inequality, transportation issues, racism, homophobia, religious institutions, lack of social support, classism and income instability.[21] Current research has drawn connections between these factors and the life experiences of YB-GBMSM that directly inhibit consistent engagement in HIV medical care and viral suppression. These factors are intersectional, creating complicated multilevel barriers for persons who navigate these lived experiences. It is virtually impossible to discuss HIV disparities among YB-GBMSM without acknowledging social barriers that facilitate HIV acquisition and subsequently decrease the likelihood of medical engagement.

Impacts of stigma and homophobia on the lives of YB-GBMSM have been well-documented. Notably, social rejection from family members and religious organizations are associated with feelings of guilt and shame. [22] Religious institutions have a significant presence within the African American community and dictate the value systems of their members. Research indicates that members of the Black community are more likely to demonstrate criticism and negative attitudes toward same-sex practices than members of other racial communities.[23] Lack of social support has been shown to influence low self-worth, which in turn inhibits engagement in self-care or medical services.[24]

Ties between YB-GBMSM's self-perception and perspectives of the medical system has been shown to influence engagement in HIV medical care. Generally speaking, many YB-GBMSM have a distrust of medical systems and structures. Studies have successfully linked negative social experiences to negative health outcomes for young MSM.[25] Research shows that histories of racist experiences within health systems, low health literacy and skepticism of medical providers lead to low levels of engagement among YB-GBMSM.[26] Internalization of negative experiences impedes patient-provider communication, medication adherence, healthcare utilization and self-advocacy among YB-GBMSM.[27] Lack of connection with HIV providers and insufficient presence of providers of diverse racial and sexual backgrounds lead to internalized feelings of disconnect and inhibit healthcare participation among YB-GBMSM.[28] Similarly, perceived socio-economic status or class discrimination have also been shown to impact participation in medical treatment by Black Americans.[29]

While this research provides an essential perspective on the lived experiences of YB-GBMSM, it centers around internalization of negative experiences by the patient rather than a critical examination of the healthcare organizations themselves. Some research has been conducted to discuss hiring processes, cultural competency training and presence of prejudice and racism within health systems.[30] However, an opportunity exists to examine these systems and structures through the lens of organizational theory. This scope would inform a multidisciplinary approach to restructuring HIV medical care that focuses on organizational reconstruction rather than pathologizing a patient population.

Weick’s Theory of Organizing in Practice

Weick describes organizations as systems of intertwined behaviors that rely on each other to decrease the complexities of problems. Organizations decrease complexity through enactment, or “the active process by which individuals, in interaction, create a picture of their world, their environment, their situation.” Enactment occurs when members collectively “make sense” of a problem, develop a shared and accepted interpretation, and determine appropriate responses to that problem. Weick argues that organizations require a balance of structure and flexibility to maintain effective responses and problem solving. The more complex a problem, the more difficult it is for an organization to respond appropriately. Successful enactment occurs when an organization's response matches the problem in complexity.[31]

There are two types of enactment: rules and communication behavior cycles (CBCs). Rules are standardized messages that can be used to respond to simple situations. Organizations often possess a "repertoire of rules" that can be referred to quickly and easily (such as responses to biochemical spills or whistleblower policies). CBCs are interlocked and dynamic exchanges that exist among all organizational stakeholders. They are flexible in nature, and often question the efficacy of traditional organizational norms.

While not common, Weick's model has been applied to the healthcare field in some situations. Recent studies have found the model of organizing highlights communication in health promotion and research.[32] Specifically, the model has been applied to retention of hospital nurses in high-stress environments. Enactment was used as a theoretical framework for evaluating high levels of turnover among nursing staff. The hospital where the nurses worked was embodied strictly rules-based approaches—decision making about workflow, patient triage and shift scheduling was made entirely by administrative bodies that were not connected to the nursing staff. Retention strategies for staff were viewed as reactionary and mechanistic, exacerbating issues of retention. The response of the theoretically driven organizational restructuring was a newly invigorated approach to recruitment and retention of staff that relied on CBCs. Mutual communication channels between staff and decision makers were constructed through focus groups, participation of nursing staff in protocol development, and participation of staff in the creation of professional development strategies. As a result, significant long-term reductions in nurse turnover were exhibited.

Additionally, Weick's model was applied to a medication adherence research study for patients with multiple chronic conditions. Medication adherence is seen as a highly complex problem for patients who have lower levels of health literacy. Traditionally, education has been primarily rules-based, relying on standardized instructions that may not be comprehensible for some patient populations. This study used Weick's definitions to inform qualitative research regarding patient's needs regarding chronic condition management. Preliminary results demonstrated increased engagement in medication adherence and increased sense of autonomy for patients.

Finally, Weick's theory of organizing was used to negotiate the complexity of palliative care in an inpatient setting. [33] Hospice and palliative care are highly equivocal fields characterized by ethical and medical are therefore insufficiently served by structured rules-based approaches. Researchers used Weick's framework to guide development of interdisciplinary care teams that relied on high levels of communication and staffing. This shift was shown to optimize patient care and provide greater dignity for patients.

Weick's model has been successfully used as a guiding model for pockets of the medical field, however the complexity of organizations and factors influencing HIV care engagement among YB-GBMSM has yet to be explored through the lens of this theory. In this analysis, we sought to apply Weick's theory of organizing to examine enactment of HIV prevention and treatment services for YB-GBMSM by healthcare and social service organizations in Atlanta, Georgia.

Methods

Study Context

This data represents a secondary analysis of qualitative data collected from interviews of key informants representing HIV clinics and community-based-organizations (CBOs) in Atlanta, Georgia. The purpose of the primary study was to obtain key informant perspectives for the purpose of developing an intervention directed toward building social capital among YB-GBMSM.[34] To this end, the study team conducted qualitative in-depth-interviews (IDIs) with HIV service professionals that discussed the experiences, strengths, challenges of YB-GBMSM. Participants also responded to questions regarding their organizations' strategies for meeting the needs of YB-GBMSM. The current secondary analysis focused specifically on the latter portions of the transcripts, in order to address our main study objective.

Participant Recruitment

Participants were nominated by members of the study team and our youth advisory board (YAB; composed of 8 YB-GBMSM living with HIV), based on perceived knowledge, experience, and competence working with YB-GBMSM living with HIV. We purposively selected participants to ensure representation of a range of settings (e.g., large CBOs, research teams, and medical clinics) and work roles. Potential participants were contacted directly by the study team via email or phone and offered participation in the interview study.

Data Collection

IDIs were conducted by our study team and members of the YAB, at mutually convenient and private locations for the participants. Our primary two interviewers were both Black and gay-identified (one male, one female) staff members with extensive training in qualitative methods. YAB members also had the opportunity to co-conduct some of the interviews; they had also received qualitative training and another staff member was always present to ensure quality and uniformity in approach. Most interviews were conducted in person, one was conducted over the phone due to participant availability. IDIs were digitally recorded and lasted approximately an hour and a half on average. Participants also completed brief demographic surveys to document features including age, race, and occupation. Recordings were sent to a professional company (Exceptional TBS, Inc.) for verbatim transcription. Written informed consent was obtained from each participant prior to the interview, and **the study was approved by the Emory Institutional Review Board.**

Data Analysis

Transcripts were imported into MaxQDA 18 (Berlin, Germany), a qualitative data management software, for coding and thematic analysis. Initial coding included a combination of deductive coding (structured, predetermined codes based on major domains of the IDI guide; i.e. “cultural competence” and inductive coding (codes capturing themes that emerged organically in the interviews, i.e. “competition between organizations”). For this secondary analysis, eight of these codes were selected based on relevance to our research objective (self-description, job-description, community interaction, institutional barriers to care, basic needs, funding, competition between organizations, and cultural competence).

Text comprising these organizational codes was then isolated and further sub-coded incorporating constructs from Weick’s model. Specifically, text was grouped by type of enactment (rules vs. CBCs), and that data was analyzed using a constant comparison approach. This approach allowed for interpretations to be compared with existing findings throughout the analysis. Data matrices were constructed to further facilitate analysis of patterns emerging from the data.

Ethical Considerations

HIV is an extremely sensitive topic; anytime a participant is being interviewed there is potential for re-traumatization--whether personal or based on the experiences of a loved one. Medical and social services are often associated with employee compassion fatigue, which may have been triggered during these interviews. Additionally, participants who identified as members of the YB-GBMSM community may have felt exposed or outed. Interviews also discussed histories of structural racial and prejudice, which often elicit feelings of hopelessness and despair. It is also possible that participants could be identified based on their employer. To circumvent these concerns, all participants were de-identified during transcription. Interviewers received sensitivity training to provide support to participants as needed.

Results

Participants provided rich descriptions of their experiences with organizational enactment of HIV treatment for YB-GBMSM. Based on Weick's Theory of Organizing, we categorized these enactment descriptions as either *rules* (simplistic and standardized responses) or *communication behavior cycles* (CBCs; more nuanced approaches requiring high levels of communication and information sharing within and across organizations). Rules, which were often presented as the default enactment method, were viewed as rigid and out of touch. At times, adherence to these rules was described as directly inhibiting engagement with YB-GBMSM. CBCs, in contrast, were presented as process-based responses to HIV care with the potential to transform rules-based approaches. Additionally, we found that rules-based enactment and CBC-based enactment differed most in their orientation toward: macro-level ideologies, employee value, collaboration with other organizations, patient-organization interactions, cultural competence training, bureaucratic factors, and intervention strategies.

Rules

Rules primarily existed as results of organizational precedent, dictated by funding structures and traditional clinical models of medical care. While Weick describes the benefits of rules as reducing complexity in the work for organization members; our participants saw rules as creating barriers to engagement for YB-GBMSM living with HIV.

Macro-Level Ideologies

Participants described many institutions and organizations with hierarchical and methodical approaches to policies and protocol. We labeled these types of overarching systems and orientations as rules-based macro-level ideologies. Institutions with this type of orientation were viewed as highly self-serving, often at the expense of the most vulnerable clientele. Participants generally argued that too much focus was placed on medical interventions for HIV, while social determinants of health are viewed as secondary concerns. As one participant stated:

> We tend to have very rigid systems. And when patients don't fit into that system, they oftentimes fall out of the system. But, again, I think that has a lot to do with just being in a rigid healthcare system. I don't think we do a good enough job of recognizing the personal struggles that these individuals are going through. And that you know unfortunately in an AIDS service, any AIDS service organization, as much as case management and counseling and other wrap-around services we have oftentimes, at the end of the day, the focus is on the medical aspect of it and the HIV and I think in that I think we're missing the boat because the HIV is the easy part to treat. I think it's trying to, we are not doing a good enough job of holistically taking care of these individuals.
> -Clinical professional: 35 years old, white, male

The inadequacy of a "one-size fits all" approach to HIV care was often discussed by participants. This perspective was related to a failure to include the perspectives of key populations when introducing new protocols. One participant highlighted the gap that rules-based approaches create:

> [Administrators] have a one size fits all approach, especially from a Health Department standpoint. What are we doing to scale up our services and in scaling up our services how does that effect each priority population? Those are the questions that we should be asking. But what's missing is that consideration, is the actual consideration of HIV positive black gay men. -Health Department Professional, 29 years old, black, male

The separation of social and contextual factors from the scope of "medical care" and "one size fits all approaches" were viewed by participants to be extremely harmful to YB-GBMSM. The result of rules-based macro-level ideologies is the perpetuation of HIV systems that fail to engage YB-GBMSM, and cause those with the highest social risk to fall through the cracks. As one participant summarized:

> The way we have care and services structured, may not be conducive to what works with that group. And if we keep trying to push people into this model that we think we've created that works, right? And we're not willing to change the model to accommodate the people that are most impacted then we're always going to miss the mark. So our systems weren't necessarily designed by them, all of their issues, needs, concerns weren't necessarily taken into consideration when these structures were created or developed. But we're trying to push people through these systems that may or may not fit."
> -Academic professional, 45 years old, black, female

Employee Value

Rules-based enactment often formed hierarchically structured HIV service organizations. Participants pointed to underpayment of front-line staff as inhibitive to quality HIV care for YB-GBMSM, arguing that low salaries keep talented and qualified individuals from working in the field. Participants also reported poor treatment of staff having a ripple effect that impacts customer service. As one participant stated:

> Because the organizations aren't paying [staff] enough or valuing them enough, they, the people are walking around with chips on their shoulders the size of fucking Chicago, mad as hell and then they're being, they're engaging or interacting with these very vulnerable, this very vulnerable population, mad as hell and traumatizing them.
> -Non-profit professional, 38 years old, black, male

Rules that determine staff compensation and support were viewed as insufficient to provide for quality of life. Some participants identified as being members of the YB-GBMSM community and experienced the same barriers to HIV care as their peers, despite working in the HIV field and paradoxically being employed to provide support to others. As one individual explained:

> I gotta worry about housing. I gotta worry about my bills. I gotta worry about going to the doctor. I gotta worry about all those things and oftentimes organizations don't give that support.
> -Non-profit professional, 27 years old, black, male

Collaboration with Organizations

Rules dictated how organizations interacted with each other. Participants cited competition (for programmatic funding and numbers of patients) as direct blockers of cross-organizational collaboration. One participant explained the tensions that emerged from emphasis on numbers:

> The government is giving them, an organization, let's say, $10,000, if you see 500 people this day. But if you don't see 500 people, I'm not going to fund you again. You know, they're [funders] not seeing these people. So, why do I have to do this for these numbers? I'm still giving them services, you know. So, why are you pushing me talking about numbers? Everybody fighting for numbers out here, you know, and it doesn't make any sense.

> -Medical professional, 48 years old, black, female

Most respondents called for increased collaboration as a way of effectively combating the HIV epidemic and increasing efficiency, but many felt that structured rules of funding disbursement lead to silos within the HIV service community. For example,

> Um, well, I'll start with how I think they should. Uh, I think they should work as one. I think a lot of times, since a lot of organizations are competing for grants, um, and things like that, they are kind of like one-up each other, we want to be here, we want to be there, we want to write that and all of that and the third, which is, I mean, that's a part of life [laughter], but we're all fighting the same fight with each other and trying to, um -- we're all trying to fight the same fight and decrease the rate of HIV, um, you know.
> -Professional: Other, 25 years old, black, male

Funding rules appeared to impact how organizational leaders interacted with each other as well. Competition at the top created organizational cultures that complicated work for direct service and front-line staff. Participants highlighted how the gaps between leaders' mission and practice trickled down to impact employees:

> I think the organizations, at a upper management level, like many executives, I think they don't play well together. I think they sit at the tables well together and they may share similar perspectives or ideas, but I don't think they naturally are like, 'Hey, let's work together and do this thing,' because it's competition, but it's not always friendly. The thing that I have witnessed my entire career is that … the rest of the staff, we play and navigate well together because we work within the community that we serve and it gets really tricky for us to not have friends or to have fallouts when we're doing it for the benefit of the community, where it should always feel good and satisfying, but it's not because the barrier usually is the, the EDs [executive directors], or the founders, or what have you.
> -Non-profit professional, 35 years old, black, male

Patient-Organization Interactions

Rules dictated the ways that organizations interacted with YB-GBMSM through funding allotment and regulation. Metrics- reporting to funders was viewed as an obstacle to HIV care. Metrics were seen as antithetical to compassion, often "turning patients into a number." One respondent described the tension that is created through the demands of organizational metrics:

> Um, they want, like, they want you to see more volume, they want you to see more numbers, but they don't want to, um, necessarily increase all of the stuff that you have to actually have in place to make sure that you can complete a patient visit in a timely fashion and connect them to all the resources that they need. So you hear a lot about patients, immediately once they get insurance, they want to go to that private office where they don't feel like they're an HIV patient.
> -Medical professional, 30 years old, white, female

Participants also described prejudiced treatment of YB-GBMSM. Many participants cited poor customer service interactions that were clouded by institutionalized prejudice. For example,

> I had somebody come up to me today and say, “Well can you talk to your young men because they’re talking kinda loud in the hall.” I was like, “Okay.” They, “Would you say that if it was a heterosexual person talking loud in the hallway? Would you come and get me? No you wouldn’t, you probably wouldn’t.” So. And we had that example just in the hall today.
> -Medical professional, 46 years old, black, male

Participants identified the accumulation of poor experiences with organizations as a reason for YB-GBMSM’s disengagement from care. It also became evident that patients often found these interactions dehumanizing and disrespectful, one participant describes this cycle:

> You probably just had like a big, bad experience, right? And it probably had all different sort of tentacles. Like it was probably like yes maybe someone in the elevator was racist. And maybe someone treated me like crap because I’m young. And maybe someone else was like telling me I was going to hell because I’m gay or whatever or I’m too fem or I got hit on by someone or whatever. It might have all of those facets. But it probably includes something along the lines of like, I was disrespected and I had no way of like, I didn’t get what I needed and I didn’t know what was going to happen next and I had no way of providing feedback.
> -Non-profit professional, 35 years old, white, female

The lack of appropriate venues for feedback was also discussed by several participants. Rules-based approaches often included customer-satisfaction surveys to gather patient feedback. These surveys were largely seen as insufficient in comparison to avenues for feedback that promoted dialogue. One participant discusses the difference:

> These organizations will do their 'customer satisfaction surveys' or whatever. But I just, I’ve never felt like we get particularly good information from those. They’re not done in

> a systematic fashion in any way. They're generally just not done in a way that I think tries to draw out the feedback that we really need, which is probably more done in focus groups and in environments where they're going to be very comfortable giving open and honest feedback.
> -Medical professional, 35 years old, white, male

These rules were generally found to have dehumanizing effects for YB-GBMSM seeking to engage in care. Most respondents acknowledged that these rules, even if they simplified the work of employees, were ultimately detrimental to quality of services.

Cultural Competence Training

Rules for cultural competency training were processes of enactment that allowed organizations to continue employee engagement and education under time and priority constraints. These trainings are often one-time daylong or half-day trainings. A common topic discussed by participants was trainings on organization-wide cultural competency. One-time trainings were largely viewed as insufficient tools for teaching cultural competency.

> In terms of cultural competency? Nothing is going well. I mean, we have the basics in place where folks are, they go through a one-day workshop or half-day workshop on an annual basis, if their agency provides it, but that's just a baseline. That's just the very beginning of the race. There needs to be, at all levels, more in-depth training. KI-IDI-KL
> -Non-profit professional, 55 years old, black, male

Most participants felt that their organizations were not providing enough education to their employees about the experiences of YB-GBMSM. These gaps resulted in a lack of practice informed by cultural consciousness.

Bureaucratic Factors

Bureaucratic rules were largely discussed as the concrete policies and procedures that organizations established to maintain order. Generally, bureaucratic rules were viewed by participants as obstacles to patient care. Examples of these obstacles included: long wait times, cumbersome referral processes, and large amounts of paperwork. Often, these processes were inconsistent and arbitrary in nature. For example:

> But there's also, like this whole thing where you need an ID to get care at [county health department], but that's technically not true, you can be seen without an ID. Or they tell you that you have to show proof of income for the sliding scale but, that's technically not true, because they won't turn you away. So what happens is I have people running around feeling helpless and like they can't get any care because certain people who answer the phone want to make the money and not to provide the care. Um, so that's really different. So, um, so, so that's really different, fragmented in the sense that you have to go through so many barriers basically to get seen."
>
> -Non-profit professional, 35 years old, black, male

These processes were often referred to as "jumping through hoops" and cited as initial deterrents to HIV care. Rules about technologies for contact with patients often limited how providers could speak with patients and when they were available. For instance, one participant expressed frustration with limited communication as a barrier to building rapport with their patients:

> I shouldn't be working 8 to 4:30 because patients are not, like, functioning during those times. Or very few are. Or if they are, they are at work, so they can't come in and see me. There should be extended hours and many of my patients aren't even getting up until noon. So our hours and stuff don't work. I think that the method of communication with patients is also terrible. Like, I don't have a number that I can text from or that I can, like, I think probably technically I'm not even supposed to be like, emailing - I can't email results or anything like that. I can just email and be like, 'Hey, can you call me?' Or something, but I can't communicate with patients the way that they communicate. And so it's - even if they try the mainstream methods of communication, just calling on the phone, they can never get anybody. And then the methods that they do communicate by, like we as healthcare providers are not allowed to use, so it's like how are we going to get their buy in and get them on board if we can't communicate with them the way that they normally communicate? And so, I think, we lose a lot of patients because they're just not going to pick up the phone and call us if they miss an appointment or something. They would text or send some other type of message through a messaging service. But we're not going to - we're not allowed to do that."
> -Medical professional, 30 years old, white, female

Intervention Strategies

HIV prevention messaging is often relegated to rules of "best practices" to provide consistent and appropriate health communications. However, participants felt the messaging practiced by organizations was outdated and inefficient. Specifically, the narrow view of sexual behaviors was limited and isolating for patients. Many participants felt that prevention was not aligned with the dynamic experiences of YB-GBMSM.

> You know there are other ways, we're in 2017. There are other ways to have sex, everybody's not having boring (that was stigmatizing) everybody's not having missionary sex. Everybody's not having penetrative sex in that sense.
> -Non-profit professional, 31 years old, black, male

Similarly, respondents felt that a focus on condoms as the only prevention method failed to incorporate scientific evidence demonstrating the effectiveness of HIV treatment as prevention.

> So the individuals living with HIV [are] in treatment and taking care of themselves and finally suppressed now and undetectable. The truth is they're not passing HIV. But all we think of is condoms, condoms, condoms, get tested and condoms, condoms, condoms.
> -Non-profit professional, 31 years old, black, male

Generally, participants felt that the condom-centered prevention messaging was static and failed to meet the needs of YB-GBMSM.

Communication Behavior Cycles

Communication behavior cycles (CBCs) are nuanced approaches to HIV care that require high levels of communication and information sharing. Where rules are static and simplified, CBCs were dynamic and interactive. The results of these CBCs were often novel approaches to combating the HIV epidemic that hinged on input from all levels within organizations.

Macro-Level Ideologies

Macro-level CBCs sought to redefine the approach to HIV care through re-orienting approaches toward YB-GBMSM, expanding HIV care definitions, and including a call for community-based structures of care. Participants identified a need to shift focus toward de-pathologizing and embracing patients as holistic human beings operating within complex socio-ecological systems. One participant suggested a conceptual shift for health systems:

> Not like, let's start with HIV and work backwards. I think that's a completely wrong approach. But it's the approach that most people seem to take. And that's what public health does. It's like a - it's usually downstream, disease first, and then you work your way back. So that's how we do. So I think there's a lot of components to kind of making sure people understand we're part of the community, we're all part of a larger community, though different generations. We all have a lot to learn from each other. Um, starting to celebrate who we are, the good parts of ourselves, and then not focusing on pathology as the only part of our health.
> -Academic professional, 48 years old, male, black

Additionally, participants viewed the scope of HIV care as too limited. CBCs considered socio-contextual determinants as major obstacles to engagement in care for YB-GBMSM. One participant suggested specific organizational roles designed to target these factors:

> Maybe like social barriers … specialists, where they're dealing with like more social issues, like stigma and things like that and they go out and they present like to high schools and, you know, other community things."
> -Professional: Other, 25 years old, black, male

Participants generally felt that an answer to the limited scope of HIV care could be answered by institutional inclusion of a variety of backgrounds and experience. Emphasis was placed on community-powered approaches. One participant stated:

> We are so divided, the government keeps us divided that way. Because if you're an Asian organization you're only going to focus on the Asian experiences. If you're a black organization you're only going to focus on black experiences. When you start crossing those intersections and those lines and bringing what the Asian people know, bringing what the black people know, bringing what the Latino people know all into one area, and say this is a solid plan that can work for us as a community not us as separate entities, I think that's where our biggest problem lies at. Until we are able to come together as one and really truly be diverse in our conversations and diverse in our actions as well, we are never going to end this thing.
> -Non-profit professional, 35 years old, black, male

Ultimately, there was a push from participants to shift current HIV paradigms to include space for multidimensional interventions and approaches to care that involve communities.

Employee Value

Enactment as CBCs often led to heightened feelings of value from employees at all levels within an organization. This value often resulted from direct inclusion of YB-GBMSM in programming and decision making. Intentional hiring and professional development of these individuals was seen to have positive effects for organizations overall. For example:

> I’ve seen us make some intentional hiring choices to diversify and I’ve also seen engagement in people who work … closest with the people that we’re trying to recruit from community. So like a lot of the program coordinators have experience in community. A lot of recruitment retention specialists have experience with community groups and community organizations. So that definitely helps people to be more effective, from the university perspective, when they’re in the community because they know those people in the community.”
> -Academic professional, 45 years old, black, female

Respondents often cited personal connections to HIV+ individuals as an instrument in creating allies that provided quality care. As one participant explained:

> Um, a lot of people that I work with here in, at [HIV clinic name], either have someone they've lost to HIV, somebody they know who's living with HIV, family, um, they are just passionate about the work of helping people... There's something that drew them to this work. They didn't just wake up one day and decide, 'I want to go work in HIV.' Um, something brought them here. And that's the great thing about the people who work here, is that they didn't need a lot of motivation after they got here, they had it before they came. You have a few people who did come in, kind of naïve, and didn't know much about HIV and learned some stories and, and heard from us and all that kind of stuff.
> -Medical professional, 43 years old, black, male

Personal connections and alliances were viewed as productive exhibitions of humanity that should be nurtured and viewed by organizations as desirable qualities.

Collaboration between organizations

CBCs presented during times when organizations worked together to combat the HIV epidemic. These instances were viewed as productive interactions that distributed the workload evenly.

These interactions relied heavily on interagency trust to guarantee programmatic success. For example:

> [The GA Coalition to End HIV Criminalization] I think is an amazing model. I have had - it's so interesting that we're all able to kind of come together and sit at a table and have this kind of intersectional dialogue and all walk away with a task and then we accomplish a task and we're able to come back to the table and talk about it.
> -Non-profit professional, 39 years old, black, male

Information sharing among organizations was also emphasized among participants as an essential part of HIV care. One participant demonstrated the ways in which data can be wielded to provide quality care:

> [The electronic medical record] generates an alert and it says, "This patient may be out of care." And so those alerts come to myself and one of the ED attendings [physicians], which if it's during working hours, we actually forward it to one of the social workers in the emergency room that is dedicated to doing HIV screening because they have a testing program in the ED. They'll approach the patient or reach out to the patient and just inform them that we learned that you might not be in care and they make an attempt at that point to relink them to care.
> -Medical professional, 35 years old, white, male

Generally, participants acknowledged the need for cohesive approaches to community events. CBCs presented opportunities for collaboration within structures that already existed, although organizations did not necessarily capitalize on these opportunities. One participant describes the city Gay Pride events as one such aspirational event:

> Even with Pride, like, you have everybody... you've got 85,000 parties going on and every organization is at a party versus everybody saying, 'Okay, we're going to get together and have just one big team of people and we're going to disperse and do everything we need to do from an advocacy standpoint. But we're working together.' That doesn't happen. If it did happen, a lot of things would probably be different from, um, from just an agency standpoint"
> -Non-profit, 33 years old, black, male

Patient- Organization Interaction

CBCs of enactment often consisted of relationship-driven interactions between staff and YB-GBMSM. These relationships provided space and autonomy for the workers and allowed individual patients to be experts on their own care. Many participants stressed the importance of compassionate care when providing HIV services. Flexibility, open-mindedness, and strengths-focused perspectives were ideal qualities for providers. As one participant explains:

> I just try and meet my patients where they are. Um, I think in the time that I've been here it's, gone over the days of sort of well, you know, how do you want to do this or do that? It's more just like, okay, well, what can we do today? Where are you with things? How are you feeling about things? And I'm like, what do you feel like you could work on? And sometimes I get patients that I know what they need, I mean, I know what I think they need. And medically I definitely know what they need. But that's just so not where they are, they need to get stable housing or come to terms with their diagnosis."
> -Medical professional, 30, white, female

These relationships often formed a familial dynamic, helping to fill gaps in social support for YB-GBMSM. Often, they were considered highly effective instruments for engagement.

> So, as big brother, I guess, it's weird to say in the work setting that I serve the role as the person's big brother. But for the last three years I worked in a program that was just strictly designed to support black gay men. And through that program I found a lot of, you know, learned a lot about myself and fortified myself a lot about my own HIV positivity. And because of that I was able to cofound this amazing network and you know and community-based organization. And so the reason that in that capacity I operated mostly as big brother is because there's no way to support someone as a CEO you know? There's no way to support somebody as a director or anything like that. I think that you have to, in order to really, truly support a person and to impact their life, you have to really connect with them. So I've connected with the people within my network and outside of it on a level or try to connect with them on a level of familiar level because I feel like it's the most impactful way to really help them.
> -Non-profit professional, 38 years old, black, male

CBCs that targeted relationship-building were credited with changing individual narratives around HIV status. Closeness was viewed by participants as an essential tool to constructing spaces where individuals moved from "surviving to thriving." As one participant explains:

> That's truly what we do, we transform HIV *resentment*. When people thought there was no hope, there was no way out besides just to live this life with HIV and be scared and in the closet and we're transforming that into some victories, it's like having the event we had not too long ago where 12 or 13 people came out about their status and they're living their truth and we had our THRIVE campaign where it showcases individuals that made it along this journey and now they're okay with saying, 'I'm HIV positive'. I'm HIV, that's me who else is doing it? You tell me, I don't know. I mean because right now everyone don't want

> to talk about being HIV positive. And so we're sitting here coming together as a family; and I think that's one thing that's unique about our organization is that it's like a family.
> -Non-profit professional, 31 years old, black, male

In addition to relationships that organizations built with YB-GBMSM, participants expressed the importance of feedback loops as part of engagement with YB-GBMSM. These loops took on several forms such as in-depth-interviews, focus groups, community advisory boards and inclusion of patient in programmatic decisions. One respondent described the strengths of focus groups:

> We do some focus groups of course, when that is the goal. When we need, like I said, thoughts, feelings, experiences regarding either care of decreasing health disparities. Of course, like I said, referral base if somebody needs resources, we're here for that. If not, then we're I mean we're here
> --Non-profit professional, 31 years old, black, male

Cultural Competency Training

CBCs within training materialized as ongoing, comprehensive and dialogue-based. Participants demonstrated that effective trainings result in complex team-based problem-solving. Often, effective organizational learning stemmed from interactive experience sharing among all levels. For example:

> Like I said, a big portion that we do focus on is education. And so, before we can educate anybody out there, we have to educate ourselves first. And so, you know, we do like little sort of like trainings, and then, you know, like we said, we post our messages up and we'll send things to each other. Um, so before, you know, anything happens, we can go in and be like, okay, well, I'm confident about this, I know about that. But I also have a brother or a sister or a father, uh, if I do have any questions, or like, you know, a crossover, something that I might not be too sure of, I can rely on them, um, to assist with that. But we are very confident, um, when it comes to, um, black MSMs and the challenges that they possibly face.
> -Medical professional, 30 years old, black, female

Participants also felt that current training modules were static and insufficient. Cultural competency often arose as subject matter that was insufficiently discussed within organization. When describing ideal cultural competency trainings, participants described a need for a shift in training approaches that would lead to more of a CBC approach:

> [Cultural competency] needs to be the curriculum, I haven't seen it unfortunately. It needs to certainly be robust so that when you do know and see and identify people who identify differently from you, you know how to navigate that. You know how to create an environment that's inviting or welcoming.
> -Health-department professional, 29 years old, black, male

Bureaucratic Factors

CBCs were found to include patient-centered approaches that focused on quality customer service. Participants expressed that frequent contact with medical providers created comforting and engaging environments for YBGBMSM. As one participant stated:

> [When patients are enrolling in the clinic] we meet with them sort of ahead of time just to sort of introduce themselves and get their baseline labs and make sure that they're feeling okay and comfortable with everything"
> -Medical professional, 30 years old, white, female

Flexible communication methods were an essential part of the engagement process with YB-GBMSM. Participants generally felt that these methods should be paralleled to the preference of the patients for highest levels of effectiveness. For example:

> I had to learn, for example, to stop emailing my patients. They don't email. You are not going to get a 20-year-old to email you, they don't email. So I got a Google Voice number so they could text me and they could reach me. Um, I think, you know, um, social media, um, is important. Um, and I think if you - if you want to engage people from a particular group you have to get the help of people from that particular group, right?
> -Medical professional, 33 years old, black, female

Other bureaucratic factors were that focused on care facilitation were new-patient orientations, consolidation of redundant paperwork, and "touchpoint" activities that reaffirm HIV baseline knowledge such as:

> Um, what we do is we have a new model now, before people can even come to the events and stuff, they have to do a touch point activity of order. So that's our admission into our events. You have to do some of the games and learn the things. So some of them can be trigger questions around HIV and AIDS, around, um, safer sex, around, um, housing, living, all these different topics we try to touch with our touchpoint activities.
> -Non-profit professional, 35 years old, male, black

Intervention Strategies

Intervention strategies in the CBC category were creative and innovative interventions geared toward YB-GBMSM. Notably, most of the CBC-type interventions were created by YB-GBMSM themselves. These interventions relied less on traditional didactic approaches to education and emphasized participant dignity. One participant points out this transformation:

> Because working with young, black gay men, particularly positive men, it's not transactional, it's not just about the linkage. It's about bolstering, you know, a person's belief in their success trajectory.
> -Professional: Other, 33 years old, male, black

Significantly, participants expressed a need to emphasize the unique, dynamic and diverse culture of YB-GBMSM. “Best practice” standards were viewed to come from traditionally white strategies and perspectives. Culturally grounded interventions were viewed as a necessary part of HIV care for YB-GBMSM. As one participant stated:

> So there is a such thing as a black gay culture and it can never be a spinoff of something for white gay people. Honoring the fact that black people, before they’re black, are African and, as such, have Africanisms, and especially black gay men. We operate in a very African way. We’re very, you know, gaudy and loud and expressive and communal and we’re clanly. And I think it’s honoring that African part of blackness and not just seeing it as you know, black Americanness or you know some spinoff of, you know, some shit that occurred in American but also in Africa.
> -Non-profit professional, 38 years old, black, male

Additionally, traditional “support groups” were reconceptualized to incorporate social media as a means of increasing impact:

> So [organization name] sets up networks; secret, private networks around the country or highly impacted populations. So we have two in Atlanta; one for women that has almost 200 women, one for black gay men that has about 640 men. So basically we set up support networks for us via support networks. Networks that you know include nothing but people that are HIV positive, be it the you know, homeless kid that just moved to this city and was connect through an ASO or like a person that actually works at the ASO, you know. And what happens is that they get to interface in a way that just supports life regardless and not just viral suppression, not because of your HIV life but just supports life you know? You share who you are and a person that’s in a same health situation as you, gets to chime in

> and share who they are and you get to learn and grow by just simply gleaning inspiration and information from people just like you."
> -Non-profit professional, 38 years old, black, male

Participants also provided in-person examples of creative new approaches structured around CBCs:

> So, like, we do this thing called Queer Movie Nights as well, where we, um, do a screening of a film that' very queer-friendly. Um, and like last - no, a couple of days ago on Tuesday or Monday, I think, we, um, saw the screening of Kiki, it's this new documentary that takes about the Kiki scene in New York. And we would talk about the importance of, um, like us using the privilege that we have to help in LGBT youth homelessness. Um, and making sure that, yeah, we can, you know, definitely talk about how to decrease barriers to care, um, for queer folks, but also making sure that we're affirming and addressing issues about us holistically. \
>
> -Academic professional, 22 years old, black, male

Ultimately, there was a push for innovative interventions that re-imagined and added dimension to "business as usual practices." These were viewed by participants to garner positive feedback from YB-GBMSM that facilitated engagement and relationship building.

Figure 1.1 Enactment Themes as Rules and Communication Behavior Cycles

Theme	**Rules**	**Communication Behavior Cycles (CBCs)**
Macro-Level Ideologies	• Rigid healthcare systems • “One size fits all” approach to scaling	• Diversity in action • Increased focus on socio-contextual issues. • Community-powered
Employee Value	• Organizations undervalue and underpay staff	• Engage staff from the community and involve them in decision making
Collaboration with Organizations	• Organizations compete for testing numbers, limits collaboration. • Trickle down” funding limits organizations’ reach. • Self-advertising	• Information sharing • Collaboration between organizations
Patient-Organization Interactions	• Assigning set personality traits to YBMSM • Negative customer service experiences • Customer satisfaction surveys are too limited	• Construction of familial dynamic • Social support • Flexibility in communication styles • Relationship-driven • Strengths-based approach • “Being a listener” as part of job • “Compassionate care
Cultural competence training	• “One-time” staff trainings.	• Interactive/on-going training • Robust cultural consciousness curriculum
Bureaucratic Factors	• Long wait times for uninsured individuals • Patients must “jump through hoops.” • Processes of referrals • Paperwork • Hours of operation • Patient requirements (health hx, zip code) • Contacting patients • Tracking methods • Ryan White metrics don’t align with quality care	• Increased availability of providers • Access to cell-phones/reimagining communication. • Pre-appointment meetings • Touchpoint activities • Feedback loops • New patient orientation
Intervention Strategies	• Condoms as prevention	• Informal spaces • Use of art • Incorporation of culture • Mentorship • Use of stories/narrative

Discussion

Our findings indicate that CBCs are more likely than rules to be effective and appropriate for addressing the complexity of HIV in YB-GBMSM living in Atlanta. In contrast, rules-based responses are over-simplified, and create additional barriers to care for many YB-GBMSM. In spite of this rules were often presented as the default method of enactment by organizations, while CBCs were discussed as aspirational strategies. These CBCs were process-based responses to HIV care that possessed the potential to transform rules-based approaches. Results highlighted the need for further organizational investment in CBCs, as the most successful organizations possessed a combination toolkit of rules and CBCs.

These results align with other uses of Weick's theory of organizing as a framework to guide organizational design and approaches to problem-solving. In case studies involving nurse retention, medication adherence, and palliative care [35], CBCs were found to be favorable approaches to enactment and to fulfil a need that was insufficiently met by rules-based ideologies and structures of organizing. This is largely due to the complexities of problems within the medical field. In order to be truly effective, enactment approaches and selection processes must respond with equal levels of complexity. These results add to current public health literature because they examine HIV care among YB-GBMSM as a highly equivocal pocket of healthcare that can be best served through CBC-based perspectives and structures.

Recommendations

It would be beneficial for HIV service organizations and providers to examine interorganizational and intraorganizational rules-based approaches to enactment and determine pathways for transformation into CBC-based styles of enactment. In many cases, the rigidity of rules- based approaches created additional barriers to care, rather than alleviating them.

Organizations should seek to redefine approaches to HIV care through re-orienting interactions with YB-GBMSM to be more inclusive and culturally sensitive, expanding HIV care definitions to include socio-contextual factors, and improving workforce diversity. This paradigm shift would create spaces that treat YB-GBMSM as holistic individuals and celebrate the unique and diverse experiences that these individuals face as instrumental components of HIV care. If organizations move away from rigid bureaucratic structures and toward patient-centered approaches, it will likely increase engagement of YB-GBMSM in care. Future research and interventions should consider the use of CBCs to shape narratives that effectively engage YB-GBMSM.

Enactment as CBCs often leads to increased sense of value from employees at all levels within an organization. This value could result from direct inclusion of YB-GBMSM working in the HIV field in programming and decision making. Cultural competency training would be the most impactful when re-imagined as a participatory and constant process with employee participation and buy-in. Additionally, personal connections and alliances are characteristics that should be viewed as desirable qualities to be nurtured in employees. The familial relationships that CBCs create allow for strong connections between YB-GBMSM and service providers. Existence of relationships and quality customer service experiences are fundamental to engagement of YB-GBMSM in HIV care.

Regarding intraorganizational collaboration, CBCs emerge when organizations work together to combat the HIV epidemic. CBCs present opportunities for collaboration within organizational structures that already exist. CBCs based on collaboration should be the norm for organizational behavior to increase partnerships and eliminate gaps in service coverage. As HIV service providers begin to increase collaboration, it would be effective to rely less on traditional didactic approaches to education and outreach. Clinics and CBOs should support and compensate experienced points-of-contact in the field in the development of innovative HIV intervention strategies.

Limitations

This data collection was not intended to explore enactment styles among HIV service providers in Atlanta. Therefore, it is possible that additional insight could be gained from further research primarily focused on this topic. Additionally, organizational enactment varies by institution. A need exists for additional research on the similarities between organizations that utilize CBCs and strategies to increase buy-in from decision makers within their organizations. HIV service providers could benefit from internal process reviews and evaluations of practices and procedures to best determine how to transition from rules-based enactment to CBC-based approaches.

Conclusion

Weick's theory of organizing provides a framework for re-imagining HIV care provision for YB-GBMSM. This theory highlights the effectiveness of CBCs as a process of organizational enactment. These findings are oppositional to rules-based approaches, which are often too simple to address the complexity of HIV in YB-GBMSM living in Atlanta. HIV service organizations and providers would benefit from considering a shift from rules-based structures to CBCs that emphasize communication and information sharing. Future research is needed to explore similarities in successful organizational structures that are CBC informed. Additionally, HIV and other healthcare organizations would better serve their patient populations by examining policies, procedures and structures that could be transitioned from rules-based enactment approaches to CBC-informed approaches.

Public Health Implications

If Weick’s model is used for self-evaluation by organizations and networks of HIV service providers, there is a potential for progressive radicalization of HIV care as it currently exists. This shift involves expanding definitions of care, creation of forward-thinking and innovative intervention and education strategies, the promotion of YB-GBMSM to the forefront of the HIV field, and transformation of professional development and continued education. With these changes, notions of collaboration could be redesigned to be substantive instead of competitive. Funding sources could support these metamorphoses rather than perpetuate “business as usual” rules-focused styles of enactment. Ultimately, the potential exists to significantly decrease disparities in HIV outcomes among YB-GBMSM and the general United States population through reshaping their access to care.

References

1. Singh S, Mitsch A, Wu B. HIV Care Outcomes Among Men Who Have Sex With Men With Diagnosed HIV Infection — United States, 2015. MMWR Morb Mortal Wkly Rep 2017;66:969–974. DOI: http://dx.doi.org/10.15585/mmwr.mm6637a2

2. Marano M, Stein R, Song W, et al. HIV Testing, Linkage to HIV Medical Care, and Interviews for Partner Services Among Black Men Who Have Sex with Men — Non–Health Care Facilities, 20 Southern U.S. Jurisdictions, 2016. MMWR Morb Mortal Wkly Rep 2018;67:778–781. DOI: http://dx.doi.org/10.15585/mmwr.mm6728a3External3

3. Scott, W. R., Davis, G. F., & Scott, W. R. (2016). Organizations and organizing: Rational, natural, and open system perspectives. Oxford: Routledge.

4. Weick, K. E. (2006). The social psychology of organizing. New York: McGraw-Hill.

5. Kreps, G. L. (2009). Applying Weick's model of organizing to health care and health promotion: Highlighting the central role of health communication. Patient Education & Counseling, 74(3), 347–355. https://doi.org.proxy.library.emory.edu/10.1016/j.pec.2008.12.002

6. CDC. Estimated incidence and prevalence in the United States 2010-2015. HIV Surveillance Supplemental Report 2018;23(1)

7. Millett, G. A., Peterson, J. L., Wolitski, R. J., & Stall, R. (2006). Greater risk for HIV infection of black men who have sex with men: a critical literature review. American journal of public health, 96(6), 1007–1019. doi:10.2105/AJPH.2005.066720

8. Sullivan, P. S., Peterson, J., Rosenberg, E. S., Kelley, C. F., Cooper, H., Vaughan, A., … Sanchez, T. H. (2014). Understanding racial HIV/STI disparities in black and white men who have sex with men: a multilevel approach. PloS one, 9(3), e90514. doi:10.1371/journal.pone.0090514

9. CDC. Estimated incidence and prevalence in the United States 2010-2015. HIV Surveillance Supplemental Report 2018;23(1)

10. Millett, G. A., Peterson, J. L., Wolitski, R. J., & Stall, R. (2006). Greater risk for HIV infection of black men who have sex with men: a critical literature review. American journal of public health, 96(6), 1007–1019. doi:10.2105/AJPH.2005.066720

11. Mirani, G., Williams, P. L., Chernoff, M., Abzug, M. J., Levin, M. J., Seage, G. R., 3rd, … IMPAACT P1074 Study Team (2015). Changing Trends in Complications and Mortality Rates Among US Youth and Young Adults With HIV Infection in the Era of Combination Antiretroviral Therapy. Clinical infectious diseases: an official publication of the Infectious Diseases Society of America, 61(12), 1850–1861. doi:10.1093/cid/civ687

12. Marano M, Stein R, Song W, et al. HIV Testing, Linkage to HIV Medical Care, and Interviews for Partner Services Among Black Men Who Have Sex with Men — Non–Health Care Facilities, 20 Southern U.S. Jurisdictions, 2016. MMWR Morb Mortal Wkly Rep 2018;67:778–781. DOI: 4http://dx.doi.org/10.15585/mmwr.mm6728a3External9

13. CDC. Estimated incidence and prevalence in the United States 2010-2015. HIV Surveillance Supplemental Report 2018;23(1)

14. Mitchell, K. M., Hoots, B., Dimitrov, D., German, D., Flynn, C., Farley, J. E., … Boily, M. C. (2019). Improvements in the HIV care continuum needed to meaningfully reduce HIV incidence among men who have sex with men in Baltimore, US: a modelling study for HPTN 078. Journal of the International AIDS Society, 22(3), e25246. doi:10.1002/jia2.25246

15. Reif, S., Pence, B. W., Hall, I., Hu, X., Whetten, K., & Wilson, E. (2014). HIV Diagnoses, Prevalence and Outcomes in Nine Southern States. Journal of community health, 40(4), 642–651. doi:10.1007/s10900-014-9979-7

16. Reif, S.. Whetten, K., Wilson, E., McAllaster, C., Pence, B., Legrand, S. & Gong, W. (2014) HIV/AIDS in the Southern USA: A disproportionate epidemic, AIDS Care, 26:3, 351-359, DOI: 10.1080/09540121.2013.824535

17. Office of National AIDS Policy. National HIV/AIDS strategy for the United States: updated to 2020. Washington, DC: Office of National AIDS Policy; 2015. https://obamawhitehouse.archives.gov/sites/default/files/docs/national_hiv_aids_strategy_update_2020.pdfCdc-pdf

18. Hoots, B. E., Finlayson, T. J., Wejnert, C., Paz-Bailey, G., & NHBS Study Group (2015). Early Linkage to HIV Care and Antiretroviral Treatment among Men Who Have Sex with Men--20 Cities, United States, 2008 and 2011. PloS one, 10(7), e0132962. doi:10.1371/journal.pone.0132962

19. Rupali K. Doshi, J. Li, K. Dorsey, A. Allston & M. Kharfen (2019) Earlier diagnoses and faster treatment of HIV in the District of Columbia: HIV surveillance analysis, 2006–2016, AIDS Care, DOI: 10.1080/09540121.2019.1595516

20. Dombrowski, J. C., Simoni, J. M., Katz, D. A., & Golden, M. R. (2015). Barriers to HIV care and treatment among participants in a public health HIV care relinkage program. AIDS patient care and STDs, 29(5), 279-287.

21. Gant, Z., Gant, L., Song, R., Willis, L., & Johnson, A. S. (2014). A census tract-level examination of social determinants of health among black/African American men with diagnosed HIV infection, 2005-2009--17 US areas. PloS one, 9(9), e107701. doi:10.1371/journal.pone.0107701

22. Garcia, J., Parker, C., Parker, R. G., Wilson, P. A., Philbin, M., & Hirsch, J. S. (2015). Psychosocial Implications of Homophobia and HIV Stigma in Social Support Networks:

Insights for High-Impact HIV Prevention Among Black Men Who Have Sex With Men. Health education & behavior : the official publication of the Society for Public Health Education, 43(2), 217–225. doi:10.1177/1090198115599398

23. Glick, S. N., & Golden, M. R. (2010). Persistence of racial differences in attitudes toward homosexuality in the United States. Journal of acquired immune deficiency syndromes (1999), 55(4), 516–523. doi:10.1097/QAI.0b013e3181f275e0

24. Wilson, P. A., & Moore, T. E. (2009). Public health responses to the HIV epidemic among black men who have sex with men: A qualitative study of US health departments and communities. American journal of public health, 99(6), 1013–1022. doi:10.2105/AJPH.2008.140681

25. Garcia, J., Parker, C., Parker, R. G., Wilson, P. A., Philbin, M., & Hirsch, J. S. (2015). Psychosocial Implications of Homophobia and HIV Stigma in Social Support Networks: Insights for High-Impact HIV Prevention Among Black Men Who Have Sex With Men. Health education & behavior : the official publication of the Society for Public Health Education, 43(2), 217–225. doi:10.1177/1090198115599398

26. William L. Jeffries IV, Deborah J. Gelaude, Elizabeth A. Torrone, Mari Gasiorowicz, Alexandra M. Oster, Pilgrim S. Spikes Jr, Donna Hubbard McCree & Jeanne Bertolli (2017) Unhealthy environments, unhealthy consequences: Experienced homonegativity and HIV infection risk among young men who have sex with men, Global Public Health, 12:1, 116-129, DOI: 10.1080/17441692.2015.1062120

27. Quinn, K., Dickson-Gomez, J., Zarwell, M., Pearson, B., & Lewis, M. (2018). A gay man and a doctor are just like, a recipe for destruction": how racism and homonegativity in healthcare 3ettings influence PrEP uptake among young black MSM. AIDS Behavior. 2018 Dec 18. doi: 10.1007/s10461-018-2375-z

28. Malebranche, D. J., Peterson, J. L., Fullilove, R. E., & Stackhouse, R. W. (2004). Race and sexual identity: perceptions about medical culture and healthcare among Black men who have sex with men. Journal of the National Medical Association, 96(1), 97–107.

29. Perceived race-based and socioeconomic status(SES)-based discrimination in interactions with health care providers.

30. Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC health services research, 14, 99. doi:10.1186/1472-6963-14-99

31. Weick, K. E. (2006). The social psychology of organizing. New York: McGraw-Hill.

32. Kreps, G. L. (2009). Applying Weick's model of organizing to health care and health promotion: Highlighting the central role of health communication. Patient Education &

Counseling, 74(3), 347–355. https://doi-org.proxy.library.emory.edu/10.1016/j.pec.2008.12.002

33. Ledford, C. J. W., Canzona, M. R., Cafferty, L. A., & Kalish, V. B. (2016). Negotiating the equivocality of palliative care: a grounded theory of team communicative processes in inpatient medicine. Health Communication, 31(5), 536–543. https://doi-org.proxy.library.emory.edu/10.1080/10410236.2014.974134

34. Hussen, S., Jones, M., Moore, S., Hood, J., Smith, J., Camacho-Gonzalez, A., del Rio, C., & Harper, G., (2018) Brothers building brothers by breaking barriers: development of a resilience-building social capital intervention for young black gay and bisexual men living with HIV, AIDS Care, 30:sup4, 51-58, DOI: 10.1080/09540121.2018.1527007
