Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations Initiative: Intervention Monographs

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SPNS
LATINO
ACCESS
INITIATIVE

Demonstration Sites:

- AIDS Foundation of Chicago
- AIDS Project Los Angeles (APLA) Health
- Bienestar Human Services, Inc.
- Gay Men's Health Crisis
- New York City Health + Hospitals Correctional Health Services
- Philadelphia FIGHT
- Prism Health North Texas
- The Ruth M. Rothstein CORE Center
- University of North Carolina, Chapel Hill

UCSF Center for AIDS Prevention Studies
Prevention Research Center
Division of Prevention Science

Evaluation and Technical Assistance Center:
University of California San Francisco

Contents

Evaluation and Technical Assistance Center Team

Janet Myers, PhD, MPH[1]
Lisa Georgetti Gomez, MSPH[1]
Ron Brooks, PhD[2]
Sophia Zamudio-Haas, DrPH, MSc[1]
Andres Maiorana, MA, MPH[1]
Starley Shade, PhD, MPH[1]
Remi Frazier, MS[1]
John Sauceda, PhD[1]
Carlos E. Rodríguez-Díaz, PhD, MPHE, MCHES[3]

1) University of California San Francisco, Division of Prevention Science – Center for AIDS Prevention Studies (CAPS) / Prevention Research Center (PRC)
2) Center for HIV Identification, Prevention and Treatment Services, University of California Los Angeles
3) Department of Prevention and Community Health, George Washington University – Milken Institute School of Public Health

Introduction

Disparities in HIV care

Despite rapid advances in the availability and quality of HIV care in the US, Latino/as continue to be disproportionately affected. Although Hispanics/Latinos only compromise about 16% of the total US population,[i] they account for 21% of people living with HIV and are infected at a rate three times higher than their non-Latino white counterparts.[ii] Along the HIV care cascade, Hispanics/Latinos demonstrate higher percentages of linkage, retention, and prescription of ART as compared to the national population. However viral suppression among the Hispanic/Latino population remains low with only 36.9% of HIV-infected Latinos achieving viral suppression.[iii] This may be attributed in part to the higher rates of delayed HIV diagnosis and delayed engagement in care among Latinos,[iv] which has been associated with poor health outcomes.[v,vi] Rates of delayed diagnosis and engagement in care are even more pronounced among foreign-born Latinos[vii] and those born in Mexico or Puerto Rico have lower survival at 36 months post AIDS diagnosis compared to those born in the U.S. and South America.[viii]

Barriers to linkage, engagement and retention in HIV care

A range of social and structural barriers impedes timely and consistent access to HIV care for Latinos. *Social factors*, such as discrimination and HIV stigma, can negatively affect health seeking behaviors of HIV-infected Latinos/as. HIV stigma has been associated with delayed HIV testing and entry into care and HIV discrimination in the health care setting is also a strong deterrent to accessing HIV medical services.[ix,x] In addition, many *structural barriers* result from economic disparities affecting Latinos in the US. For example, many Latinos living with HIV struggle with competing needs - such as finding and keeping work and housing - that take priority over health care.[xi,xii] Structural barriers that particularly affect Latinos include lack of bilingual services in Spanish, low rates of health insurance coverage, and lack of transportation.[xii] For Latinos who are not citizens or in the US with official documents, fear of deportation can also reduce willingness to access care.[xiii,xiv]

Cultural factors can also result in delays when Latina/os living with HIV, particularly immigrants, enter medical care.[xv,xvi] Among Latina/os, cultural values such as *simpatia* (politeness and the avoidance of hostile confrontation), *personalismo* (the value of warm personal interaction), *respeto* (the importance of showing respect to authority figures, including health care providers), *familismo* (collective loyalty to extended family and commitment to family obligation) and *fatalismo* (the belief that individuals cannot do much to alter fate) can play a significant role in when they access HIV care as well as influence the decisions they make around issues of HIV care.[xvii,xviii] While these values are generalizations and may not apply to any individual patient, understanding them may help health care providers to understand a particular patient's behavior in the context of lager cultural inclinations.

Among Latinos/as, access to HIV testing and HIV medical care is further influenced by *country of origin and U.S. citizenship.* CDC reports indicate that approximately 55% of Latina/os born in Mexico and 58% of Latina/os born in Central America have a late diagnosis (defined as progression to AIDS within 1 year of diagnosis), compared to 40% of Puerto Ricans and other Latinos born in the U.S.[xix] Although HIV testing is available for all U.S. residents at public health clinics, regardless of citizenship status, accessing these services requires an understanding of how to navigate the health care system, which may be difficult for monolingual Spanish-speakers. Undocumented immigrants may have suspicion or anxiety about visiting health centers for fear that information about them will be released to other government agencies.[xx]

Transnationalism

The application of a standard set of cultural elements to interventions and programs targeting Latinos/as fails to take into account the heterogeneity of Latino cultural practices and values. Because Latino culture and identity often differ between and within countries,[xxi,xxii] it may be beneficial to incorporate a transnational perspective in order to take into account the unique experience of each individual. The transnational perspective takes into account the "duality" of the immigrant experience, exploring the immigrant's process of adapting to their host country while continuing to maintain connection to their country of origin.[xxiii] As a result, health seeking behavior may be influenced by more than one culture.[xxiv] The transnational framework looks specifically at the social, political, social and cultural ties of an immigrant to their place of origin.[xxiii-xxv] Taken together, research around social, structural and possible cultural barriers to care and research on how transnational practices influence care, suggest a need for novel and tailored intervention approaches to improve linkage and retention in care for Latinos living with HIV in the continental US.

This Initiative

Under the Health Resources and Services Administration's (HRSA) Special Projects of National Significance (SPNS) Program **Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations,** nine demonstration sites are developing innovative methods to identify Latinos who are at high risk or living with HIV and out of care or unaware of their HIV-positive status, and improve their access, timely entry and retention in quality HIV primary care. This initiative is one of the first public health adaptations of the transnational approach, with interventions targeting HIV-infected Latino subpopulations living in the US that are specific to their country or place of origin.

This manual describes each of these interventions, including:

- The local epidemiology and unique needs of the populations served
- A description of each organization
- Key components of each intervention including outreach, recruitment, and retention strategies
- A logic model and/or a description of how each key intervention component addressed various stages of the HIV Care Continuum (e.g. linkage, retention, ART adherence, and viral suppression)
- Core intervention staff
- Description of community partners, when appropriate
- Staffing requirements and cost estimates
- Program planning and development needs
- Preliminary programmatic outcomes
- Important lessons learned

Funding

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References

[i] U.S. Census Bureau (2011). *The Hispanic population: 2010. 2010 Census Briefs.* Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf

[ii] Centers for Disease Control and Prevention (2016). *HIV Surveillance Report, 2015: vol. 27. Available from* http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

[iii] Gant Z, Bradley H, Hu X, et al. (2014). *Hispanics or Latinos living with diagnosed HIV: progress along the continuum of HIV care – United States, 2010. Morbidity and Mortality Weekly Report, 63(40). Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6340a2.htm.*

[iv] Chen NE, Gallant JE, and Page KR. (2012). *A systematic review of HIV/AIDS survival and delayed diagnosis among Hispanics in the United States. Journal of Immigrant and Minority Health,* 14(1): 65-81.

[v] Hoggs RS, Yip B, Chan KJ, et al. (2001). *Rates of disease progression by baseline CD4 cell count and viral load after initiating triple-drug therapy. JAMA,* 286(20):2568-77.

[vi] Egger M, May M, Chene G, et al. (2002). *Prognosis of HIV-1-infected patients starting highly active antiretroviral therapy: a collaborative analysis of prospective studies. Lancet,* 360:119-29.

[vii] Sheehan DM, Trepka MJ, and Dillon FR. (2015). *Latinos in the United States on the HIV/AIDS care continuum by birth country/region: a systematic review of the literature. International Journal of STD & AIDS,* 26(1):1-12.

[viii] Espinoza L, Hall HI, Hu X. (2012). *Diagnoses of HIV infection among Hispanics/Latinos in 40 states and Puerto Rico, 2006–2009. Journal of Acquired Immune Deficiency Syndrome*, 60(2):205–13.

[ix] Aziz M, Smith KY. Challenges and successes in linking HIV-infected women to care in the United States. Clin Infect Dis. 2011; 52 Suppl 2: S231-7.

[x] Block RG. Is It Just Me? Experiences of HIV-Related Stigma. Journal of HIV/AIDS & Social Services. 2009; 8(1): 1-19.

[xi] Keese MS, Natale AP, Curiel HF. HIV positive Hispanic/Latinos who delay HIV care: Analysis of multilevel care engagement barriers. Soc Work Health Care. 2012; 51:457-478.

[xii] Cavaleri MA, Kalogerogiannis K, McKay MM et al. Barriers to HIV care: an exploration of the complexities that influence engagement in and utilization of treatment. Soc Work Health Care. 2010; 49(10): 934- 45. doi: 10.1080/00981389.2010.514563.

[xiii] Kinsler JJ, Lee SJ, Sayles JN et al. The impact of acculturation on utilization of HIV prevention services and access to care among an at-risk Hispanic Population. J Health Care Poor Underserved. 2009; 20(4): 996- 1011. doi: 10.1353/hpu.0.0204.

[xiv] Berk ML, Schur CL. The effect of fear on access to care among undocumented Latinos immigrants. J Immigr Health. 2001; 3: 151-6.
[xv] Dang BN, Giordano TP, Kim JH. Sociocultural and structural barriers to care among undocumented Latino immigrants with HIV infection. J Immigr Minor Health. 2012; 14(1): 124-31.
[xvi] Organista KC, Carrillo H, Ayala G. HIV prevention with Mexican migrants: review, critique, and recommendations. J Acquir Immune Defic Syndr. 2004; 37 Suppl 4: S227-39.
[xvii] Garland JM, Andrade AS, Page KR. Unique aspects of the care of HIV-positive Latino patients living in the United States. Curr HIV/AIDS Rep. 2010; 7(3): 107-16.
[xviii] Flores G. Culture and the patient-physician relationship: achieving cultural competency in health care. J Pediatr. 2000; 136(1): 14-23.
[xix] Fact Sheet: HIV among Latinos: Centers for Disease Control and Prevention (CDC); Nov 2011.
[xx] Dang BN, Giordano TP, Kim JH. Sociocultural and structural barriers to care among undocumented Latino immigrants with HIV infection. J Immigr Minor Health. 2012; 14(1): 124-31.
[xxi] Herbst JH, Kay LS, Passin WF, Lyles CM, Crepaz N, Marin BV: A systematic review and meta-analysis of behavioral interventions to reduce HIV risk behaviors of Hispanics in the United States and Puerto Rico. AIDS Behav. 2007;11:1:25-47.
[xxii] Motel S, Patten E: Hispanic Origin Profiles. Pew Hispanic Center. Accessed October, 2016 from: http://www.pewhispanic.org/2012/06/27/country-of-origin-profiles/. Published June, 2012.
[xxiii] Schiller NG, Basch L, Blanc-Szanton C: Towards a definition of transnationalism: Introductory remarks and research questions. Ann N Y Acad Sci. 1992;645:ix-xiv.
[xxiv] Vertovec S: Transnationalism and identity. J Ethn Migr Stud. 2001;27:573-582.
[xxv] Smith R: Mexican New York: Transnational lives of new immigrants. Berkeley: University of California Press; 2006.

AIDS Foundation of Chicago

Project Name: Salud y Orgullo Mexicano

Location: Chicago, Illinois

Authors: Amy K. Johnson, Ph.D. MSW, Román Buenrostro, Gilberto Soberanis, Bridget Magner

AIDS FOUNDATION OF CHICAGO

Local Epidemiology

As of 2015, there were approximately 24,000 people living with HIV/AIDS in the Chicago eligible metropolitan area with a disproportionately large representation of Latino and African American men who have sex with men (MSM) living in Chicago's South and West side neighborhoods.[1] Chicago is a racially segregated city, with most of the South and West Side neighborhoods being predominately made up of African Americans and Latinos. Chicago's linkage to care and retention in care rates are generally much better than the national rate, at 78% and 61% respectively. However, people living with HIV/AIDS (PLWHA) of color in Chicago continue to struggle with engagement in care relative to their white counterparts.

According to the Chicago Department of Public Health, Chicago Latinos' risk of acquiring HIV is elevated: their HIV infection rate (23.6 per 100,000) is 20% higher than that of Latinos elsewhere in the US and it is 50% higher than the overall US rate (Ref: Chicago DPH).[2] The local burden of the HIV/AIDS epidemic has been growing; in Chicago, AIDS diagnoses among Latinos rose 16% between 2003 and 2009. While the highest rates of new HIV infection remains among MSM in Chicago, the rate has decreased among white MSM while continuing to increase among Latino and Black MSM. Nationally, among Latinos (in general) and also specifically for Mexicans, the predominant mode of transmission is through sex among men; Sexual transmission among MSM accounted for 78% of HIV infection among Latinos living in Chicago diagnosed with HIV in 2009. This corresponds to a significant population in Chicago considering that, as of the 2010 census, Latinos comprise 29% of the city's population; 80% of that Latino population is Mexican, accounting for the fourth largest Mexican-origin population in the United States.

The disproportionate burden of HIV in Chicago's Latino community is apparent not only in infection rates but in retention in care. While Latinos in Chicago who were diagnosed with HIV in 2010 were 3% more likely to have been initially linked to care than their non-Latino white counterparts, Latinos were significantly less likely (17%) to be retained in care than non-Latino whites. Among Mexican-American men, low retention-in-care rates are attributable in part to structural, financial, and cultural barriers to accessing medical care. These barriers include lack of health insurance, lack of experience navigating the American healthcare system, and a lack of culturally competent healthcare facilities.[3] Their access to HIV primary care is further complicated by fear, stigma, and the economic reality that men of Mexican descent tend to have less education and lower incomes.[4, 5]

Program Description: The SOM Intervention

The Organizational Context

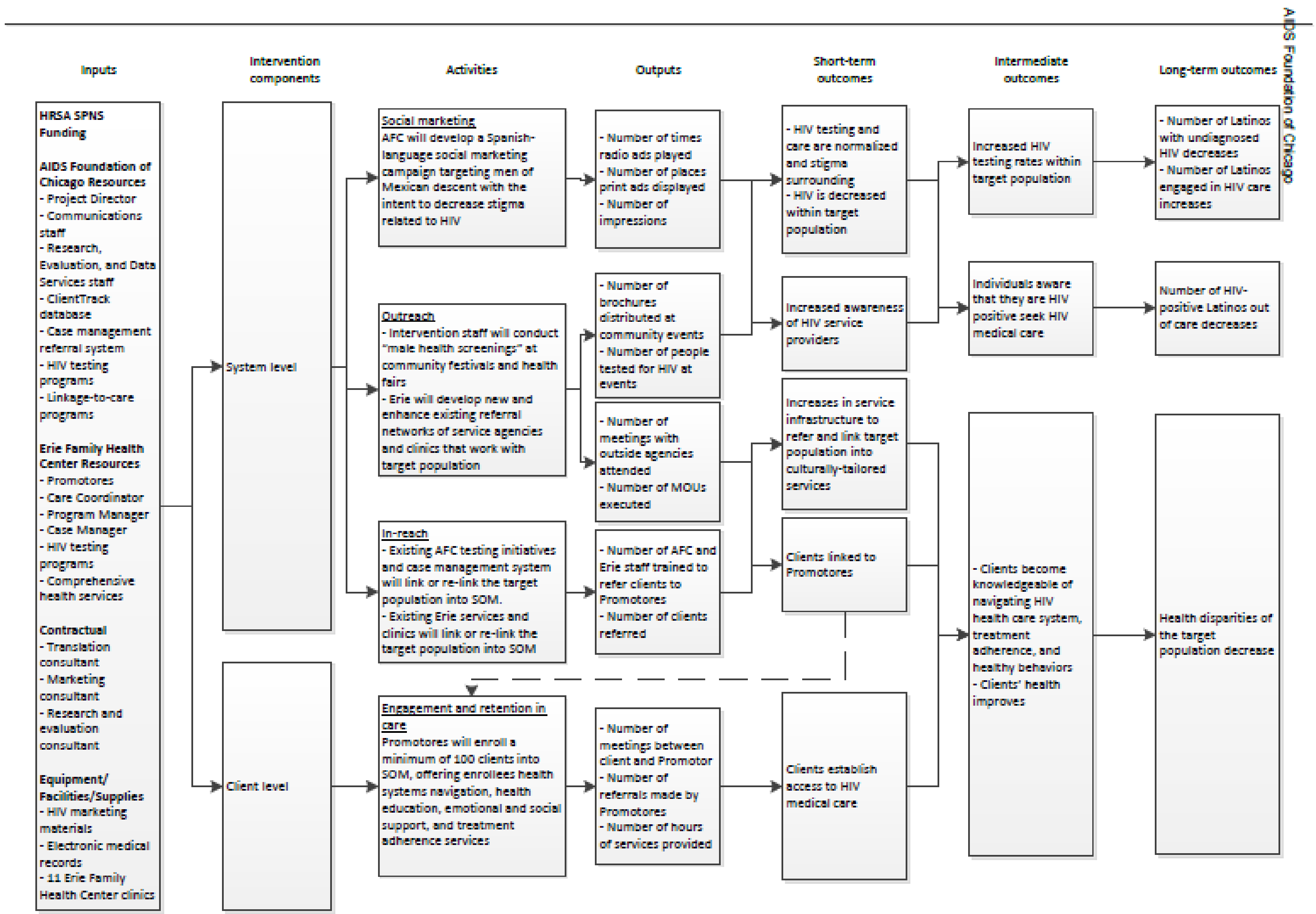
Informed by a transnational framework, and funded through this HRSA/SPNS initiative, Salud y Orgullo Mexicano (SOM), which means "Mexican health and pride," was developed to identify men of Mexican descent who are HIV positive and then engage and retain them in HIV primary care. SOM was managed by the AIDS Foundation of Chicago and principally executed with a clinical partner, Erie Family Health Center.

Theoretical Framework

The overall conceptual model for the SOM intervention was grounded in the Stages of Change theoretical framework within the transtheoretical model; this model assesses an individual's readiness to act on a new, healthier behavior and provides strategies to guide the individual through various stages of change to the point they are ready to take action and maintain that change.[12] As such, the strategies of SOM consider each person's current life circumstance and level of need and do not provide a "one-size fits all" approach, considering that within the Stages of Change framework, clients may move through the following stages when deciding whether to be tested for HIV or to participate in HIV medical care: pre-contemplation, contemplation, preparation, action, maintenance, and sometimes relapse. The Stages of Change framework has been applied in Latino-focused social marketing campaigns and HIV community health worker programs, and is easily compatible with SOM's transnational approach detailed below.[6,7]

The SOM Promotor intervention was chiefly based on two previous service delivery experiences: ARTAS and our linkage initiative from Bristol Myers Squibb/Positive Charge funded by AIDS United entitled Project IN-CARE. [8,9] Together these programs demonstrate the effectiveness of both active linkage to care accompanied by strengths-based case management and peer navigation services for HIV-positive clients.[9,10] The ARTAS intervention provides a recently diagnosed individual with strengths-based case management over multiple sessions in a time-limited period to effectively link them to care; this strengths-based case management approach encourages a client to identify and use his personal strengths, create goals for himself, and develop an effective, working relationship with a Linkage to Care Coordinator. Two completed ARTAS studies showed that participants who received the ARTAS intervention had higher levels of linkage to primary care than participants who did not receive the ARTAS intervention[11,12] SOM Promotores utilize a session-limited, strengths-based model to work with men of Mexican descent that include strengths based interviewing, a fixed number of sessions, and 180 days to work with individuals. In the SOM project this period was extended from 90 days to 180 days. While the intervention is based on the ARTAS and Project IN-CARE models, the peer training is based on the People-to-people training curriculum, an intensive three session training for peers/Promotores de salud.[13]

Salud y Orgullo Mexicano Logic Model



Additionally, SOM was informed by peer health navigation interventions, particularly those targeted at minority men and MSM. These interventions employ navigators who come from the same community as their target population, making them uniquely qualified to help clients navigate population-specific barriers to care. In 2013, the AIDS Foundation of Chicago (AFC) completed its IN-CARE project, which targeted minority MSM; this intervention successfully linked 87% of male participants to HIV primary care through its peer health navigation services.[9] Lourdes Campero's recent research based in Mexico demonstrates, peer social support helps men improve their quality of life and seek medical care after an HIV diagnosis.[14] The elements of the IN-CARE project incorporated into SOM include this use of HIV-positive peer navigators in the form of SOM Promotores, an intensive supervision structure, and the expectation of on-going contact requirements beyond the initial six-month linkage period to engage and retain participants.

Peers Adapting a Transnational Framework

The SOM intervention was specifically developed with a transnational approach stitched into its education sessions with clients. As part of formative work to develop the intervention, SOM created an advisory board of community experts who work in the HIV Latino community. This advisory board was comprised of six members representing Mexican men from different organizations including faculty at the University of Illinois at Chicago, the National Latino Commission, Midwest AIDS Training and Education Center and several community-based organizations, discussed the intervention and provided input regarding the needs of the Chicago HIV-positive Latino community and what type of intervention would benefit newly diagnosed individuals or patients who are out of care. They also identified the barriers that affect this population's medical care and adherence to treatment. Barriers identified by the community advisory board were synthesized thematically and informed intervention content creation. Staff then completed 13 qualitative interviews where "near-peer" participants (e.g., participants similar to our intervention population but ineligible for the program) were asked questions about barriers, ties to family and Mexico, work, stigma, immigration, confidentiality and transnationalism. With the information gathered from the qualitative interviews, the intervention was updated to address a peer-led intervention emphasizing HIV education, where the Promotor shares more about his own life experience regarding his HIV diagnosis; navigating HIV care and treatment; disclosing to family members and friends; and engaging in romantic relationships, sex, and dating. Consistent with the Transnational Framework, the identities, practices, and social engagement opportunities of Mexican immigrants to Chicago are shaped both by experiences in their home countries and by their new lives in Chicago and in the United States. They often maintain a number of cross-border practices and activities including ongoing communication with loved ones in their home countries, traveling back and forth from their home country and host country, sending remittances back to people in their country of origin, and sustaining political and social affiliations/activities that span countries.

Dr. Hector Carillo, an expert in transnational approaches to public health interventions particularly as they relate to the Latino and Mexican population, suggests that interventions incorporating a transnational framework consider a client's cultural points of reference, sources of information, sources of emotional and practical support, sources of discrimination and social stigma, sources of beliefs about health, and access to healthcare and health practices. [17, 18] As an HIV/AIDS intervention with Mexican-American men, transnational considerations for SOM include;

- Helping participants determine how they can share their HIV status and seek social support from family and friends in their country of origin,
- Helping to offer participants social support through Promotores here in their country of settlement,
- Helping participants adapt their healthcare beliefs and behaviors to the available U.S. HIV healthcare model when a participant's point of reference about healthcare is his place of origin,
- Assessing a participant's level of transnational identity and cross-border practices and determining to what degree that shapes his retention in care,
- Navigating cost-effective HIV care and seeking supportive services, given the added expense of remittances to their families,
- Addressing cultural norms that might shape a participant's engagement in healthcare, including;
  - *Machismo:* a pride in and responsibility towards identifying with and displaying traditional, often dominant, masculinity. This can influence men's perception of their sexuality and their willingness to engage care*,*
  - *Familismo*: a strong orientation and commitment towards the family in Latino culture, especially as it relates to marriage, childbearing, and familial obligation,

Fatalismo: a sense of powerlessness to effect change or resignation to a perceived inevitability that might prevent some Mexican MSM from seeking HIV care.

SOM Goals and Objectives

Program Goals

1. Conduct a multi-year social marketing campaign to raise HIV/AIDS awareness, encourage HIV testing and recruit HIV-positive men of Mexican descent into HIV primary care.
2. Enroll 100 HIV-positive men of Mexican descent.
3. Provide Promotor services to link and retain all clients in HIV primary care at Erie Family Health Center or their clinic of choice.

Components of the SOM Intervention

The intervention consisted of two main strategies:

- A Community **Social Marketing Campaign** to raise HIV/AIDS awareness, encourage HIV testing and recruit HIV-positive men of Mexican descent into HIV primary care.

- **Peer Navigation Services**, including standardized SOM intervention education sessions (outlined below), provided by Promotores to link and retain clients in HIV primary care at Erie Family Health Center. Promotores' main role was to provide peer education about HIV care; resources are also provided to the clients when appropriate. In the scenario where the participant is in need of more services or referrals, the Promotor refers the participant back to the patient's Ryan White case manager that the client is assigned whether that be at Erie or another of our case management agencies.

Client-Level Measurable Outcomes:

Outcome 1: Clients establish access to HIV care
Indicators:
1. Clients attend two medical appointments within 12 months
2. Clients have their CD4 count and viral load drawn twice a year
3. Eighty five percent of clinically indicated clients begin medications

Outcome 2: Clients' health improves
Indicators:
1. Eighty percent of clients report an improved or maintained perception of health
2. Eighty percent of clients achieve viral suppression within 12 months of initiating antiretroviral therapy
3. Clients' utilization of emergency rooms and number of hospital stays decreases by 50%

Recruitment and Referral Goals:
1. Screen no less than 50 individuals per year for years two through four? five of the project.
2. Refer no less than 75% of all eligible clients who wish to receive their primary care at Erie to SOM.
3. Enroll no less than 25 individuals per year for years two through four? five of the project.

Target Population and Eligibility Criteria

SOM targeted men whose country of origin is Mexico; are HIV-positive, and are over age 18. Eventually due to the need for targeting our recruitment efforts we narrowed eligibility to men who have sex with men. In addition:

Long-Term Program Objectives:
- Increase retention in HIV medical care for newly diagnosed individuals living with HIV and individuals living with HIV who have been lost to care.
- Increase client knowledge of HIV disease and treatment.
- Improve client self-sufficiency.
- Increase the number of individuals living with HIV who are virally suppressed.

Short-Term Program Objectives:
- Client adheres to regular HIV primary care appointments during first year (engaged or re-engaged in care).
- Client increases independence and transitions to self-management or case management.

Promotores de Salud work with three client populations:
1. Newly diagnosed: clients first diagnosed with HIV during the previous 180 days.
2. New to Care: clients previously diagnosed with HIV infection but not previously linked to HIV medical care.

Out of Care: clients with fewer than four medical appointments with a provider with prescribing privileges in the last 24 months, OR client has experienced a gap greater than six months between HIV-specific medical appointments within the past 24 months.

Promotores de salud, or peer community health workers, who come from the same community as the target population facilitate clients' timely entry, engagement, and retention in HIV primary care at EFHC by providing a culturally adapted intervention that consists of systems

navigation, health education, and peer counseling. Prior research has shown that Promotores are effective at improving healthcare service utilization by HIV-positive men of Mexican descent by helping participants overcome obstacles to accessing care.[17, 18, 19] As peers who, like the clients, are HIV-positive men of Mexican descent, the Promotores are well-suited to helping clients address their structural, financial, personal, and cultural barriers to accessing medical care. EFHC and AFC worked together to select the Promotores for SOM. The ideal candidate is open about sharing his HIV life experience such as coping with HIV, disclosing HIV status, experience with dealing with HIV stigma barriers and history of HIV treatment.
Some of the key navigation services Promotores provide to foster consistent engagement in care include: individualized general health education; skills building around patient-provider; communication; referrals and coordination of services with Ryan White case managers; accompanying participants to medical or other service appointments; reminders to participants of upcoming medical visits; build problem-solving skills for navigating housing, substance use, and employment issues.

The SOM intervention sessions include information on PrEP for partners, immigration, harm reduction, and disclosure of HIV status. The sessions encourage the Promotor to ask the participants questions and to allow a peer-to-peer dialogue on HIV/AIDS and are completed in the order requested by the client. Although numbered the sessions are not linear. The sessions' contents are detailed in Figure 2.

Staffing requirements

Project Director Responsible for the overall planning and coordination of the SOM project's daily operations, oversees contact with all collaborating agencies.

Program Manager Responsible for receiving all referrals to the program at AFC. Oversees daily operations and works closely with the Promotores.

Clinical Site Supervisor Responsible for all supervisory functions of the Promotores, in close consultation with the Project Director.

Promotores Responsible for education session delivery and primary interaction with program participants. Based on our

FIGURE 2

Session One
- HIV 101 (transmission and viral life cycle)
- Importance of primary care
- Strategies to improve appointment adherence
- Strategies for how to talk to doctor/medical provider

Session Two
- Medication readiness assessment
- Medication adherence assessment
- Demonstration of how HIV medications act against the virus
- Medication beliefs discussion

Session Three
- Understanding lab values
- Tracking your lab values and their impact in your health
- Discussion of co-morbid conditions (diabetes, hypertension, etc.)

Session Four
- Assessment of HIV risk behaviors
- HIV risk reduction
- Impact of STI's and HIV disease

Session Five
- Disclosure
- A social support assessment
- Maintaining your care while traveling to Mexico
- Immigration

project recruitment goals our program planned a client to promotor ratio of 1:50. Due to lower than anticipated recruitment we hired one promotor at Erie and a promotor at AFC.

Agency Backgrounds

The AIDS Foundation of Chicago (AFC) mobilizes communities to create equity and justice for people living with and vulnerable to HIV and related chronic diseases. Today AFC oversees case management services for nearly 5,000 clients in the Chicago area through its case management cooperative of nearly 30 agencies.

Erie Family Health Center (EFHC) provides high-quality, culturally-sensitive, bilingual healthcare to more than 70,000 medical patients in Chicago, serving a population that's nearly 72% Latino. In addition to offering free rapid HIV-testing six days a week at their location in Humboldt Park, a Chicago neighborhood that is nearly half Latino. This Humboldt Park site houses the Lending Hands for Life program which offers comprehensive HIV medical care and support services that are designed to meet the Mexican MSM community's specific needs and was the service delivery site for SOM.

SOM Activities, Procedures and Policies

Training Promotores

SOM Promotores are trained in various stages. The first stage of training involves a four-day People-to-People training facilitated by AFC. People to People is a peer-to-peer education program that supports individuals living with HIV/AIDS. People to People is intended to improve the health of those living with HIV/AIDS by providing trained, qualified peers to the community and building local organizations' capacity to use peers. The program targets HIV-positive individuals who reflect the epidemic in each local area. Training modules includes HIV transmission, disease progression, treatment adherence, and clinical preceptorships to address identified needs. As a peer-oriented popular education program, this training captures crucial elements of AFC's Project IN-CARE by informing peer navigation services for Promotores. [20]

Promotores were required to attend at least six professional development/training sessions per year to stay updated on new trends in HIV/AIDS and remain grounded in the best approaches for reaching our specific body of participants. Examples of those trainings included: The Face of ACA, Ready, Set, PrEP, HIV and STI's update, and HIV Treatment Update. In addition, the SOM Program Manager was onsite at Erie Family Health Center to help train the Promotores and serve as a resource for them. The role of the SOM Program Manager at EFHC was used to provide day-to-day training on program-related subjects like immigration, STI/HIV transmission, disclosure, and management of HIV medications.

Promotores are also trained by the Project Director on several modules not included in the People to People training, such as cultural competence, ethics and boundary setting, ClientTrack data collection procedures, program evaluation expectations, and the general ARTAS-inspired structure of the SOM program. The Project Director incorporates materials from various online cultural competence/cultural humility trainings online. Also, the Promotor viewed the Northeastern Illinois HIV/AIDS Case Management Collaborative's "Ethics and Boundaries" online training module that was developed for its case manager orientation. In addition, the Project Director delivered an ARTAS-inspired session based on the CDC's service delivery model.[21]

Participant Recruitment and Referrals

The SOM initiative's client recruitment took place through three strategies: 1) a targeted social marketing campaign; 2) in-reach through existing programs of AFC and its clinical partner, EFHC; and 3) outreach to agencies working with the target population and to clients at health fairs and community festivals.

Referrals through community testing and other linkage to care initiatives

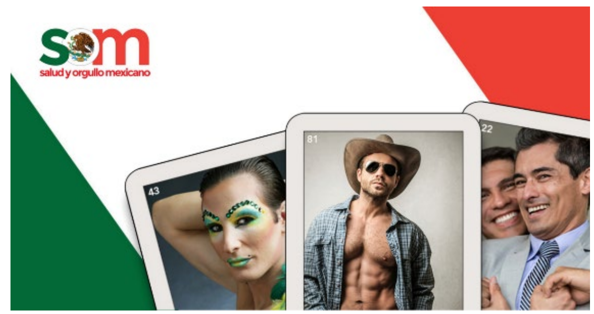
Referrals through the HIV-VIP Program, aimed at linking newly diagnosed men living with HIV into HIV primary care. Clients were screened for eligibility by the staff from the pool of individuals who test positive during outreach testing. All eligible clients were referred via telephone referral to the Promotor

Referrals through the Case Management system at AFC

All clients requesting case management services through AFC were screened for eligibility for the SOM project by the Intake and Referral Staff on the Care team during their initial telephone screening for case management services.

Referrals through online outreach

Internet outreach targeting MSM's living with HIV was conducted by creating profiles on sex-seeking websites. Adhering to an online policy and procedure manual, the SOM Program Manager spent an average of two hours a week on sex-seeking websites for recruitment purposes. All outreach was conducted by AFC staff using the AFC secure online network.



Online outreach website

EFHC recruitment procedures:

Clients for the SOM project were recruited through outreach via the following mechanisms:

- Health fairs and public events
- Referrals of HIV-positive patients from all Erie locations to the SOM Site Supervisor
- Newly diagnosed patients eligible for the program are referred to the Promotor via a warm handoff directly after

their intake to the HIV program. The Promotor meets with the patient to discuss SOM and schedules a time for intake.

Recruitment through relationships with outside agencies

Outreach meetings are frequently held with community agencies to increase awareness of the SOM project and to establish Memoranda of Agreement with organizations that provide HIV testing or other services that may reach eligible clients. SOM staff meets with agency representatives to provide background on the project, highlight project goals, and establish whether a collaboration with the agency would feasibly result in the recruitment of eligible SOM participants. If the collaboration seems agreeable, a Memorandum of Agreement is signed. Erie and the signing agency maintain a minimum of monthly contact to answer questions and to provide support and information.

Intake Assessment and Action Plan Development

A brief intake assessment occurs during an initial meeting with the client. During intake the Promotor explains the scope of SOM services and expectations for client participation in the program. The Promotor gathers information on the client's immediate barriers to care. The client signs an agency-specific service agreement to indicate enrollment in SOM services.

Barriers to engagement in medical care identified by the client and/or Promotor during assessment are prioritized and translated into an action plan that defines specific action steps to address barriers. The Action Plan serves additional functions, including: focusing client and Promotor on priorities; providing a tool to the Promotor to know how to tailor the intervention to meet the participants' needs; assisting clients in negotiating service delivery systems.

The majority of the Promotor's work occurs through the implementation of the action plan, which involves completing the education sessions with the participant and addressing identified issues. Activities performed during implementation are individualized and vary based on the barriers to care identified by the client; however, all action plan implementation requires scheduling of HIV medical appointments, preparing clients for medical appointments, attending medical appointments, and coordinating efforts with the client's care team. The care team includes the Promotor, the primary care provider, and the case manager when the client is enrolled in case management.

Ongoing Action Plan implementation includes:

A. Scheduling HIV Medical Appointments

- Promotor assists the client in scheduling the first and second HIV medical appointments while explaining and modeling the process to the client, and providing reminders for those appointments.
- The client independently schedules third and subsequent appointments.

B. Preparing the Client for HIV Medical Appointments

- Promotor discusses what the client can expect during the visit.
- Promotor assists client in preparing a list of questions they want to ask the provider.
- Promotor encourages the client to fully participate in the medical appointment.
- Promotor confirms plans for transportation and meeting with the client for the appointment.

- Promotor contacts the client before their appointment to remind the client of appointment date and time, if the Promotor has this information.

C. Attending HIV Medical Appointments

- With the client's consent, the Promotor attends the first medical appointment with the client, if getting medical care at EFHC.
- Promotor attends the second and third medical appointments if the client requests, if getting medical care at EFHC.
- At the appointment, the Promotor acts as a support and advocate and leaves the exam room when requested to do so by the client or medical provider, if getting medical care at EFHC.

D. Coordination with the Client's Care Team

- Promotor is responsible for introducing themselves to the care team and explaining his role, if client is getting medical care at EFHC.
- Promotor maintains a minimum of quarterly contact with appropriate members of the client's care team, if getting medical care at EFHC.

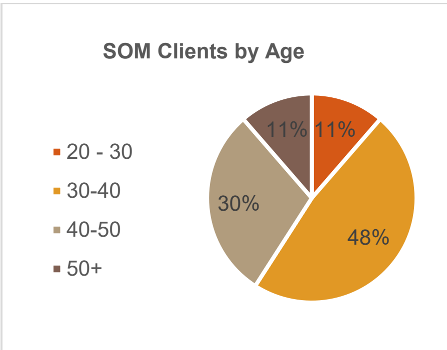
SOM action plans are updated as action steps are completed or as the client's life circumstances change. Due to the time-limited nature of SOM services, informal plan reviews occur regularly between the Promotor and client. Formal reviews between the Promotor and Promotor supervisor occur at regularly scheduled intervals.

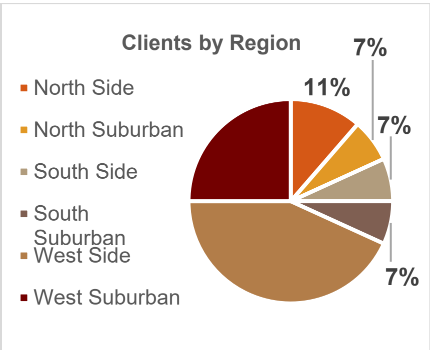
SOM Education Sessions

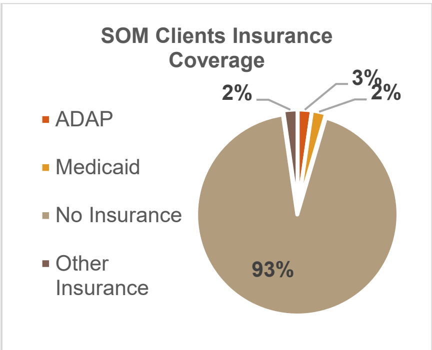
The Promotor schedules and engages clients in five education sessions to be completed ideally within the first six months of the individual's enrollment in the SOM project, approximately one education session per month. These standardized education sessions are negotiated with the client to help them meet their needs and are documented in the client's chart and in ClientTrack. The Promotor should explain to the participant the time commitment of the program and discuss the best way to schedule the session and that the participant can complete the education sessions during normal business hours of EFHC and/or once a month on Saturdays. In addition, sessions two, three, and four can be done over the phone or skype. If the participant is not able to go to EFHC, the Promotor should coordinate a phone meeting date and ask for the patient when is a good time and date to complete the session over the phone. Since all education sessions may be conducted at any setting, the client can coordinate with the Promotor to get them done at their medical home or over the phone, if they are not getting their medical care at EFHC. If that is the case, the Promotor should also confirm the address that was collected during enrollment and ask the participant if it's okay for them to get mail. If the patient agrees, the Promotor is to mail the participant the education sessions. Once the patient has received the education sessions, the Promotor is to complete the education sessions over the phone.

Participant Intervention Characteristics

The Salud y Orgullo Mexicano project screened a minimum of 90 clients per year between years two and four of the project. The majority of clients screened were ineligible to participate due to having seen an HIV provider within the last six months. Clients were interested in participating in the program to obtain culturally specific programming and/or access additional resources. A total of 44 participants were deemed eligible and enrolled in SOM. Participants were between the ages of 26 and 67 years old with an average age of 38 years; 52% of clients were newly diagnosed (HIV diagnosed in the previous six months) and 48% had not seen an HIV provider within the past 6 months ("lost to care"); 63% of participants were receiving their primary medical care at EFHC; and 98% of our clients were born in Mexico. The program participants represented diverse geographic areas of Chicagoland with 39% living on the West side of the city (near EFHC). Finally, participants faced challenged in obtaining medical insurance with 93% reporting they were uninsured. Participants reported and ranked barriers to their retention in HIV care, the top reported barriers were medical mistrust, stigma and immigration status. The flexibility of the SOM intervention allowed Promotores to personalize intervention content to address individual client barriers. The most frequent topics discussed by the Promotores outside of the education sessions include: emotional support, HIV education, and medication adherences support. The intervention sessions were well attended with 84% of participants completing all 5 education sessions.







Education Sessions

The approximate cost of the intervention, including all efforts at recruitment and project staffing, is an annual estimate of $203,198.

Annual intervention costs include a reduced staff allocation in Years 1 and 2 of the 5 year project to pay for costs related to the planning, creation and implementation of a public bus shelter advertising campaign and radio ad creation and dissemination. Through years 3 and 4 the program utilized a digital marketing campaign that cost approximately $30,000 yearly utilizing the content created in Year 1. Year 2 expenses include additional staff effort at AFC for recruitment, and testing staff at Erie. Year 2 also saw the hiring of the Promotores at both Erie and the AIDS Foundation that continued through Year 5 with no funds for the marketing and recruitment campaigns, but staff for the evaluation and dissemination of program finding

Lessons learned

For purposes of replication and program sustainability, it is imperative to review lessons learned. Below are some of our program wide lessons:

- In developing and implementing a peer-based navigation program it is critical to ensure proper start up time and staff supervision structure. This includes strong training and ongoing review of healthy boundary setting between the Promotores and their participants. This is particularly true as staff may be encountering many of the same struggles as participants and this may impact effective boundary setting.
- A large amount of training is needed for peer health workers, which pays off in terms of skills developed and participant outcomes in the long view. Having a peer with a similar Mexican background as clients helps facilitate relationships and trust.
- In developing a culturally appropriate intervention it is important to be flexible and adaptable.
- Our program team conducted three rounds of qualitative research with various audiences to refine our intervention and define the education sessions. We also learned that including a wide range of topics in education sessions allowed clients to focus on what was important to them, rather than having project staff dictate what is important.
- Finally, it is crucial to ensure the target population is accessible to project staff. Our team tried multiple recruitment strategies and expended a lot of effort to recruit, however, the target population proved to be largely inaccessible. We believe that two factors may have negatively affected our recruitment: stigma remains a very strong deterrent for Mexicans to seek testing and seek care, additionally we feel the socio-political environment of the last three years has led to fear and concerns of deportation that inhibit Mexicans from seeking care.

Top 10 Topics Discussed with Promotores

Topic	Percentage
Education Session 1	100%
Education Session 2	80%
Education Session 3	80%
Education Session 4	84%
Education Session 5	76%

- Food and Nutrition Issues- 5%
- Medication Readiness- 5%

SOM References

1. **Chicago** Department of Public Health. STI/HIV Surveillance Report, 2011. Chicago, IL: City of Chicago; November, 2011.
2. **Centers** for Disease Control and Prevention. HIV Surveillance Report, 2011; vol. 23. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. Published February 2013. Accessed March 1, 2013.

3. **Lopez**-Quintero, C., Shtarkshall, R., & Neumark, Y. D. (2005). Barriers to HIV-testing among Hispanics in the United States: analysis of the National Health Interview Survey, 2000. AIDS Patient Care & STDs, 19(10), 672-683.
4. **Dang**, B. N., Giordano, T. P., & Kim, J. H. (2012). Sociocultural and structural barriers to care among undocumented Latino immigrants with HIV infection. Journal of immigrant and minority health, 14(1), 124-131.\
5. **Wohl**, A. R., Galvan, F. H., Carlos, J. A., Myers, H. F., Garland, W., Witt, M. D., ... & George, S. (2013). A comparison of MSM stigma, HIV stigma and depression in HIV-positive Latino and African American men who have sex with men (MSM). AIDS and Behavior, 17(4), 1454-1464.
6. **Norcross**, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of clinical psychology*, *67*(2), 143-154.
7. **Donovan**, R. J., & Henley, N. (2003). *Social marketing: Principles and practice*. Melbourne: IP communications.
8. **Weinreich**, N. K. (1996). A more perfect union: Integrating quantitative and qualitative methods in social marketing research. *Social Marketing Quarterly*, *3*(1), 53-58.
9. **Maulsby**, C., Charles, V., Kinsky, S., Riordan, M., Jain, K., & Holtgrave, D. (2015). Positive charge: filling the gaps in the US HIV continuum of care. AIDS and Behavior, 19(11), 2097-2107.
10. **Jain,** Kriti, Holtgrave, D. Charles, V. Maulsby, C., Zulliger, R. Kim, J. Massey, M. (2016) Improving Access to HIV Care: Lessons from 5 US Sites, Johns Hopkins University Press.
11. **Kim**, J. J., Maulsby, C., Zulliger, R., Jain, K., Charles, V., Riordan, M., ... & Holtgrave, D. R. (2015). Cost and threshold analysis of Positive Charge, a multi-site linkage to HIV care program in the United States. AIDS and Behavior, 19(10), 1735-1741.
12. **Gardner**, L. I., Marks, G., Metsch, L. R., Loughlin, A. M., O'daniels, C., Del Rio, C., ... & Wilkinson, J. D. (2007). Psychological and behavioral correlates of entering care for HIV infection: the Antiretroviral Treatment Access Study (ARTAS). AIDS patient care and STDs, 21(6), 418-425.
13. **Craw**, J., Gardner, L., Rossman, A., Gruber, D., Jordan, D., Rapp, R., ... & Phillips, K. (2010). Structural factors and best practices in implementing a linkage to HIV care program using the ARTAS model. BMC health services research, 10(1), 246.
14. **Hallum**-Montes, Rachel et al. “Linking peers, patients, and providers: A qualitative study of a peer integration program for hard-to-reach patients living with HIV/AIDS.” AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV. 2013 epublished ahead of print first. DOI:10.1080/09540121.2012.748869
15. **Campero**, Lourdes. “Soporte emocional y vivencias del VIH: Impactos en varones y mujeres mexicanos desde un enfoque de género.” Salud Mental. 2010:33:309-417.
16. **Carrillo**, H. (2004). Sexual migration, cross-cultural sexual encounters, and sexual health. Sexuality Research and Social Policy, 1(3), 58-70.
17. **Organista**, K. C., Carrillo, H., & Ayala, G. (2004). HIV prevention with Mexican migrants: review, critique, and recommendations. JAIDS Journal of Acquired Immune Deficiency Syndromes, 37, S227-S239.
18. **Hede**, Karyn. “Agencies Look to Patient Navigators To Reduce Cancer Care Disparities.” J Natl Cancer Inst. 2006: 98(3):157-159.
19. **Lemak**, Christy Harris et al. “Collaboration to Improve Services for the Uninsured: Exploring the Concept of Health Navigators as Interorganizational Integrators.” Health Care Management Review. 2004:29(3):196-206.
20. **CDC**. Fact Sheet: HIV in the United States: The Stages of Care; July 2012.
21. **Prochaska**, J.O. and C.C. DiClemente. “Transtheoretical theraphy: Towards a more integrative model of change.” Psychotheraphy, Theory, Research, and Practice. 1982:19:278-288.

AIDS Project Los Angeles (APLA) Health

Project Name: Fuerza Positiva

Location: Los Angeles, California

FUERZA POSITIVA

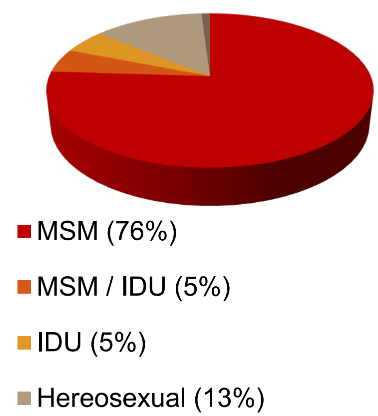
Local Epidemiology

General Epidemiology

Identifying, linking, and retaining persons living with HIV (PLWH) in primary medical care is a priority for both providers and public health organizations, and remains a focus of the National HIV/AIDS Strategy.[i] Recent estimates of the proportion of HIV-infected persons who received regular HIV clinical care in the US have ranged from 37% to 55%.[ii] In Los Angeles County, California, the implementation site for Fuerza Positiva, the Los Angeles County Department of Public Health Division of HIV & STD Programs (DHSP) reports that as of December 31, 2014, 71% of PLWH were engaged in HIV primary care, 59% retained in care, and 59% achieved viral suppression.[iii]

Latinos represent the largest number and proportion of HIV cases in Los Angeles County (LAC). They comprise 41.8% of all PLWH and 46.2% of persons recently diagnosed. LAC's HIV epidemic is predominantly male (87.5% of all PLWH and 87.6% of recently diagnosed PLWH) and among the male population living with HIV, 41.4% are Latino. In terms of risk for transmission, men who have sex with men (MSM) continue to be the group most highly impacted by the HIV epidemic in LAC, accounting for more than three-quarters (77.7%) of all PLWH and 83.0% of recently diagnosed. Latino MSM account for 41% of MSM living with HIV in LAC.[iv]

Figure 3. Estimated Transmission Categories of Persons of Mexican Origin Living with HIV in L.A. County as of 12/31/11 (n=21,344)



Target Population

The overarching goal of *Fuerza Positiva* is to significantly improve health outcomes among HIV-positive Latino MSM of Mexican origin, 18 years of age and older, and living in Los Angeles County, California–a uniquely vast and diverse geographic region, in which persons of Mexican origin make up by far the largest single ethnic subgroup.

Unique Needs

Latinos experience disproportionately high rates of delayed diagnosis and entry into HIV care, are less likely than whites to remain engaged in HIV care, less likely to use ART and other HIV medications, and are more likely to become lost to care.[v] Latino MSM living with HIV face a wide range of barriers that complicate access to and adherence in care including, poverty, housing instability, access to health insurance coverage, lack of English literacy and lack of cultural competency and/or sensitivity by primary care providers, and a broad range of Mexican cultural beliefs related to religion, family, gender, and health. Yet, homophobia and HIV stigma present the greatest impact on access to HIV testing, care access, and retention. Among Latino MSM of Mexican heritage, HIV stigma is also associated with higher HIV risk behaviors, reluctance to seek care, lower HIV care retention rates, and poorer overall health outcomes.[vi]

Program Description

Organizational Context

Founded in 1983, APLA Health (APLA) is a non-profit, community-based organization based in Los Angeles, California, providing a broad portfolio of evidenced-based HIV prevention, care, and treatment services to individuals and communities disproportionately impacted by HIV/AIDS across Los Angeles County. With over 35 years of offering core medical and support services to PLWH and evidenced-based HIV prevention and counseling and testing to those most at-risk for HIV infection, APLA was designated a federally qualified health center (FQHC) in 2013, leading to the formation of a separate and distinct corporation, APLA Health & Wellness. Inclusive of PLWH, APLA Health & Wellness offers primary care to the community in south Los Angeles. APLA Health & Wellness is not a Ryan White medical care provider, a distinction critical to the linkage and retention of Latino MSM of Mexican origin as most do not qualify for Medi-Cal, California's Medicaid program.

David Geffen Center, administrative location of Fuerza Positiva

Los Angeles County, California, a uniquely vast and diverse geographic region that can best be understood in comparison to other U.S. states, rather than other U.S. counties, spans 4,084 square miles.[vii] This region is comprised of both urban rural areas and wilderness areas, and is typified by great disparities in income and health status, with neighborhoods of great wealth often located adjacent to areas of extreme poverty. This leads to significant disparities in both general health outcomes and care access, and poses challenges to providers in coordinating and delivering care.

Although *Fuerza Positiva* was developed and implemented through a community-based organization, the program can be adapted to different organizational settings focused on HIV linkage and retention efforts. *Fuerza Positiva* can also be adapted for other Latino populations.

Intervention

The overarching goal of *Fuerza Positiva* is to significantly improve the health outcomes of HIV-positive MSM of Mexican origin. Using culturally appropriate strategies, the intervention incorporates the following methodologies: (1) Identification, Recruitment, and Engagement; (2) Linkage and Retention, which is achieved through integrating strength-based case management and patient navigation, and (3) Social Support provided through *Hermanos*, a group-level intervention comprised of five sessions. Hermanos was adapted from the original Hermanos de luna y sol developed by Dr. Rafael Diaz, which emphasizes cultural pride, community building, and personal empowerment as key factors that enhance a person's ability to practice safer sex, avoid HIV infection, and have healthy relationships. In the context of *Fuerza Positiva*, these constructs have been adapted for HIV-positive MSM of Mexican origin, with a focus on promoting retention in HIV primary medical care and adherence to HIV treatment.

Theoretical Basis

Social Action Theory (SAT) is the underlying framework for *Fuerza Positiva*. Clinical medicine treats individuals with an emphasis on symptomology, not whole person focused. Public health focuses on communities, but it often neglects the individual. Thus, SAT blends clinical and public health approaches by specifying causal pathways in behavior change and accounting for socio-environmental constraints and supports. *Fuerza Positiva* builds the capacities of the person across life context and not just around risk behaviors. The premise of this is that by learning adaptive patterns and coping strategies across various aspects of life, one can generalize and apply those tools to risk behaviors and health compliance.

Fuerza Positiva and the Transnational Framework

A unique component of *Fuerza Positiva* is the incorporation of the transnational framework. Transnationalism refers to the varied means by which immigrants maintain connections with their place of origin while continuing to establish themselves in their place of settlement. This is accomplished via practices and relationships that link migrants and their children with their place of origin, where these practices have significant meaning and are regularly observed.[viii] Transnational factors can serve as both a facilitator and barrier related to health outcomes. *Fuerza Positiva* focuses on four domains as they relate to transnationalism.

- ***Social Spaces*** relates to the settings predominately used by people from their home country/setting (markets, clubs, community settings, church, or any other settings).
- ***Transnational Life*** represents significant practices/behaviors and relationships that are observed regularly that link individuals to their place of origin.
- ***Points of Reference*** includes influences or from where a person derives their understanding about their personal health issues (place of origin, place of settlement, or both)
- ***Migration*** relates to an individual's patterns or migration between countries of origin and current residence. This may include the frequency of, or nature of migration in individuals' social networks and visiting from or traveling between countries of origin and residence. Examples include documentation status and reporting sexual orientation as reason for migrating.

Fuerza Positiva integrates components of the framework by hosting and creating engagement and retention activities in social settings that resonate with Mexico. Through the individual and group-level intervention, the program builds upon participants' life experiences and health beliefs derived from their nation of origin to facilitate linkage to care and support retention.

Figure 1: *Fuerza Positiva* Logic Model

Resources

- The expertise, resources, grants management experience, and Latino/a client base of APLA
- The expertise and cultural competency of staff members who will oversee and operate the program.
- The community-focused research expertise of Sentient Research and its Principal, Dr. Jorge Montoya
- The enthusiasm and commitment of participating clients living with HIV
- The high quality, culturally competent HIV medical homes in Los Angeles County
- The participation of local agencies and programs in community coalitions

Components

- A multi-pronged recruitment and engagement strategy involving in-reach, venue-based outreach, social media, and community networks
- Strength-based care linkage case management using the ARTAS model
- Intensive care retention support using an adapted version of the *Hermanos de Luna y Sol* model
- Ongoing linkage and retention case management for clients with special needs
- Social events and educational sessions
- Outreach to local Latino-serving health agencies, businesses, and community organizations

Outputs

- # of HIV-positive Latino MSM of Mexican origin linked to high-quality, culturally competent care, including HIV-unaware and aware individuals
- # of HIV-positive Latino MSM of Mexican origin who participate in the intensive linkage case management-based ARTAS-based intervention
- # of HIV-positive Latino MSM of Mexican origin who participate in the retention-based *Hermanos de Luna y Sol* intervention
- # of partnerships established to promote HIV engagement and retention in HIV care

Outcomes

- % of HIV-positive Latino MSM of Mexican origin linked to high-quality medical services
- % of HIV-positive Latino MSM of Mexican origin retained in care
- % of HIV-positive Latino MSM of Mexican origin who report compliance with HIV medication
- % of HIV-positive Latino MSM of Mexican origin with undetectable viral load
- % of HIV-positive Latino MSM of Mexican origin demonstrating reductions in the effects of HIV stigma
- % of HIV-positive Latino MSM of Mexican origin demonstrating an increase in self-efficacy with navigating the HIV service delivery system

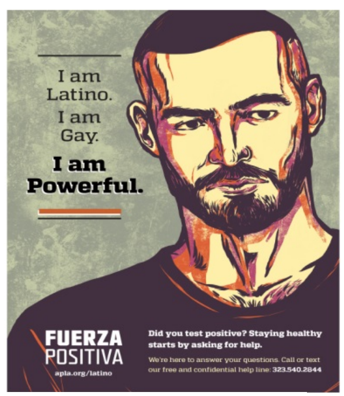
Intervention Components

Identification, Recruitment and Engagement

A. Venue-based outreach: *Fuerza Positiva* adapts the CDC's outreach definition[i] by conducting venue based recruitment and engagement activities to provide information on the importance of accessing HIV primary care and adherence to HIV treatment regimens. Program staff conducts outreach at bars, clubs, and other social venues (e.g., coffee houses frequented by Latino MSM.

B. In-Reach: Using principles outlined in the CDC's *Data to Care* strategy, in-reach is an intervention strategy that focuses on recruiting clients from within an organization where the client receives services. This intervention strategy is achieved in two ways; (1) disseminating project specific information to clients and program staff within the agency, and (2) utilizing internal client data management systems to identify potentially eligible participants.

C. Community Partnerships: Development of partnerships with local organizations (e.g., housing providers, substance use treatment centers, primary care clinics) that conduct HIV and STD testing/screening and/or medical and other social services to the target population. The purpose of developing these relationships is to increase the likelihood that service providers will provide a client with a referral to the program.



D. Social Marketing: *Fuerza Positiva* incorporates this recruitment and promotion strategy through print and social media to engage and recruit the target population into the program.

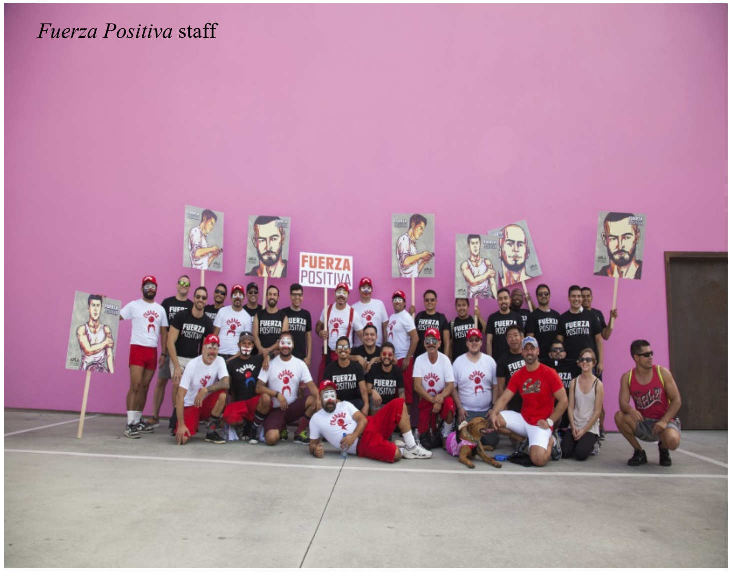
Linkage and Retention

The Strengths-Based Case Management (SBCM) model employed by *Fuerza Positiva* adapts core elements of the Antiretroviral Treatment and Access to Services (ARTAS) model. ARTAS is rooted in Social Cognitive Theory (especially the concept of Self-Efficacy) and Humanistic Psychology. SBCM encourages the client to identify and use personal strengths; create goals for himself and establish an effective, collaborative relationship with the Linkage Specialist.

Fuerza Positiva adapts components of the ARTAS model by modifying the five-client session shorter-term framework into a long-term 18-month model which consists of five steps. The 18-month model allows the client to maintain a long-term relationship with the Linkage Specialist who supports the client at various intervals in his efforts to implement changes and overcome barriers. This is intended to provide the client with greater accountability and motivation to participate in services and maintain gains, increasing overall retention in services. The *Fuerza Positiva* SBCM model maintains the strength-based and collaborative design with the goal of increasing the client's sense of self-efficacy in navigating the system and meeting his/her needs.

Group Level Support/Skills Building

The group-level component of *Fuerza Positiva* incorporates key concepts of *Hermanos de Luna y Sol* (HLS), an



Fuerza Positiva staff

intervention that was originally developed as an HIV risk reduction program for Spanish-speaking gay/bisexual men. The intervention is based on research by Dr. Rafael M. Diaz that emphasizes cultural pride, community building, and personal empowerment as key factors that enhance a person's ability to practice safer sex, avoid HIV infection, and have healthy relationships. In the context of *Fuerza Positiva*, these constructs have been adapted for HIV-positive MSM of Mexican origin, with a focus on promoting retention in HIV primary medical care and adherence to HIV treatment.

The five-session group level intervention:

- Provides social support, social belonging, and enhanced self-esteem in the context of a Latino MSM and HIV-positive identity and community;
- Promotes critical awareness of social and cultural forces that impact and shape participant's social and health care seeking beliefs and attitudes;
- Increases participant's self-knowledge, with particular emphasis on individual beliefs, attitudes and situations of personal vulnerability that limit participants' ability to maintain adherence to HIV primary medical care and treatment.

Two important themes are integrated into each session. One is utilizing the concept of the Ideal Self in managing the negative impact of HIV, coping with stigma, making adaptive disclosure decisions, and remaining engaged in HIV care and adherent to prescribed HIV medications.

Core Intervention Staff

Position	Core Requirements/Competencies
Program Manager/Director: 25% Full-time Equivalent (FTE)	The Program Manager/Director is responsible for the overall planning, coordination, implementation, and management of *Fuerza Positiva*. The person assuming this role should have experience and knowledge with planning, implementing, and evaluating public health programs, program management, including budgeting, staffing, marketing, and reporting. If desired, the Program Director/Manager may also serve as the Evaluator.
Program Coordinator	The Program Coordinator (PC) is responsible for coordinating the logistics of program implementation and implementing the intervention. The PC works closely with the Linkage Specialist and Outreach Coordinator to promote the intervention, collects client-level data, and facilitates *Hermanos*. The PC should have experience with program oversight and management, providing case management services and group facilitation. Demonstrating a background in public health or a human services field is recommended. Spanish speaking required. Reports to the Director.
Linkage Specialist: One (1) 100% FTE	Reporting to the Program Coordinator, the Linkage Specialist (LS) is responsible for the implementation of core program activities - meeting with clients, attending the first medical appointment and subsequent appointments as needed, promoting retention, and assisting with outreach. The LS works closely with the Outreach Coordinator to promote the intervention, collects client-level data, and assists with the facilitation of *Hermanos*. The LS should have experience providing case management services and group facilitation. Demonstrating a background in public health or a human services field is recommended. Spanish speaking required.
Outreach Coordinator: One (1) 100% FTE	Responsible for the coordination and implementation of recruitment strategies. The OC should demonstrate knowledge of social spaces frequented by the target population, expertise with using social networking sites, and engaging community partners and businesses. Spanish speaking required. The OC reports to the Program Coordinator.
Evaluation Specialist: 30% FTE the first year of the project; 25% years 2-4; and 40% FTE final year.	The Evaluator designs the monitoring and evaluation plan and oversees process and outcome monitoring-related activities including data collection, developing instruments, and reporting results. Data entry may be included in the Evaluator's role, or performed by the implementation team. The Evaluator position may be filled by an agency staff person or consultant with experience designing and executing, monitoring and evaluating plans. Note: This position may be secured through a consultant agreement and perhaps would devote more time on the project during the planning stage and first year of implementation. The Evaluation Specialist reports to the Director.

Note: Agencies should also identify a mental health professional employed at the organization to provide clinical supervision or support at 20% of one (1) FTE

Community Partners and Collaborators

The following community partners were integral to the successful implementation of *Fuerza Positiva.* An emphasis should be placed on partners that can assist with recruitment and engagement.

1. **Engagement**
    - In-reach – programs internal to APLA. Ensure all staff and programs are aware of eligibility (i.e., newly diagnosed, out of care, tenuous care)
    - HIV Counseling & Testing (HCT) providers: Execute business agreements; HCT sites need to understand that the program will not "poach" their clients. Clinical providers that offer HCT services but do not have HIV primary care specialists may require sensitivity training and additional education about HIV.
    - Social Venues: Bar and bathhouse owners, social media companies, and community event organizers
    - Community Organizations: Groups indigenous to the target population.

2. **Linkage and Retention**
    - Medical Clinics: s agreements to enable the collection of medical data. Clinical sites must demonstrate cultural humility and have Spanish speaking staff.
    - Housing providers: Because housing is a central need, establishing partnerships with agencies offering HOPWA services offers an opportunity to locate clients enrolled in the program but lost to follow-up.

Program Planning & Development

Start-up Steps

Staff Selection: Recruiting and selecting the most qualified staff for the project is a critical component of the planning process. Step one in the process is developing a job description that outlines the tasks associated with each program position and what requirements the candidates need to present to be considered (e.g., experience working with the target population, understanding of the target population's social networks, experience working in HIV, etc.).

Staff Training: Training required to implement the intervention includes Motivational Interviewing. ARTAS (provided by a certified ARTAS trainer), basic HIV 101, HIV treatment overview, facilitating skills, working with client's in crisis, transnationalism and Latino cultural constructs, outreach safety, HIPAA, and data collection and management.

Convening a Planning Committee: Agencies wanting to implement *Fuerza Positiva* are encouraged to form a planning committee comprised of agency staff and community partners to inform and assist with all aspects of the pre-implementation and implementation process described below. Agencies may also want to consider forming a community advisory board comprised of members of the target population to provide feedback on marketing materials and to inform program staff about recruitment and engagement strategies.

Formative Assessment Process: Engaging in a formative assessment process is recommended to gather critical and detailed information about where to reach Latino MSM of Mexican origin who are infected or may be infected with HIV and how to reduce barriers to HIV care and connect them with a medical home, retain them in care, and improve health outcomes. This process may include convening focus groups comprised of the target population and speaking with key informants.

Buy-In/Stakeholders: Securing support from the target population, community stakeholders, and agency staff is crucial because it assures the support of agency administration and facilitates the allocation of agency resources for implementing the intervention. Obtaining this "buy-in" is most effectively accomplished by a mid- to upper-level administrator within the agency who serves as the intervention's spokesperson, can demonstrate the ability to advocate and answer questions about the need for the intervention, and is familiar with the resources needed to implement the intervention.

Business Agreements: Because of the sensitive nature attributed to collecting medical data connected to program participants, business agreements developed and agreed upon between the program and clinical partners is necessary. Local public health departments may have a template of an agreement. Clinical providers may also have an example used with insurance companies or billing entities that can be adapted These agreements may need to be vetted by a legal expert.

Budget: Additional non-personnel/operating costs will need to be planned for including, including local travel and transportation costs (engagement through venue-based outreach, equipment costs (smartphones for team members to communicate with participants while in the field, text messaging to promote retention), and marketing and recruitment costs (promotional materials and use of social media to expand reach).

Development of Recruitment & Engagement Strategies: *Fuerza Positiva* focused on identifying HIV-positive Latino MSM of Mexican origin not engaged in care as numerous linkage efforts implemented in Los Angeles County already focused on newly diagnosed individuals. Locating and ultimately engaging this population should represent the primary focus of the program. Recruitment and engagement strategies fulfill multiple goals.

1. Identify eligible program participants
2. Promote HIV support services
3. Normalize the importance of HIV care
4. Reduce stigma
5. Increase community support and buy-in

Implementation and Maintenance

Program Modifications: The following modifications were made from the original design to account for challenges with recruitment and engagement.

1. **Addition of an Outreach Coordinator**: Intervention benefits by having a person focused on recruitment and engagement efforts. Planning outreach events and maintaining a presence on social media requires a dedicated staff person.
2. **Emphasis on social media recruitment**: Traditional recruitment and engagement strategies that include venue-based outreach did demonstrate an effective recruitment strategy. While in-reach activities proved successful, recruiting HIV-positive MSM through social networking sites (e.g., Grinder, Growlr) proved most successful.
3. **Group-level intervention**: Less emphasis was placed on the group-level intervention as recruitment and engagement strategies and follow-up sessions were identified as more critical with increasing retention.
4. **Non-cash incentives**: *Fuerza Positiva* uses non-cash incentives to demonstrate respect for the amount of time clients spent during the first session and each subsequent follow-up. The amount of the non-cash

incentive was increased from $25 to $40 as clients reported $25 was not sufficient for the amount of time they spent with the Linkage Specialist. Many clients were employed and taking time off of work to meet with staff was not an option.

5. **Communication:** Over the course of the intervention, texting participants via a smartphone were more successful than phone calls and emails. Participants who have "free phones" often have their number changed once their assigned number of minutes is used up.
6. **Flexibility:** Initially, staff anticipated that clients would come into the APLA Health to engage strength-based case management; however, it became apparent many of the recruits and participants were employed which necessitated staff to meet clients in the field during non-traditional work hours.

Implementation Barriers

Recruitment: Given the emphasis within all health jurisdictions on linkage and retention efforts, there is considerable competition to identify PLWH who are not engaged in HIV primary care. Recruitment efforts therefore require considerable formative planning, avoiding duplication of other local efforts, and establishing partnerships that offer services to PLWH but not connected to the traditional HIV service delivery system.

Group-Level Intervention: The Hermanos intervention takes a considerable amount of planning and staff time. Organizations interested in implementing *Fuerza Positiva* need to be mindful that recruitment efforts be the priority.

Clinical Care Options: While the availability of clinical services is a facilitator, participants enrolled *Fuerza Postiva* were connected to 18 different clinics. The diversity of clinics proved challenging with collecting medical data.

Implementation Facilitators

Intervention Staff: Staff reflective of the target population are critical to the success of the program. Knowledge about the target population, cultural values, and their social spaces should be a priority during the employee recruitment and selection process.

Social Media: Use of social networking sites used by Latino MSM is a cost-effective strategy to recruit members of the target population who are not engaged in HIV primary care.

Connection to Support Services: Having a variety of additional support services promotes retention efforts. When participants are lost to follow up they can often be found accessing other services within the organization.

Flexibility: Ability to meet participants in the field during non-traditional working hours is key for both recruitment, enrollment, and follow-up. Job descriptions therefore need to make clear the expectations of program staff.

Reciprocal Effort: Establishing and maintaining community partnerships and engaging key stakeholders are critical to the success of the program. Expanding relationships outside of traditional HIV service providers and engaging organizations indigenous to the community broadens support and assists with reducing HIV stigma. All partnerships must incorporate a reciprocal effort in which each organization support one another.

Ongoing Staff Training

- Motivational Interviewing requires ongoing training and reinforcement
- Updates on HIV treatment, PrEP and relevant issues related to PLWH
- Immigration policy
- Data collection

Staff Turnover

Staff turnover is inevitable. Working with the HR department to be proactive in recruiting a qualified pool of candidates is important. Attendance at community events and through community partnerships, qualified candidates who have a connection to the program can be identified.

Intervention Activities

Preliminary Outcomes

Sixty-Six Latino MSM clients were enrolled and provided services by Fuerza Positiva staff. All men were of Mexican origin residing in multiple locations throughout Los Angeles County with 15.2% indicating they were homeless at the time of enrollment. Clients were referred to Fuerza Positiva from multiple internal (other APLA departments or programs) and external sources with a majority or the largest percentage being recruited from ads placed on Grindr, a geosocial networking application. Clients ranged in ages from 25 through 67 with a mean age of 36.8 (median=34.5, range 42) and skewing younger with 52.9% ages 25 through 35, 24.3% ages 36 through 45, and 22.7% age 46 or older.

Intervention Cost

The annual cost to implement the program, including personnel, employee benefits and operating costs total $255, 584. Additional costs to consider built into this total include $30,000 in program evaluation and $4,745 in non-cash incentives. Removing these two line items brings the total program cost to $220,840.

Lessons Learned

The program elements of *Fuerza Positiva* may be adapted for other jurisdictions and HIV-positive Latino MSM populations. If this program were to be replicated within another organization, there are some lessons learned from this initial implementation to be shared. Below are some of the observations made throughout program implementation which could prove helpful for other organizations to take into consideration during the program planning process.

- Establish realistic recruitment goals.
- Traditional print media strategies may not be useful and are expensive.
- Field-based strategies are critical to the success of the program.
- Employ non-traditional business hours.
- Clients respond more quickly and often via text, as compared to phone or email. Clients often experience changing phone numbers and contact information due to lack of service/free phone access, etc. For this reason, it is important to consistently ensure all contact information is up to date.
- Implementing Fuerza Positiva within an organization with multiple service offerings makes it easier and more convenient to connect clients to important resources.

- Having Spanish-speaking personnel and medical providers is important and can help to ensure clients are having their needs addressed, while also preventing feelings of discrimination or stigma due to misunderstandings due to language barriers.

References

[i] National HIV/AIDS Strategy. https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update

[ii] Marks, G., Gardner, L.I., Craw J., & Crepaz N. (2010 Nov). Entry and retention in medical care among HIV-diagnosed persons: a meta-analysis, *AIDS*. 13, 24 (17): 2665-78. doi: 10.1097/QAD.0b013e32833f4b1b; Gardner, E.M., McLees, M.P., Steiner, J.F., Del Rio, C., & Burman, W.J. (Mar 15, 2011). The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. *Clinical Infectious Diseases*, 52 (6): 793–800. doi: 10.1093/cid/ciq243; Hall, H.I., Frazier, E.L., Rhodes, P., Holtgrave, D.R., Furlow-Parmley, C., Tang, T. Skarbinski, J. (July 27, 2012). *Continuum of HIV care: Differences in Care and Treatment by Sex and Race/Ethnicity in the United States*. XIX International AIDS Conference; Washington, DC. (Oral abstract).

[iii] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016:1-165.

[iv] IBID; Division of HIV and STD Programs, Los Angeles County Department of Public Health, *An Epidemiologic Profile of HIV in Los Angeles County*, 2015: 1-127.

[v] Larios S, et al., Concerns about stigma, social support and quality of life in low-income HIV-positive Hispanics, Ethnicity & Disease, 19(1), 2009; Rock Whol A, et al., Do social support, stress, disclosure, and stigma influence retention in HIV care for Latino and African American men who have sex with men? AIDS and Behavior, 15(6), 2011.

[vi] IBID

[vii] County of Los Angeles Website. Available from: http://www.lacounty.gov/

[viii] Basch et al., 1994; Duany, 2011; Levitt et al., 2007 Basch et al., 191994; Mouwt al., 2014; Basch, Schiller, & Blanc, 1994; Greder et al., 2009; Stone, Gomez, Hotzoglou, & Lipnitsky, 2005; Smith 2005

Bienestar Human Services, Inc.

Project Name: Proyecto Vida

Location: Los Angeles, California

Agency:

BIENESTAR Human Services, Inc. is a grass roots, non-profit community service organization established in 1989. BIENESTAR originated as a direct result of lacking and non-existent HIV/AIDS services for the Latino community. BIENESTAR has been committed to enhancing the health and well-being of the community through education, prevention, and the provision of direct social support services. BIENESTAR provides services out of six offices located throughout Los Angeles: Hollywood, East Los Angeles, Pomona, San Fernando Valley, Long Beach and South Los Angeles. The Proyecto Vida intervention is provided out of each office.

Local Epidemiology:

BIENESTAR implemented an innovative project that targeted HIV-positive Mexican and Mexican Americans, primarily men who have sex with men (MSM), who were residing in Los Angeles County, California. Los Angeles County, with over 10 million residents, is the most populous county in the United States[1] and Latinos comprise the largest proportion (48.5%) of the total population.[1] Mexicans are the largest subgroup of Latinos in LAC, comprising 74.9% of the Latino population.[2]

According to the Los Angeles County Department of Public Health (DPH), an estimated 58,503 persons were living with HIV/AIDS in Los Angeles County as of December 31, 2014.[3] This represented the second largest number of persons living with HIV of any Ryan White jurisdiction in the U.S., after New York City. In Los Angeles County, the majority of Persons Living with HIV/AIDS (PLWH) are from communities of color, especially Latino communities. In 2014, Latino/as comprised the largest percentage (41.8%) of all PLWH and the largest percentage (46.2%) of all persons recently diagnosed.[3] Since 1997, more AIDS cases have been diagnosed among Latino/as than any other racial or ethnic group. In addition, since 2009, Latinos/as represent the largest proportion of new annual AIDS diagnoses of any racial or ethnic group in the region, suggesting that the number and rate of new infections in this population is continuing to increase.

The Latino/as sub-populations most affected by HIV/AIDS in Los Angeles County is MSM. In 2014, Latino MSM comprised the largest percentage (42%) of all new HIV infections in Los Angeles County.[3] In addition, Latino MSM represented 45% of all new HIV diagnoses among MSM of all racial or ethnic groups.[3] MSM comprised 75.9% of the Latino HIV epidemic (13,418 persons). In 2014, DHSP estimated that there were about 8,352 undiagnosed Latinos living in Los Angeles County.[4] Given that MSM comprised 83% of Latinos newly diagnosed BIENESTAR assumed an estimated 6,933 undiagnosed Latinos were MSM. Among HIV positive persons who were aware of their infection but had not been in care for the previous 12 months, DHSP estimated there were 18,668 PLWH who were not in care. More than half of this number (51.1% or 9,535 PLWH) were Latino; given that 75.9% of HIV+ Latinos are MSM, there was an estimated 7,237 Latino MSM who were aware of their HIV status but not in care.[4]

In Los Angeles County (LAC) and across the US, one of the major issues among Latinos is a pattern of testing late for HIV.[5,6] Latinos of Mexican descent have been found to be more likely than other Latino groups to have never been tested for HIV.[7] Latinos are also more likely than other groups to delay entry into care.[8] In addition, only 59% of HIV-positive Latinos in LAC are retained in medical care.[9]

There are numerous factors that contribute to delayed testing and entry into care for Latinos. Among Latinos in LAC, Wohl et al.[5] found five factors that were associated with late testing: older age, born outside the US, less than a high school education, completion of the study interview in Spanish, and a history of injection drug use. They subsequently found that completion of the survey in Spanish was the main predictor of late testing, after controlling for age, country of birth, education and injection drug use, suggesting that Spanish language was a key factor associated with late testing.

In addition, there are also cultural factors that may impact Mexicans' and other Latinos' health-seeking behavior. BIENESTAR's Director of Research and Evaluation, Dr. Frank Galvan, conducted research and published academic articles that have examined specific Latino cultural factors influencing the lives of HIV-positive Latino men. In one study, Dr. Galvan focused on Latino men's adherence to HIV medications.[10] This study sought to address the disparity in medication adherence that has been found between Latinos and Whites, with poorer medication adherence among HIV-positive Latinos compared to Whites.

While HIV/AIDS disproportionately affects the entire U.S. Latino population, there are significant within-group variations in national surveillance data that play out locally in Los Angeles as well. For example, Latinos born outside the U.S. have higher rates of HIV diagnoses compared to U.S. born Latinos.[11] This suggests that issues such as language, acculturation, and residency status may be contributing to the HIV/AIDS disparity experienced by Latino/a populations.

Proyecto Vida Program Overview

Program Description:

BIENESTAR in partnership with JWCH Institute, the Los Angeles Gay and Lesbian Center (LAGLC), Los Angeles Children's Hospital, AIDS Health Care Foundation, Rand Schrader Health & Research Center, Northeast Valley Health Corporation and AltaMed Health Services, implemented Proyecto Vida, an 18-month comprehensive, innovative and much-needed program designed to improve the timely entry, engagement and retention in quality HIV care for Mexican and Mexican Americas in Los Angeles County. We designed our program to respond to the needs of this community by utilizing the best and most innovative practices in the field and by leveraging our own organizational capacity and expertise, along with those of our clinical and clinic partners. This program is designed to respond to the specific needs of MSM of Mexican descent living with HIV and incorporates cultural values and norms(e.g., caballerismo, personalismo, familismo) of relevance to this community. It also addresses potential barriers (e.g., machismo, HIV stigma) to identifying, engaging and retaining MSM of Mexican descent in HIV medical care).

Los Angeles County and BIENESTAR:

Los Angeles County covers an area of 4,751 square miles. BIENESTAR operates six different offices throughout Los Angeles County to meet the needs of the community across this vast area. Proyecto Vida is offered to Mexican and Mexican American MSM in Los Angeles County. Due to the size of Los Angeles, BIENESTAR partnered with multiple Federally Qualified Health Centers in Los Angeles County to make sure the needs of all community members were met. BIENESTAR originally only partnered with three medical clinics as part of this initiative (LA LGBT Center, Los Angeles Children's Hospital and Northeast Valley Health Corporation). Due to the size of Los Angeles and because clients were moving between neighborhoods, BIENESTAR established a MOU with additional medical providers to ensure geographically sensitive medical care could be provided for all those who enrolled in the program.

The Intervention:

BIENESTAR's Proyecto Vida is a culturally-specific innovative program designed to improve the identification, timely entry, engagement and retention in quality HIV care for Mexican and Mexican-MSM. Proyecto Vida's trained Linkage Coordinators/Peer Navigators (LC/PNs) facilitate the initial linkage to/engagement into HIV medical care. This intervention is based off the transtheoretical model and motivation interviewing. Once participants are linked to care, LC/PNs provide participants with ongoing support for 18 months, build their internal motivation, self-efficacy for remaining in care and adherence to their treatment protocol. To facilitate engagement and retention in care among all participating HIV-positive Mexican and Mexican-Americans, Proyecto Vida uses Motivational Interviewing coupled with a linkage to care/peer navigation intervention as its primary strategy. Proyecto Vida is a culturally-specific program that uses a variety Mexican cultural components in the aspects of the program (e.g., machismo/caballerismo, personalismo and familismo) that have been found to contribute to behaviors that enhance a participant's engagement with his HIV medical care.

Proyecto Vida implements Social Network Testing (SNT) (Kim et al., 2011; CDC, 2005) as the key strategy to identify Mexican heritage MSM who are HIV-positive but unaware of their status, as well as those who are at high-risk of acquiring HIV. SNT is a strategy that relies on HIV-positive (HIV+) and high-risk HIV-negative (HRN) individuals to identify peers at risk of contracting HIV within their social, sexual and drug-using networks and then refer them to the program. We chose this strategy not only because it is highly effective, but also because it directly addresses those factors that Mexican heritage MSM identify as barriers to testing (e.g., denial, stigma, distrust in service providers, etc.). Proyecto Vida uses HIV mobile testing vans and storefront testing to provide testing services to Mexican heritage MSM in locations that are frequented by them (e.g. bars, nightclubs, cruising sites, community events, health fairs, etc.).

Proyecto Vida is designed to be a peer-based intervention, with Linkage Coordinators/Peer Navigators reflective of the target population. LC/PN's express an understanding of the barriers Mexican heritage MSM may experience thereby easing their fears, providing knowledge, and facilitating a trusting relationship with HIV service providers. This personalized approach increases the likelihood that more Mexican heritage MSM of unknown status get tested and engage in prevention services or HIV medical care.

The integration of Motivational Interviewing techniques into our service delivery also helps participants address whatever ambivalence they may have about accessing or remaining engaged in care. To meet the myriad needs of our participants that may fall beyond the scope of BIENESTAR's services, we enhance the agency's culturally-appropriate referral network. BIENESTAR's HIV mobile testing vans provide access to testing where it is most convenient for Mexican heritage MSM, and thus removing transportation barriers to testing, which was identified among the top five service needs of Latinos living with HIV in Los Angeles County (DHSP, 2011).

Key components of the intervention:

Social Network Testing: The primary goal of Social Network Testing (SNT) is to identify persons with undiagnosed HIV infection within various networks and link them to medical care and prevention services. SNT is a strategy that enlists HIV-positive people and High-risk HIV-negative people to recruit people from their social, sexual and drug-use networks for HIV-testing. To identify recruiters, we approach both our HIV-Positive and HIV-Negative clients and explain the program to them. We share a brief description of the program's purpose; what their participation involves; their roles as a recruiter; potential benefits the program might have for them and the network associates (NAs) they recruit for testing, and what risks might be involve in participation. After we identify recruiters, we coach them on how to approach associates about getting tested; about disclosing (or not disclosing) their own HIV status; how to respond to NAs' questions about HIV transmission risks, and how and where each NA can get HIV testing at BIENESTAR.

Mobile HIV Testing: Another strategy that we utilize to identify HIV-positive clients is mobile testing. We conduct testing via our mobile unit in the evenings, late evenings and weekends, making it extremely convenient for our clients to get tested when they are frequenting their regular venues.

Motivational interviewing-based linkage and peer navigation: In order to help clients resolve their ambivalence about accessing care or engaging in care, staff were trained in Motivational Interviewing (MI). MI, as defined by its founders, is a "person-centered goal-directed counseling method for helping people to change by exploring and resolving ambivalence" and draws upon the transtheoretical stages of the change model described above. MI is meant to be applicable to a wide variety of problem areas and is able to be delivered by a broad range of helping professionals.

Linkage: Once a person is diagnosed with HIV via our testing program, he immediately meets with one of two LC/PNs. The LC/PN will assess the client's emotional state and his readiness to enter medical care, drawing from the transtheoretical stages of change model. While the LC/PN will encourage the client to enter medical care as soon as possible, if the client is ambivalent, resistant or otherwise not ready, the LC/PN will not try to coerce him to do so. Instead, the LC/PN will address whatever needs the client may prioritize at that time.

Peer Navigation: Once a client is successfully linked to care, we utilize our peer navigation service to ensure he is engage and retained in care. Our peer navigation intervention is designed to guide clients through Los Angeles County's complex medical system and facilitate their utilization of services in order to retain them in HIV care and increase their quality of life. Specific services provided by our LC/PNs include clinical appointment coordination and accompaniment; appointment coordination and accompaniment to social and other services at BIENESTAR and partner agencies; coaching clients to prepare them for their appointments; translation assistance; and the provision of HIV-related education and information. The success of the peer navigation strategy is dependent on our ability to build trusting relationship with our clients.

Transnationalism:

Prior to the intervention BIENESTAR evaluated journal articles on how cultural competency around nationality affects accessing medical care. BIENESTAR staff assessed the transnational status of the participants by using a transnationalism screening tool. This information was then used when working with participants. BIENESTAR staff learned about accessing HIV care in Mexico for participants who were visiting Mexico or moving back so there would not be a break in their HIV care.

Intervention Logic Model:

Below is where each key component of the program intersects with the HIV treatment cascade.

Inputs	Activities	Outputs- Short Term	Outputs- Long Term
Staff	Peer Navigation and Linkage to Care Services	Diagnosis New HIV-positives persons	Retain in medical care
HIV Testing	Store Front/Mobile HIV Testing	Identify individuals who have fallen out of care or never engaged in care	Achieve viral suppression
HRSA Funding	Community Outreach	Link to medical care	Have the ability to navigate the medical system independently
Motivational Interviewing	Social Network Testing/Engage ment	Prescribe antiretrovirals	
Medical Clinical Partners			
Transnationlism Framework			

Community Partnerships:

In addition to clients that we recruited, BIENESTAR also created community partnerships to recruit for Proyecto Vida and provide medical and support services. In order to obtain referrals from other agencies, we actively promoted our program and worked to strengthen our established partnerships and build new partnerships in the community. One barrier we faced is that providers in the community may be reluctant to support a new linkage/navigation program if they believe that it is duplicative of their work. Therefore, to promote our program, BIENESTAR clearly communicated the purpose of the program and created a MOU with our partners to clearly define the roles of each agency. BIENESTAR also clearly with identify the services provided by Proyecto Vida to reduce confusion when promoting the initiative.

List of Partners- We learned throughout this program that it was better to have multiple clinical partners because each partner has its strength and weakness. The role of the LC/PN was to find the clinic that was right for each client based on the client's needs:

- LA LGBT Center- Original Partner
  - Strength- Leading LGBT service provider in Los Angeles providing HIV Care, legal services, mental health service and other services.
  - Weakness- Only provides medical services in the Hollywood area, at times during the program had long waiting periods for medical appointments. Not a good referral source for clients who are not open about their sexuality.
- Los Angeles Children's Hospital-Original partner
  - Strength- Leading agency for providing medical care for LGBT youth under 25 years of age.
  - Weakness- No clients were linked to care due to their age restrictions (12-25 years old).
- JWCH Institute-Original partner
  - Strength- Provides HIV Care, dental services, housing services and other support services. JWCH does a great job getting people into care within 72 hours and does not have wait times experienced at other clinics.
  - Weakness- JWCH HIV clinic was located in Skid Row. Some clients did not like attending the clinic due to the neighborhood. Skid Row has extensive drug use. In the last year, JWCH has opened new clinics in other neighborhoods that might work better for clients with past drug use.
- AIDS Healthcare Foundation (AHF)
  - Strength- The largest HIV provider in Los Angeles County. Has multiple locations throughout Los Angeles County. Offers transportation assistance when linking new clients to medical care.
  - Weakness- AHF has struggled to retain medical providers which has frustrated clients and resulted in longer wait times between appointments.
- Northeast Valley Health Corporation
  - Strength- Provides HIV primary care and non-HIV primary care. Consistency in clinic staff which has helped build client rapport. In 2017 opened a new state of the art office.
  - Weakness- Only provided service in one area of Los Angeles. Clients faced

barriers with the clinic renewing their AIDS Drug Assistance Program (ADAP) paperwork.

- Rand Schrader Health & Research Center
  - Strength- County run HIV specialty clinic. County funded and provides medical services not cover with ADAP for those uninsured or undocumented. Offers late night hours on Tuesday.
  - Weakness- Only has one location. Wait times can be long due to some clients having to access care from the county.
- AltaMed
  - Strength- Very easy to access linkage team and get people into HIV care quickly, Spanish speaking front desk, office and medical providers.
  - Weakness- Took very long to develop a MOU.

Staffing

The following staff have been used to implement Proyecto Vida:

Program Director (In-Kind-.15 FTE): The Director is responsible for intervention program fidelity, recruiting new staff and program monitoring activities, financial reporting to the funder, and meets with linkage coordinator once a month.

Required trainings: NIH certification for Protecting Human Research Participants.

Program Manager (.50 FTE): Responsible for the overall daily coordination of the program activities; prepares reports and keeps accurate up-to-date records and documentation; acts as liaison with the program's medical providers to promote the goals of the program. Reports to the Program Director.

Training Required: Social Network Engagement; Peer Navigation; NIH certification for Protecting Human Research Participants.

Linkage Coordinator/Peer Navigator (2.0 FTE) : The LC/PN conducts outreach, recruits participants for intervention and facilitates the intervention. The LC/PN also conducts initial assessments, creates a plan to eliminate barriers to link and maintain participant in care. Reports to the Program Manager.

Trainings Required: HIV Test Counselor Certification; Basic II: HIV Test Counselor Certification; Motivational Interviewing; Social Network Engagement; Peer Navigation, NIH certification for Protecting Human Research Participants.

HIV Testing Counselor (.15 FTE) The HIV Testing Counselor provides pre and post-test counseling; assures compliance with all regulations and requirements of alternative test site programs and remains current with accurate information in the area of HIV/AIDS. Reports to the Program Director.

Trainings required: Basic I: HIV Test Counselor Certification; Basic II: HIV Test Counselor Certification, Motivational Interviewing, NIH Certification for Protecting Human Research Participants.

Program planning and development

Year 1 Pre-Implementation Activities: (Startup steps)

1. BIENSTAR submitted its application for study review for Proyecto Vida to the IRB, the Los Angeles County Public Health, and Health Services Institutional Review Board. BIENSTAR received preliminary comments from the IRB.
2. Hiring key program staff:
   - Two Linkage Coordinator/Peer Navigators
   - One Program Manager
   - Program Director (already in place)
3. Develop all initial local evaluation tools (may require later modification by IRB). Additionally, finalize all standard operation procedures (SOPs) and protocols.
4. Develop and enhance partnership with partner providers. Staff visit each clinic to notify them of the program and formalize the referral process when linking clients to medical care
5. Develop promotional material to be given out during outreach and to medical providers.
6. Discuss Proyecto Vida with BIENESTAR Community Advisory Boards (CAB). Get the CAB's input on promotional material.

Year 2 (Implementation)

- Proyecto Vida begins HIV testing.
- Proyecto Vida LC/PN begins to recruit for SNT recruiters.
- Proyecto Vida enrollment begins.
- Produces monthly reports of program progress.
- Holds monthly team meeting to review program progress and strategies.
- Continues to meet with medical providers to review linkage to care process.
- Continues to develop new MOU with other medical providers that can provide primary HIV-care.
- Posts promotional material online and in print where participants can access the program.

Year 3-5 (Implementation and maintenance)

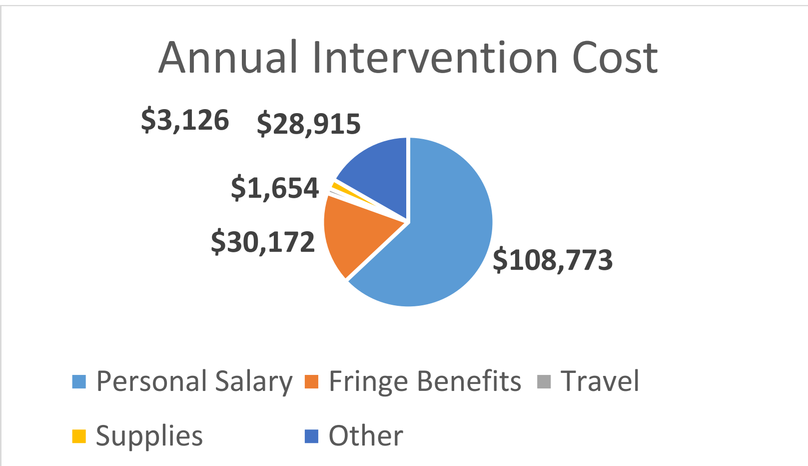
- Continues to provide services identified in Year 2.
- In Year 4, Proyecto Vida holds Gay Men's Wellness Conference. This conference was held based on the needs clients reported as part of Proyecto Vida. This conference was also a recruitment tool for the program to bring new Mexican and Mexican American MSM to BIENESTAR.
- In Year 5, Proyecto Vida hold retention events that offer fun activities for participants to come to BIENESTAR and for LC/PN to check in on their progress. These include movie night, St. Patrick's day party and Havana nigh.
- For participants who LC/PN have lost contact with staff verify their contact information with medical clinics.
- Barrier: BIENESTAR was not as effective in engaging participants for SNT and SNE. BIENESTAR hoped these strategies would help generate new participants but staff was unable to recruit participant for these strategies. BIENESTAR had multiple trainings for staff on these interventions but they did not improve the outcomes of these strategies. BIENESTAR has had

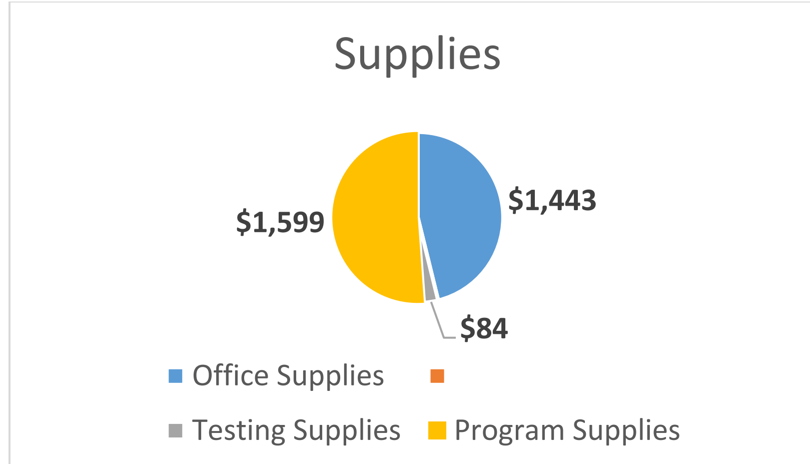
success with these recruitment strategies when working with Transgender women.

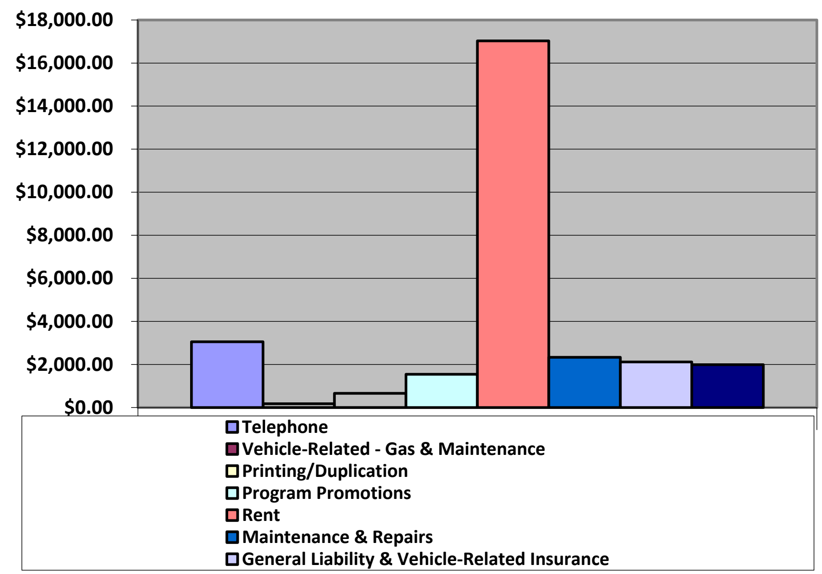
Intervention Participants' Outcomes:

Table 1: Demographic Outcomes	Total to Date Number and (%)
Total Enrolled:	104(100%)
Age: MEAN	M = 36
18-25	13 (13%)
26-35	43 (42%)
36-45	32 (31%)
46+	14 (14%)
Missing	2 (2%)
Place of Birth:	
USA	20 (20%)
Mexico	80 (78%)
Central American Country	1 (1%)
Puerto Rico	1 (1%)
Missing	2 (2%)
Stage of Care Continuum at Enrollment	
Newly Diagnosed	64 (62%)
Fallen out of care/never engaged in care	40 (38%)
Highest level of Education:	
4th grade or less	2 (2%)
Grade 5, 6, 7, or 8 (primary and two year of secondary)	22 (22%)
Grade 9, 10, or 11 (third year of secondary and two years of preparatory)	18 (18%)
Grade 12 or GED (or preparatory exam)	26 (26%)
Some college, Associate's Degree, or Technical Degree	23 (23%)
BA (Bachelor's Degree) or above	11 (11%)
Missing	2 (2%)
Relationship status:	
Single	75 (73%)
In relationship-living together	14 (14%)
In relationship-not living together	8 (8%)
Married	4 (4%)
Other	1 (1%)
Missing	2 (2%)
Client's passed away	3 (3%)
Dropped out of program	1 (1%)
Client that have moved back to Mexico	3 (3%)

Program Cost:
BIENESTAR spent $172,640 annually implementing Proyecto Vida. Below are tables documenting how this money was allocated. A few items are not included these estimates. First, BIENESTAR did not include its Indirect Charges that make up 29% of the total budget. Secondly, all cost associated with the evaluation component of the project are removed. Third, out of state travel expenses were removed. Finally, BIENESTAR did not include any of our incentives. As part of the evaluation, clients were given an incentive to come and complete a follow-up survey every six-months.







Lessons Learned:

These are things we wish we would have known before the program started.

Meeting client's needs:

- Housing was one of the biggest barrier clients had to retaining in care. Clients reported missing appointment or wanted to move to new clinics because of housing. In total, 46 clients reported some type of housing vulnerability. If we could do it again, Proyecto Vida would have tried to secure beds for some clients before the program started.
- Proyecto Vida would have developed MOUs with substance abuse treatment providers. Multiple clients suffered substance abuse needs during the program. This affected their ability to attend appointment with BIENESTAR and health care providers.
- Proyecto Vida would have worked legal assistance into its program. A majority of Proyecto Vida clients are not born in the US and a number do not have documentation. Multiple clients wished Proyecto Vida would have been able to provide them with legal counseling.

Medical providers:

- Proyecto Vida only got four referrals from its medical clinics. Medical clinics had clients who dropped out of care, but stated they could not notify BIENESTAR of these clients to assist with getting them back into care because of HIPPA. Proyecto Vida would have been more effective if before the program we reached agreements with these health clinics so that at enrollment clients agreed to let BIENESTAR contact them if they dropped out of care.
- Proyecto Vida did not enroll anyone at the Los Angeles Children's Hospital because of their age requirement. Proyecto Vida would not have spent so much energy on developing this relationship, but would have put it towards reaching other clinics.

Agency capacity:

- Proyecto Vida had three clients pass away during the program. BIENESTAR would have done more grief training for staff so their own needs were met.
- BIENESTAR would have offered more assistance around during the 2016 election. Many clients were concerned about how the election would affect the services they were receiving and the AIDS Drug Assistance Program (ADAP).
- BIENESTAR created other programing to recruit for Proyecto Vida. In Year 4 of the contract, BIENESTAR held a Gay Men's Wellness Conference. This event was for gay and bisexual men and offered an array of speaks on health issue, food, drag show and prizes. At the event Proyecto Vida staff were able to do HIV testing, outreach and recruit for SNT. BIENESTAR would have held this event sooner to help with recruitment and retention.

BIENESTAR had a few components in its original proposal that were not effective when the program was implemented. BIENESTAR was hoping to provide 6 one-on-one health education sessions to participants over the course of the 18-month intervention. It was difficult to have individuals come to the sessions especially after they had accessed care.

Individuals engaged in programing at the start of the program but once they had accessed care their focus was placed on employment and other priorities. BIENESTAR adjusted by trying to put these health education sessions at the start of the intervention. Nevertheless, turnout continued to be low.

References

1. US Census Bureau Quick Facts, 2016, https://www.census.gov/quickfacts/fact/table/ca,US/PST045217
2. Motel S, Patten E. The 10 largest Hispanic origin groups: characteristics, rankings, top Counties [Internet] Pew Research Center; 2012. Retrieved from http://www.pewhispanic.org/files/2012/06/The-10-Largest-Hispanic-Origin-Groups.pdf.
3.Division of HIV and STD Programs, Los Angeles County Department of Public Health. 2014 Annual HIV/STD Surveillance Report. http://publichealth.lacounty.gov/phcommon/public/reports/rptspubdisplay.cfm?unit=dhsp&ou=ph&prog=dhsp. Published February 2016.
5. Wohl, A.R., Tejero, J. and Frye, D.M. 2009. Factors associated with late HIV testing for Latinos diagnosed with AIDS in Los Angeles. *AIDS Care*, 21(9): 1203–1210. Traylor & Francis Online.
6. Lopez-Quintero C. Shtarkshall R. Neumark YD. Barriers to HIV-testing among Hispanics in the United States: Analysis of the National Health Interview Survey, 2000. AIDS Patient Care STDS. 2005;19:672–683.
7. Hu YW, Kinsler JJ, Sheng Z, Kang T, Bingham T, Frye DM. Using laboratory surveillance data to estimate engagement in care among persons living with HIV in Los Angeles County, 2009. AIDS Patient Care STDS. 2012 Aug;26(8):471–478.
8. Frank H. Galvan, Laura M. Bogart, Glenn J. Wagner, David J. Klein & Ying-Tung Chen (2014) Conceptualisations of masculinity and self-reported medication adherence among HIV-positive Latino men in Los Angeles, California, USA, Culture, Health & Sexuality,16:6, 697-709, DOI: 10.1080/13691058.2014.902102
9. Sullivan PS, Campsmith ML, Nakamura GV, Begley EB, Schulden J, Nakashima AK (2007) Patient and Regimen Characteristics Associated with Self-Reported Nonadherence to Antiretroviral Therapy. PLoS ONE 2(6): e552. https://doi.org/10.1371/journal.pone.0000552
10. Centers for Disease Control and Prevention. HIV Surveillance Report, 2016; vol. 28. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2017.

The Ruth M. Rothstein CORE Center

Project Name: Proyecto Promover

Location: Chicago, Illinois

Authors: Patricia Aguado, PhD, Susan Ryerson-Espino, PhD, Elena Vertti, MSW, Pamela Vergara-Rodriguez, MD

Local Epidemiology

In 2016, there were 2,099,428 Latinos in the Chicagoland area with 803,476 in the City of Chicago.[1] The Chicago Eligible Metropolitan Area, including Cook County, represents one of the metropolitan statistical areas most affected by HIV/AIDS. The city of Chicago carries the burden of HIV in Illinois; home to 22,875 PLWHAs. In 2014, Chicago's HIV incidence and prevalence rates were 36.1 per 100,000 and 847.6 per 100,000, respectively, both nearly three times the national average.[2] The Chicago Department of Public Health data shows that historic Latino immigrant ports of entry, with high Mexican populations, like Pilsen or the Lower West Side and *La Villita* or South Lawndale are disproportionately affected by HIV/AIDS. Latinos in these two neighborhoods, the Lower West Side and South Lawndale outnumber any other racial/ethnic group and make up (81%, 27,693) and (85%, 62,928) of the population respectively.[1]

The interplay between structural/financial and socio-cultural barriers contributes to health disparities affecting Latino PLWHA.[1, 3] The large foreign-born Mexican population, who on average are poorer, more likely to face language-related barriers, and more likely to lack immigration documentation and health insurance; continue to experience barriers to care and poorer HIV-related outcomes. Community factors impacting prevention, testing and care include socio-cultural factors such as lack of HIV knowledge, health care practices carried over from Mexico, work schedules, *Machismo*, stigma related to homosexuality, and the associated internalized homophobia. At risk *Mexicanos* are known to live and work in areas that lack community-based bilingual, bicultural providers and those comfortable caring for communities experiencing HIV-related health disparities. In addition, migration trends and geographic dispersion compound barriers to HIV testing and primary care access.

Program Description

Brief Description. In line with our goals to: 1) Decrease individual and community stigma related to HIV testing to increase awareness of HIV Serostatus; and 2) Increase early linkage and retention in care of HIV positive *Mexicanos,* we developed and implemented a community level and individual level intervention. The key components of our community intervention included: social marketing, educational talks/educational *Charlas* and networking/testing. Our individual level intervention was made up of *Charlas* (one-on-one psychosocial-educational discussions), designed to identify and address barriers related to engagement and retention in care.

Organizational Context. *Proyecto Promover* is housed in the Ruth M. Rothstein CORE Center, one of the largest HIV/AIDS clinics in the United States. Established between the Cook County Health and Hospital System (CCHHS) and Rush University Medical Center, the CORE Center is the safety net health delivery system serving those who are uninsured, underinsured, unemployed, and undocumented. The CORE Center coordinates HIV primary care and referrals with CCHHS affiliate clinics of the Ambulatory and Community Health Network serving communities in Chicago/Cook County, including heavily populated Latino areas in suburban Cook County. The county measures 1,635 square miles and hosts over 5 million inhabitants (41% of the state's population[1])

In 2016, the CORE center delivered over 22,500 ambulatory care visits to more than 5,200 unduplicated patients living with HIV. Approximately 1 in 4 Chicagoans living with HIV receives care at the CORE Center.[4,5] While more than 90% of the CORE Center's patient population resides in Chicago, the majority live in the West and South side neighborhoods who are most affected by HIV/AIDS.[4,6] The CORE Center patients reflect the HIV positive population of Chicago; 73.4% of patients are male and 83.6% are 26 years of age or older, and 23.5% identify as Hispanic versus 19% citywide.[2,7] The CORE Center and CCHHS partners have experienced success engaging and retaining patients in care once identified within clinic or hospital services. Despite the many successes, the system still needs to increase early linkage and retention in care of HIV positive *Mexicanos*. Strikingly, over 50% of our existing CORE Center Bilingual Clinic's new/Latino patients enter HIV care with a CD4 < 200 cells/mm3.[7]

The Intervention

Theoretical basis. The theoretical perspectives influencing *Proyecto Promover* include intersectionality and the social ecological framework. Cultural values of *familismo, personalismo* and *respeto* were also instrumental in *Promover* as was Motivational Interviewing.

Intersectionality acknowledges that social identities overlap and create an experience of social marginalization unlike that which is experienced by any single identity. Intersectionality is the lens through which we frame and acknowledge the struggles and resiliency of *Mexicanos* at risk and infected with HIV.[8, 9] Our target group holds multiple identities, shaped by social and political experiences that have been historically oppressive and marginalizing. The intersection of these identities compounds the experience of oppression and contributes to health disparities. For example, a Mexican, MSM, poor, HIV positive and undocumented individual may have worse health outcomes than someone else who can live and work freely without fear of discrimination based on national origin, sexual orientation, and socioeconomic status. Social ecological theory further highlights the nested nature of the risks and resources impacting HIV testing, care and retention within the individual and their surrounding contexts (transnational interpersonal, community and structural contexts) .[10, 11, 12] A diagram of socio-ecological risks and resources is summarized in Figure 1.

The cultural values of *familismo, personalismo* and *respeto* were guiding principles for the key interventionists, Clinical Patient Navigators (CPN), in their efforts to develop rapport and deepen the relationships with patients. *Familismo* is a strong identification and attachment to one's family (nuclear and/or extended).[4,6] In *Promover*, CPNs explored participants' coping with wellness and HIV within the family context and also became a strong liaison to what became a sort of extended family for participants, the Bilingual Clinic and CORE. *Personalismo* refers to the importance of strong personal relationships, acknowledging all in warm and respectful ways: family, friends, and even acquaintances. *Respeto* refers to specific levels of courtesy and decorum in personal relationships based on age, sex, and social status. In *Promover*, *respeto* played out most specifically as deference to elders.

Lastly, Motivational Interviewing (MI) is a technique that the interventionists utilized to in part operationalize *personalismo* and *respeto*. The CPN supported knowledge development and behavior change by applying MI and utilizing the patient's own values and concerns specifically exploring and resolving ambivalence as a mechanism for growth.

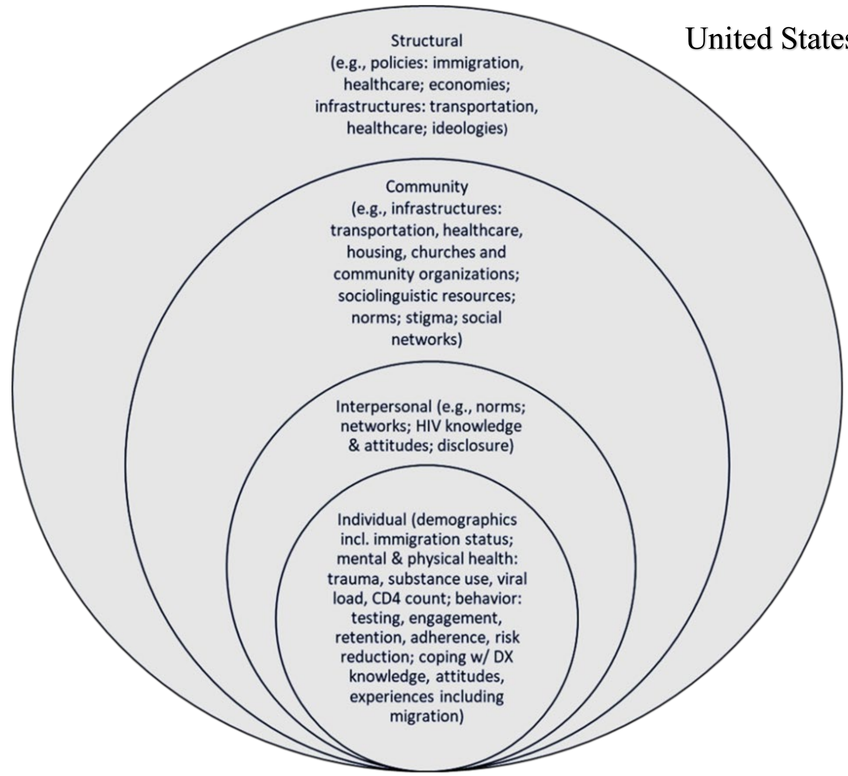


Figure 1: Socio-ecological framework

Transnational framework. *Proyecto Promover* strove for sociocultural and ecological relevancy by validating the personal and community struggles and resiliency in coping with the constraints and resources defining transnational Mexican immigrants living in Chicago. As the socioecological model suggests, both Mexico and the US provide context for things like knowledge, attitudes, behaviors, norms, networks, and utilization of support and services at play in the lives of participants. *Proyecto Promover* focused on empowering HIV positive patients by listening to and acknowledging their transnational experiences, overlapping identities and struggles; raising awareness of key HIV knowledge points and helping the patients manage their illness in a transnational context.

Specifically, *Proyecto Promover* focused on helping participants manage emotions with diagnosis, physical and mental health, and relations with families and significant others, understood as three key areas of practical knowledge for their everyday lives (See Figure 2). *Promover* aimed to increase a person's belief in their ability to make decisions and act to implement this practical knowledge.

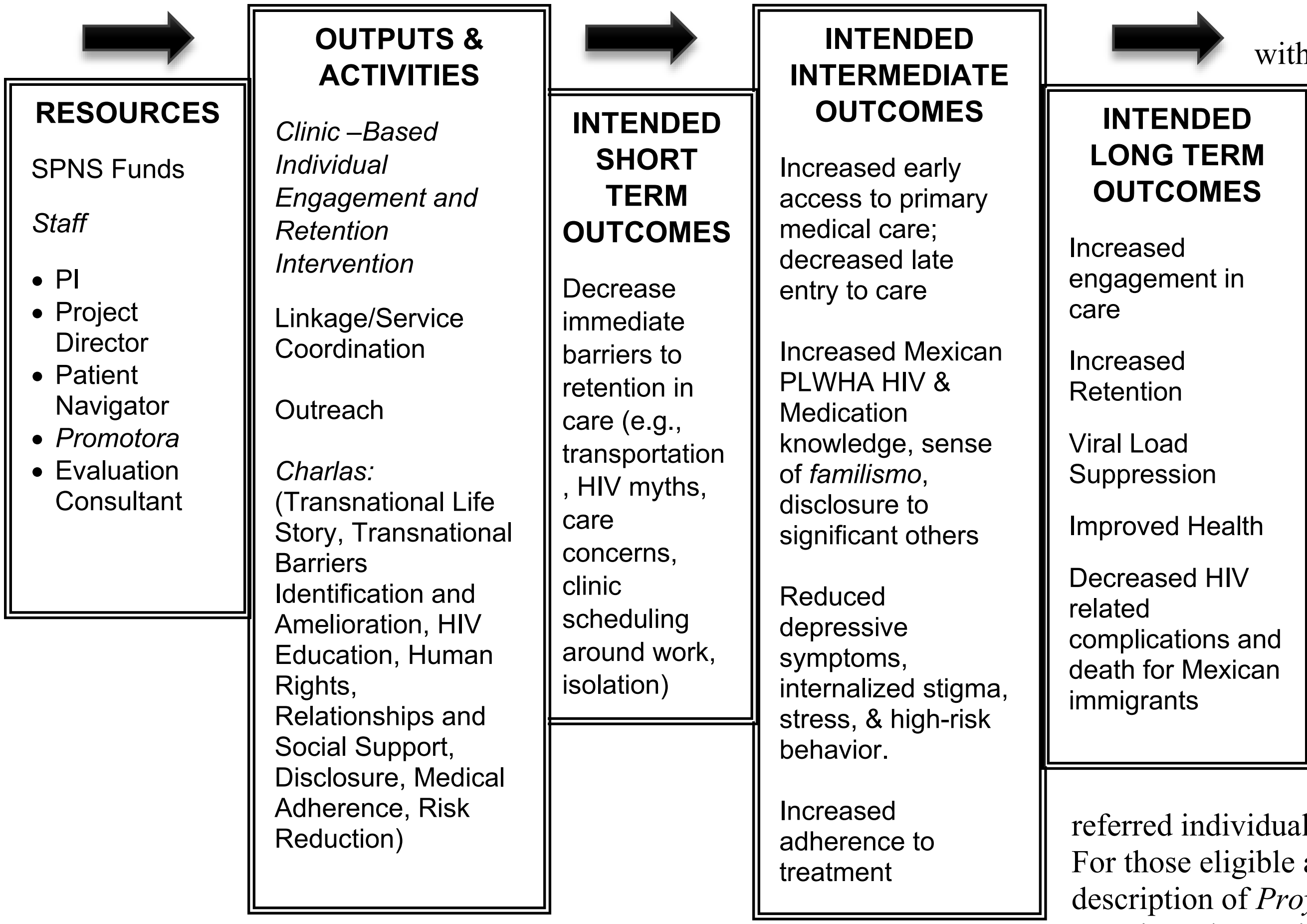
Figure 2: HIV Self Care

To further understand our participants' transnational lives, we incorporated a migration interview as part of our intervention. The migration interview helped to inform our understanding of our participants' connections to Mexico. Specifically, why and under what conditions they decided to migrate; what their migration journey entailed; how they had maintained connections to Mexico and in what ways; and how they incorporated and integrated pieces of a Chicago and American identity since their arrival to the United States. We also sought to systematically understand what their health seeking practices were both in Mexico and the United States. The migration story helped to shed insight into migration trauma, and our understanding of support systems in Mexico, U.S., and Chicago. This story allowed participants a forum to be nostalgic about life in Mexico, to mourn the loss of no longer living in their home country and to reflect on their resiliency living in the United States. This information greatly increased our knowledge and understanding about our participants' lives and helped to strengthen and cement our relationship with participants and help in care retention. Ultimately, the migration questionnaire served to help build rapport with the CPN in addition to giving us a lens to understand the history, struggle and resilience of our participants.

Proyecto Promover Logic Model

Through *Charlas*, the CPN and participant identified and addressed immediate barriers to care and retention and developed knowledge and efficacy so as to retain *Promover* participants in care and support their viral suppression (See the basic Logic Model in Figure 3). *Charlas* in Spanish mean talks or discussions, and represented how we wanted our intervention to feel to participants: familiar, supportive, and communal all within a safe, non-judgmental, and shared space.

Figure 3: Logic Model



Intervention Components

Screening. Individuals were eligible for *Promover* if the following criteria were met: 1) English or Spanish Speaking; 2) Self-identified as Mexican; 3) 18 years of age or older; 4) HIV infected; and 5) A patient of the CORE Center in one of the following four categories:

1. Newly diagnosed: Diagnosed with HIV within 6 months of date of referral and had never received HIV-related medical care in the past.
2. New to care: Diagnosed with HIV more than 6 months ago and had never received HIV-related medical care in the past.
3. Sporadically engaged: Irregular HIV primary care; a lapse in care for more than 6 months in the prior 2 years.
4. Lost to care: Had received HIV medical care previously and not attended medical appointment with HIV primary care provider in the previous 12 months.
5. *Project Introduction and*

Consenting. The CPN screened the referred individual and documented ineligibility as relevant. For those eligible and interested, the CPN provided a description of *Proyecto Promover* and answered any questions the participant had. If interested, the participant completed *Proyecto Promover's* consent and HIPPA form. All of our tools and interventions were translated into Spanish. The CPN described or reiterated the CORE Center's confidentiality policy and the Illinois Health mandate that all health information (data) remain confidential and secure. An intake appointment was arranged; dates, times and locations of meetings were specified. Participants received a CPN's business card and contact information. The CPN completed an enrollment checklist to ensure that all critical information had been covered in the initial meeting.

Charlas. The intervention, delivered by the CPNs, consisted of five *Charlas* (figure 4): 60-90 minute, psycho-educational talks meant to be completed within 1 year of enrollment. *Charlas* were mainly conducted one on one, although, participants had the option of including their loved ones in the discussions. The CPNs facilitated the *Charlas* with participants and aimed to increase support and knowledge, autonomy, and self-management to improve health outcomes.

The *Charlas* were an opportunity for the participant to discuss issues relevant to their diagnosis and everyday life. Subtopics such as transnationalism (pre, in transit, and post-migration experiences related to health), human rights, personal barriers, disclosure, effective communication and sex, were addressed. Self-care practices dependent on the need or any given participant (identification/diagnosis, linkage, re-engagement, retention and HIV suppression) were emphasized. The *Charlas* were conceptualized to provide culturally tailored support by identifying and addressing sociocultural barriers to care. Depending on individual need and knowledge, the CPN would tailor the discussions by expanding or deleting *Charla* topics. Participants were encouraged to ask questions and insert their own personal experiences with the purpose of making the *Charlas* more personally relevant. The goals were to allow the participants to guide the *Charlas* in accordance to their needs and comfort.

Two specific strategies used to tailor *Charlas* included initiating the *Charlas* with the patient's personal migration and HIV narrative (*Charla* 1) and an assessment of barriers, mental health and substance abuse concerns (*Charla* 2). *Charlas* 1 and 2 focused on managing diagnosis and physical and mental health. Subsequent *Charlas* focused on managing relationships with others. CPNs were prepared to personalize *Charla* topics in the order in which the participant felt was most important.

CPNs aimed to schedule *Charlas* on the same day as clinical appointments. The CPN contacted participants to schedule and remind participants 1-2 days before their medical or *Charla* appointments. The CPN would also send reminder texts the day of appointments or would message the participant via WhatsApp (an application utilized to message people via text around the world free of charge.) Staff would monitor clinic registration, check for walk-ins and check for participants with scheduled appointments in the building or on campus on a daily basis, multiple times a day. Monitoring the clinic registrations in this way helped the team flag people who were enrolled in our project. If we recognized a participant enrolled in *Promover*, the CPNs and/or project director would engage in face to face outreach to ensure participation in *Charlas*.

Core Intervention Staff. All team members had clinical and/or research experience with Spanish speaking HIV positive community members and were bilingual and bicultural. The staff responsible for implementing *Promover* included Clinical Patient Navigators (Master's level social workers and clinical interns) supervised by a Doctoral level social worker and program director. All were bilingual, bicultural, Mexican American and female. In addition, the Principal Investigator was a bilingual, bicultural medical provider and provided overall direction and oversight to all aspects of the project. The CPNs worked closely with the multidisciplinary bilingual clinic team facilitating holistic care with colleagues to meet any mental health, substance abuse, or other medical care needs of the intervention participants. (see Table 1 for summary of staff).

Figure 4: *Charlas*

Managing your diagnosis

Charla 1:

-Diagnosis experience
-Identity
-Migration Story
-Social support and connections to Mexico
-Beginning exploration around disclosure
-HIV knowledge
-Work lives
-Current living situation
-Early healthcare and HIV experience
-Treatment planning
-Barriers assessment

*Early attention to stigma and HIV myths

Managing your physical & mental health

Charla 2:

CPN administered assessment tools:
-Barrier to care inventory
-CAGE: Substance use screener
-CES-D: Depression scale
-PC-PTSD: Post Traumatic Stress Disorder Screener

*Assessment tools identified challenges to retention in care and initiated conversations about engagement and referrals to multidisciplinary providers as necessary.

*Orientation to CORE services continued with emphasis on care engagement and medication adherence. Trust issues were addressed related to medical care and misconceptions.

Managing your relationships with

Charla 3-4:

*Addressed relationships with family and intimate partners.

Topics covered:
-Importance & challenges of dealing with stress associated with HIV status
-Successful communication
-Disclosure
-Sex negotiation

*Patients chose to focus on: family or intimate partner relationships and disclosure

*Emphasis on HIV knowledge and skill development in the areas of communication engaging with supportive others, and risk reduction

Review & termination or referral

Charla 5:

The final *Charla* reinforces the services CORE can offer and ensure they are connected for further support as needed. Much of what is discussed over this last *Charla* is a review of progress, strengths, and future work.

Additional *Charlas* (as needed):
After *Charla* 5, there is the possibility for two additional meetings if there is still a significant stressor/ barrier that can be appropriately attended to with the support of the CPN.

Table 1: Summary of *Promover* staff

Title	Role
Principal Investigator	Provided overall direction and oversight to all aspects of the project.
Project Director	Responsible for overseeing the day to day program operations; in conjunction with the PI conceptualized, refined and led implementation of interventions. Supervised program staff; Responsible for IRB protocol, amendments, project reporting and participating in the dissemination or study findings.
Local Evaluator	Worked closely with project staff and partners in project implementation, intervention refinement and evaluation. Led the overall evaluation local effort and coordination with multi-site evaluation. Responsible for guiding data analysis activities and dissemination activities.
Clinical Patient Navigators & *Promotora*	The clinical patient navigators Took the lead in the implementation of clinic level *Charla* intervention including: screening, recruitment, engagement and retention of study participants. The *promotora* took the lead in all aspect of our community intervention.

Community Partners and Collaborators. The CORE Center, an ambulatory outpatient infectious disease clinic, part of the larger Cook County Health and Hospital Safety Net System already and embedded within it strong relationships with a vast network of multidisciplinary partners. *Promover* navigated this broad health system network to facilitate referrals as needed for participants. *Promover* also strengthened old and established new community relationships. *Promover* was built upon the relationships with The Mexican Consulate of Chicago, Pilsen Wellness Center, *Proyecto Vida* and created MOU's for referral and linkage with several churches, substance use treatment groups and two community health centers.

Program Planning and Implementation

Startup steps. All staff participated in trainings conducted by the Midwest AIDS training and Education Center (MATEC) and Chicago Department of Public health (CDPH). MATEC is the largest HIV/AIDS training and educational program in the Midwest and provide targeted training and direct expert HIV information. CDPH is the division of STI and HIV/AIDS public policy and programs department in the city of Chicago. They provide intensive trainings and education for the prevention and treatment of STIs and HIV/AIDS. Other training topics included: managing and creating boundaries, how to conduct interpersonal interviews and engagement, motivational interviewing, trauma informed care and research associated with helping staff deepen their understanding of common barriers associated with Latinos and *Mexicanos* linkage and retention in HIV care.

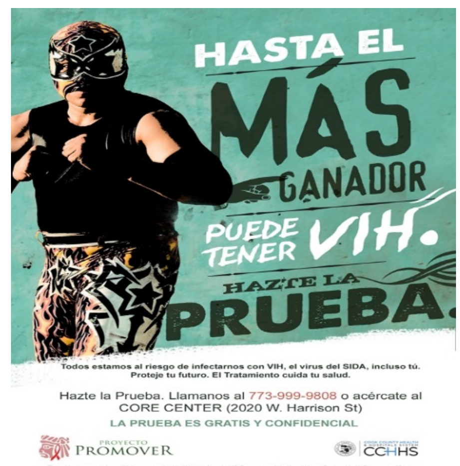
In collaboration with another medical provider at CORE, the Project Director facilitated a series of six focus groups aimed at understanding what the barriers to testing and engagement in care were for Spanish Speaking Latinos. This information, in addition to the feedback garnered from multidisciplinary HIV care providers, clinic patients, community partners and cultural advisors helped develop and refine our intervention. Additionally, during the development and early implementation stage of *Promover*, feedback was sought from multisite and local evaluators and a cultural advisory board made up of academics, researchers and practitioners in either the HIV or Latino health fields, as well as from CORE staff and HIV positive patients about the content areas for a Latino, Mexican focused intervention. Another area of early activity included raising awareness of HIV and available services in the originally targeted neighborhoods of Pilsen and Little Village in an effort to bolster early identification and linkage. While the CORE Center had community-testing initiatives, none previously prioritized Spanish-speaking neighborhoods. Our *promotora* engaged in asset mapping to identify sites for posting social marketing material, hosting community education and testing events, and clinical referrals. Social marketing materials were created with community and cultural advisor input.

A print campaign, including posters, palm cards and small hand flyers, designed to promote testing and reduce stigma emerged specifically aimed at reaching everyday working class, Mexican immigrant, community members and emphasized: 1) Everyone is at risk, 2) Testing is preventive care & being responsible to self and loved ones and, 3) free confidential testing at CORE (see figure 5).

Figure 5: Social Marketing

Posters

The *luchador* is a popular Mexican symbol that transcends the border and reflects the Mexican fighting spirit in Mexico and abroad, Mexican agility, ability to persist and "fight" on against many odds. With the *luchador* image, we hoped to inspire everyday *luchadores* to maintain their fight to take care of themselves and loved ones. El ranchero y "la virgin" images reflect the many faces we see in and around our communities, within our families, and amongst ourselves. These images depict proud, everyday working people who carry a strong sense of Mexican identity and realities as they navigate life in Chicago.



Back of Palm Card

Print campaign

Commitments were secured and over 33 community partnerships were formed facilitating the distribution of over 1,700 pieces of social marketing materials (palm cards and posters) and the implementation of 45 community education sessions (*Charlas*) involving over 340 community members, and 122 testing events occurred involving over 1,750 individuals. *Promover* successfully engaged Spanish-speaking community members, most commonly from Mexico, in all community components. Intercept survey solicited feedback from residents of the target neighborhoods. Participants affirmed the importance of the campaign and stated that materials prompted them to reflect on risk and need for testing. The majority of community members tested were Latino (93%); 83% were Mexican; importantly, overall half were first time testers. Relative to community education *Charlas*, 67% of participants were male and 72% were Mexican. Knowledge and intentions significantly increased (.42-.65 effect sizes) pre- to post- *Charla*. Prevention knowledge, post knowledge of local resources, personal testing intentions, and intentions to refer a friend or loved one for testing were all interrelated (p <.05). Over all, to our knowledge community intervention work helped link only two community members to care (1 newly diagnosed and 1 out of care).

Examining zip codes from our clinic-based intervention confirms that while *Promover* successfully recruited 107 new and lost to care Mexican participants, the majority came from areas not targeted by our stepped up community work (87% of those with valid zip codes (n=100) came from outside of targeted areas). However, data suggest important additional areas to target with community work and many are adjacent to the target communities. Specifically, 25% came from neighborhoods south and southwest of Pilsen and Little Village and 11% of participants came from Cicero (a suburb of

Chicago immediately south of Little Village). Over one quarter came from neighborhoods north and northwest of the CORE Center (27%). A next step for *Promover* and CORE includes considering mechanisms for disseminating strategies for partnership formation, social marketing, community education and testing throughout Chicago and suburban Cook County such that access and awareness of HIV prevention and treatment can grow within the many neighborhoods Mexican and Latino community members call home.

Implementation and Maintenance. The most significant modification to the intervention was the addition of a migration questionnaire. Initially, we thought that given our topic areas, transnational lens and assessment of social and structural barriers, CPNs would be able to explore and document participant migration stories. After the initial 5-6 participants, we made a decision to include a semi-structured, open-ended interview to facilitate this process and provide some structural support for the CPNs. Originally, it was meant to be used as a mechanism to gain deeper insight into the lives of our participants, the unexpected and significant gain from the migration story was the strengthening and solidification of our relationship with each other.

Intervention Outcomes

Proyecto Promover consented 114 individuals; 7 withdrew before participating in the intervention; 107 enrolled in our clinic level intervention; the majority of whom were male (89%) with small subgroups of women and transgender women (n<10 in each of these subgroups). Outcomes are forthcoming however early data analysis suggests strong clinical retention and viral suppression at 85% and 92% respectively. However, an early trend has emerged in our retention data that suggests returning to care patients (those who were lost to care or not optimally engaged, recruited into the intervention and re-engaged in clinical care) were more challenging to retain in the intervention and the evaluation over time. A difference of approach and efforts were observed among lost to care patients and newly diagnosed. Newly diagnosed participants were more willing to learn about their diagnosis, fully participated and took advantage of the *Charlas*, and where readily available while more efforts were put forth to communicate, engage, and retain lost to care participants. Returning to care patients could benefit from even more targeted initiatives going forward including those that can prioritize additional collection of narrative data around their experiences with life, HIV and clinical care so that interventions are even more aligned to their experiences and needs.

Costing

We were allotted a budget of close to $300,000 yearly; approximately 65% of this budget was used directly for programmatic activities including staffing, supplies, patient transportation and grant management indirect costs. The remaining 35% was directed towards our local and multi-site evaluation efforts including patient recruitment incentives. Projected staffing needs associated with the sustainability of this project would include a half-time program coordinator and two clinical patient navigators

Lessons Learned

Refining, developing, implementing and evaluating interventions takes time and resources. When starting from beginning steps in a demonstration project full maturity of program and evaluation of outcomes may be premature during a 5-year project. Due to the intervention being finite, the CPN is not able to fully assess, much less address long-term mental health concerns or internalized stigma. Long-term support, beyond 12 months is needed, to fully address these concerns, which likely already existed prior to diagnosis or were exacerbated after diagnosis due to secrecy of status, lack of a support system, or other competing priorities. To this end, it is important to have a concrete plan for how to handle referrals to either care as usual or to higher levels of care outside the organization.

Significant to the success of *Proyecto Promover* included building relationships with not just clients but staff from the CORE or clinic from where participants were recruited. There were intentional efforts on the team's part to become integrated within the clinic setting and to be perceived as an extension of the work already being done. We did this by participating in all clinic activities, fostering relationships with all providers, recurrently explaining the benefits of our project and providing personal feedback to providers about their clients. This was seminal to establishing buy-in from the clinic; it helped with referrals and ultimately, care coordination for participants.

Lastly, we cannot underscore how important it is to be flexible. The success of this intervention was integrally tied to flexibility in terms of when and where *Charlas* were conducted. Often, the intervention happened within the communities where clients lived, after traditional work hours, in the evenings, and occasionally on weekends.

References

1. United States Census Bureau / American FactFinder. *2011 – 2015 American Community Survey 5-Year Estimates*. U.S. Census Bureau's American Community Survey Office, 2015. Web. 10, September, 2017 http://factfinder2.census.gov
2. Chicago Department of Public Health. STI/HIV Surveillance Report, 2015. Chicago, IL: City of Chicago; November, 2015.
3. CDC. Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data - United States and 6 US Dependent Areas -- 2010. HIV Surveillance Supplemental Report 2012; 17(3, part A).
4. Chen NE, Gallant JE, Page KR. (2010). A systematic review of HIV/AIDS survival and delayed diagnosis among Hispanics in the United States. *J Immigrant Minority Health*, 14: 65-81.
5. Glasman LR, Weinhardt LS, DiFranceisco W, Hackl KL. Intentions to seek and accept an HIV test among men of Mexican descent in the Midwestern USA. *AIDS care 22*(6): 718-728.
6. Rios-Ellis B, Frates J, Dâ€™Anna LH, Dwyer M, Lopez-Zetina J, Ugarte C. (2008). Addressing the need for access to culturally and linguistically appropriate HIV/AIDS prevention for Latinos. *Journal of Immigrant and Minority Health; 10*(5): 445-460.
7. Badri S, Orsi J, Lubelchek R, French A. Late presentation to HIV care among African-Americans and Hispanic/Latinos since adoption of universal HIV screening: a persistent problem In: ICAAC. Chicago, IL; 2011.
8. Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. *American journal of public health*, *102*(7), 1267-1273.
9. Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Social science & medicine*, *75*(12), 2099-2106.
10. Auerbach, J. D., Parkhurst, J. O., & Cáceres, C. F. (2011). Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Global public health*, *6*(sup3), S293-S309.
11. Bronfenbrenner U. (1979). *The ecology of human development*: *Experiments by nature and design*. Cambridge, MA: Harvard University Press.
12. Bronfenbrenner, U. (1998). The ecology of developmental processes. In U. Bronfenbrenner, P. Morris, W. Damon, & R. M. Lerner (Eds.), *Handbook of child psychology*. Hoboken: Wiley.
13. Stangl, A. L., Lloyd, J. K., Brady, L. M., Holland, C. E., & Baral, S. (2013). A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *Journal of the International AIDS Society*, *16*(3Suppl 2).

Prism Health North Texas

Project Name: Viviendo Valiente

Location: Dallas, Texas

Local Epidemiology

Rationale and Description of Need

Latinos make up 38 percent of the 2.36 million people living in Dallas County. People of Mexican descent comprise of 85 percent of the Latino population and 34 percent of all Dallas County residents. Latinos are less likely to get tested for HIV and are more likely to get diagnosed with AIDS. (Census, 2010) Between 2005 and 2009, 36 percent of Latinos receiving an HIV diagnosis were diagnosed with AIDS within one year and 29 percent were diagnosed within one month (Ryan White, 2010). This means that the infection had progressed and serious symptoms had developed by the time an HIV diagnosis was made. In order to address this, a focused intervention was necessary to assess and resolve the specific barriers faced by people of Mexican descent with regard to accessing and staying in HIV care.

Priority Population

Viviendo Valiente strategies and program messaging at the individual, group, and community levels of service are developed for individuals of Mexican origin (born in Mexico or of Mexican descent), 18 years or older, regardless of gender, gender identity, or sexual orientation, and residing in or attending a program or event in Dallas County, Texas. Only at the individual intervention level of service is the eligibility criteria limited to priority population members of Mexican origin with a known HIV diagnosis.

Program Description

The Viviendo Valiente Program is developed and implemented in Dallas, Texas. In order to address concerns related to HIV among the Mexican population, the program was specifically tailored to meet the needs of this community. Viviendo Valiente was developed as a unified, multi-level intervention that promotes HIV testing and assists those who test positive for HIV to get linked to and engaged in HIV medical care.

About Prism Health North Texas

Prism Health North Texas (PHNTX), formerly known as AIDS Arms, Inc., established in 1986 and designated as a 501(c)(3) nonprofit in 1989, is the largest community-based AIDS service organization in North Texas providing coordinated, comprehensive HIV services ranging from prevention to treatment of HIV and related conditions. The agency's *mission* is advancing the health of North Texas through education, research, prevention and personalized integrated HIV care. This guides our programs which aim to a) address prevention of acquisition and/or transmission of HIV and sexually transmitted infections (STIs) through culturally relevant and effective interventions; and b) to identify those who are HIV positive, link them to medical care, behavioral health, and psychosocial support services in order to improve health outcomes. PHNTX provides outpatient HIV medical care and behavioral health services at two clinics: *Oak Cliff Clinic* and *South Dallas Clinic*, onsite and mobile case management and outreach, testing, and other services. All PHNTX case managers and promotores de salud (promotor, promotores) are Affordable Care Act Certified Application Counselors and assist clients with enrollment in the health insurance marketplace.

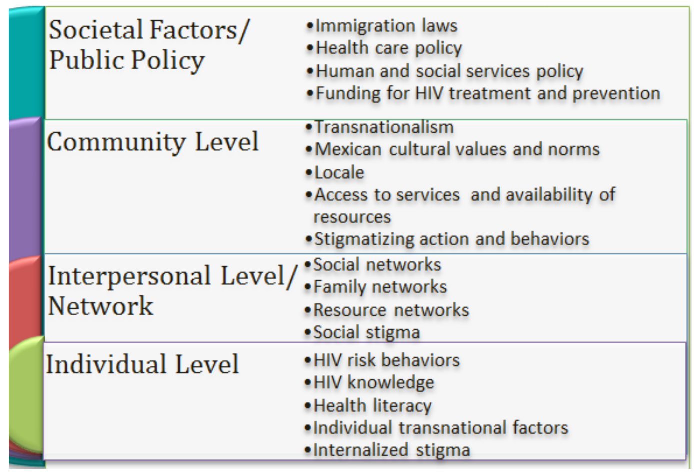
Prism Health North Texas' Administrative Offices

The Intervention

Theoretical Basis – The ***Transtheoretical Stages of Change Model*** conceptualizes a five-stage process that individuals must move through to accomplish positive behavior change: Precontemplation, Contemplation, Preparation, Action, and Maintenance. The ***motivational interviewing (MI)*** literature provides practical guidance for helping an individual to progress through specific stages of change, as set forth by Prochaska and DiClemente in the Transtheoretical Stages of Change Model (1992; Prochaska et al., 1992), which describes predictable stages of change for people with substance use disorders. These stages can also apply to persons who are HIV positive or at-risk for HIV and may need to be addressed to promote engagement in care. Research has demonstrated that MI, originally developed for substance abuse treatment, is the evidence-based practice of choice for motivating individuals to change behaviors in order to achieve positive health outcomes (Miller & Rollnick, 1991; CSAT, 1999, 2008). The approach is associated with greater participation in treatment and positive treatment outcomes (Miller & Tonigan, 1996; Prochaska & DiClemente, 1983). MI has been adapted for successful application with people who have serious mental illnesses and/or co-occurring disorders, homeless persons, HIV positive or at-risk persons, and for other populations. MI sets forth both principles and techniques for moving clients, sensitive to their state of readiness and at their pace, towards greater commitment to change-focused services.

Application of MI has been found effective in reducing disparities in access to care among Latinos and is recommended for creating a client-centered and culturally-congruent therapeutic milieu (Añez at al., 2008). MI has also been found effective for long-term engagement, offering greater flexibility than traditional outreach because it can be provided in a clinic or office (Glanz et al., 2008; Naar-King et al., 2006, 2009; Miller & Rose, 2009).

The ***Social Ecological Model*** is used to guide the strategies for the multi-level Viviendo Valiente intervention. In the context of HIV in the Mexican Community, this model outlines the multi-level risk factors that may exist within the Community. In this model, social and economic factors are identified at four levels: individual, interpersonal /network (group), community, and societal factors/ public policy levels. Viviendo Valiente interventions focus primarily at three levels: individual, group, and community.



4 Levels of social and economic factors identified by the Social Ecological Model

Migration patterns in the U.S. emphasize the need for culturally tailored programs, specifically those that integrate a transnational framework.

While research of **transnational concepts** is becoming more common, a widely accepted definition of transnationalism has not yet been established. Transnationalism has been described in the literature as:

> "…*sustained ties of persons, networks and organizations across the borders across multiple nation-states, ranging from little to highly institutionalized forms*" (Faist, 2000).

> "…*the processes by which immigrants build social fields that link together their country of origin and their country of settlement*" (Schiller, Basch & Blanc-Szanton, 1992).

The Viviendo Valiente intervention encourages clients to consider how transnational and cultural factors may impact their HIV care. Viviendo Valiente defines **transnational factors** as those characteristics that influence or are influenced by a person's connectedness to two or more nations, societies, or cultures. Transnational factors can have both positive and negative associations for people as well as positive and negative effects on client behaviors and health outcomes. The intervention focuses on four domains as they relate to transnationalism. Each domain is explored as appropriate in sessions with clients and documented on an assessment tool developed to help the client process the information.

Social factors relate to relationships with family and friends, support networks, social environments and social outlets. Examples include reporting no friends or family in the local area and/or communicating daily with family in the country of origin.

Economic factors relate to an individual's employment, saving and spending behaviors and/or financial status. Examples include living with others to share expenses and/or sending money to family.

Migrational factors relate to an individual's patterns or migration between countries of origin and current residence. This may include the frequency of, or nature of migration in individuals' social networks and visiting from or traveling between countries of origin and residence. Examples include documentation status and reporting sexual orientation as reason for migrating.

Other transnational factors include education, involvement, and an individual's political practices. Examples include expressing interest in trade school, expressing desire to help others living with HIV, and a low level of education.

Transnational domains explored by the Viviendo Valiente Program

Similar to transnational factors, **cultural factors** may impact both engagement and retention in care as well as adherence to treatment. The intervention assesses cultural factors in the three primary areas shown in the table

	*Cultural values and norms* include holidays celebrated, cultural traditions practiced, rituals performed, and more. Examples include being homesick during holidays and celebrating traditional Mexican holidays such as *El Dia de Los Muertos* (Day of the Dead).
	*Religious and spiritual factors* may relate to an individual's beliefs, values, attitudes and rituals. Examples include identifying as Catholic but not attending services and/or relying on Mexican rituals to help with coping.
	*Language factors* include language and writing abilities, and preferences. Examples include low reading/writing English proficiency, expressing an interest in English as a second Language (ESL) classes, and speaking only the Spanish language.

Cultural factors explored by the Viviendo Valiente Program

The integration of transnational concepts into individual-level interventions is a new and mostly unexplored concept in the field of HIV service delivery. While the impact of transnationalism is being studied more, there is much to understand about the effects of transnationalism on engagement and retention in HIV care. With limited guidance available, the Viviendo Valiente intervention sought to better understand transnational factors among people of Mexican descent living with HIV and how these factors may serve as barriers and/or facilitators to accessing and engaging in HIV care. While validated methods to address transnational factors are not available at present, there are many methods with which we explore and identify transnational characteristics of a client receiving care. The Viviendo Valiente intervention utilizes probing guidance processes and a transnational assessment tool to explore the presence of transnational and cultural factors, provides follow-up guidance and conducts case reviews to determine whether and how these factors may be addressed.

Key components of the intervention – Viviendo Valiente is a multi-level intervention focusing on individuals of Mexican descent. The program implements strategies at the individual, group and community levels. The goals of Viviendo Valiente are to: a) increase the number of individuals who test for HIV; b) increase the number that engage in HIV care; and c) increase the number that are retained in HIV care. In order to achieve these goals, Viviendo Valiente conducts activities with the priority community to increase their knowledge of HIV (individual, group and community levels), to increase their perception of risk of HIV (individual, group and community levels), and decrease the stigma associated with HIV (individual and group levels).

The following section includes a description of activities conducted during the implementation of each type of intervention.

Individual Level Strategy

Promotores provide culturally appropriate support services and guidance to engage HIV positive individuals in HIV medical care and treatment and help them to stay in care. Promotores provide assistance with linkage to HIV care and necessary referrals for support services that will promote retention such as transportation assistance, food, etc. They also encourage clients to utilize Viviendo Valiente's key strategies - *Inform yourself, Talk about it, and Take action* - in support of each behavior impacting their health care.

Group Level Strategy

A four session, health education program is provided to those who may be at risk for HIV infection as well as others. Each session is two-hours in length and promotes Viviendo Valiente's three key strategies - *Inform yourself, Talk about it, and Take action* - through educational presentations, group discussions, and activities. Topics covered in the sessions are: 1) Defining Health and Wellness; 2) HIV/STI Transmission and Risk Reduction; 3) HIV/STI Testing and Treatment as a Key Component of Healthcare; and 4) Engagement and Retention in Care. Participants are encouraged to attend all four sessions.

Community Level Strategy

Promotores participate in priority community-focused events to provide culturally appropriate education to reduce stigma associated with HIV/AIDS. The purpose is to promote HIV resources and services with the goal of serving as a direct link to individuals who are not connected to needed HIV services. All program messaging is built upon Viviendo Valiente's key strategies that the recipients are encouraged to adopt: *Inform yourself, Talk about it, and Take action*. These three strategies promote action regardless of the behavior (HIV awareness, HIV testing, engagement in HIV treatment, retention in HIV treatment) or the stage of change (pre-contemplation, contemplation, ready for action, action, maintenance) at which the person is at the time the message is received. Promotores share the program messaging and these three key strategies through community forums and conference presentations, promotion of HIV services through social, radio, print media, and scripted brief education sessions at medical clinics and health fairs.

Viviendo Valiente logic model

Problem Statement:	People of Mexican origin in Dallas, Texas are not getting tested for HIV and/or accessing HIV medical care.
Intervention Goal:	To link individuals who are HIV positive and who identify as being of Mexican origin to care expeditiously, by reducing barriers to services.
Intervention Objectives	1. Identify and provide individual support to people of Mexican origin that are living with HIV and are aware but never engaged in care, aware but refused referral to care, or dropped out of care for six months or longer during the 24 months prior to engagement with Viviendo Valiente (VV). 2. Ensure care access and treatment engagement for those who are HIV positive. 3. Remove barriers to HIV medical care.

	BARRIERS	ACTIVITIES	OUTPUTS*	INTERMEDIATE OUTCOMES*	LONG-TERM OUTCOMES
INDIVIDUAL LEVEL	Lack of HIV knowledge (acquisition, transmission, testing resources, health care options) Low perceived risk	**Encourage** individuals at high risk for HIV/STI infection to get tested using appropriate tangible reinforcements **Promote** testing among partners and social networks of HIV positive individuals, using appropriate tangible reinforcements **Provide** risk reduction counseling to individuals	**X** people will be referred for HIV testing **X** HIV positive people will engage in the ARTAS intervention, if appropriate **Promotores** will maintain contact with client based on	**X** people will test for HIV **X%** of participants will successfully complete ARTAS intervention **X%** of those who test HIV positive will be linked to HIV care	**Increase in # of people that** - test for HIV - engage in HIV care - are retained in HIV care

	HIV stigma	at high-risk for HIV **Assess** HIV positive individuals for acuity/need and ongoing engagement in medical care **Utilize** Anti-retroviral Treatment and Access to Services, motivational interviewing, strength based case management with HIV positive people who are not ready to engage in care	acuity/need level		
GROUP LEVEL	Lack of HIV knowledge (acquisition, transmission, etc.) Low perceived risk HIV stigma	**Provide** the four-session health education program	**X**, four-session interventions will be conducted	**X%** of participants will identify HIV testing resources **X%** of participants will identify HIV treatment resources **X%** of participants will correctly identify modes of HIV acquisition and transmission **X%** of	**Increase in # of people that** - test for HIV - engage in HIV care - are retained in HIV care

				participants will graduate	
COMMUNITY LEVEL	Lack of HIV knowledge (acquisition, transmission, etc.) Low perceived risk	**Provide** HIV/STI prevention messages through partnerships **Distribute** HIV/STI education materials **Disseminate** HIV/STI prevention messages through media **Disseminate** individual messages at community events	**X** partnerships will be developed **X** sites will distribute materials **X** outreach events will be held **X** presentations will be made at community events	**X** people reached **X** people engaged **X** people will be referred to HIV testing **X** HIV+ people will be linked to care	**Increase in # of people that** - test for HIV - engage in HIV care

*People implementing this program can insert their own numbers within the logic model as appropriate.

Core intervention staff / responsibilities

Program director	Directs the overall operations of the program. This position is responsible for the development, management, and cultivation of relationships with stakeholders to ensure continuous engagement and timely access of program staff at priority community events, activities, and health fairs. Reports to chief program officer.
Lead promotor de salud (1)	Manages assigned special programs, develops and maintains partnerships within the priority community, provides individual and group level guidance to engage people in healthcare especially in the context of HIV, and provides guidance to other promotores. Reports to program director.

Promotores de salud (2)	Develop and maintain partnerships within priority community. Provide individual and group level guidance to engage people in healthcare, especially in the context of HIV. Report to program director.

Intervention components: outreach, recruitment, and retention strategies – The Viviendo Valiente program is a multi-level intervention for individuals of Mexican descent. Intervention recipients are identified from outreach efforts in the community and through groups, HIV testing events, as well as internal and external referrals. This section provides a brief description of the activities that occur during the implementation of each level of the Viviendo Valiente intervention.

For
- HIV positive individuals

Individual level intervention

Purpose: To support engagement and retention efforts of HIV positive individuals that meet program eligibility criteria.

Responsible staff: Promotores with the support of the program director.

Process: Viviendo Valiente clients are identified from community linkage efforts, HIV testing events, as well as internal and external referrals. They include those who receive a ***new HIV diagnosis***, know their status but are ***not in HIV medical care***, or those who ***have fallen out of care for six or more months*** in the 24 months prior to program referral. In all situations, the following steps are taken:

- Program director assigns a promotor to meet with the referred individual for the purpose of conducting a welcome session (intake).
- Promotor meets with the referred individual to conduct the welcome session.
- Program director assigns the case to a promotor.
- Promotor connects with the client as soon as possible to conduct the ARTAS intervention in order to help:
  - Link the client to care; and
  - Confirm linkage (2 medical visits) prior to graduation from ARTAS
- Once linked to and confirmed in medical care, if client does not feel the need for

additional services from the promotor, promotor continues ARTAS intervention to:
- Assess any additional needs.
- Link client to additional resources such as case management, if necessary.
- Graduate client and close file.

- If client is willing to continue working with promotor, promotor continues ARTAS intervention to:
  - Work with client to remove barriers to retention in HIV medical care.
  - Assess client's acuity/needs, and review and update care plan upon client's graduation from ARTAS (i.e., once linkage to HIV medical care is confirmed), and as needed.
- Promotor, upon client's graduation from the ARTAS intervention:
  - Determines contact schedule based on acuity /need and the care plan established at ARTAS graduation:

	Acuity Assessment Categories		
	High Acuity (45+) ↓	Moderate Acuity (29-44) ↓	Low Acuity (14-28) ↓
Minimum standard contact frequency	Once per week	Once every month	Once every other month

  - Provides ongoing support to address retention in care, treatment adherence and other concerns using strength based counseling and Motivational Interviewing (MI) grounded in the transnational approach, Mexican cultural values, and the standards related to providing culturally and linguistically appropriate services (CLAS)**.**
  - Promotes ongoing engagement in Viviendo Valiente.
- Client disengagement:
  - If lost to care, promotor works to locate and re-engage the client in care through phone calls, text messages, a letter mailed to the client's address,

or a home visit.
- If client wants to discontinue participation in Viviendo Valiente, the promotor addresses concerns and connects client to other resources prior to inactivating client.

Tools: Strength based counseling techniques (ARTAS, MI), acuity measurement, Electronic Health Record, internal (agency) and external (community stakeholder) partners. The ARTAS framework used by Viviendo Valiente is described below:

- *Session 1: Building the relationship*
    - Introduce the goals of the Viviendo Valiente individual level intervention and ARTAS.
    - Discuss concerns about recent HIV diagnosis.
    - Begin to identify personal strengths, abilities, and skills, and assess others' roles in impeding or promoting access to services.
    - Encourage linkage to medical care.
    - Summarize the session, the client's strengths, and agreed-upon next steps.
    - Plan for the next sessions(s), with the medical care provider and/or promotor.
- *Session 2, 3, 4, and 5:*
    - Solicit client concerns and questions from the initial session.
    - Continue identifying personal strengths, abilities, and skills.
    - Encourage linkage to medical care.
    - Identify and address personal needs and barriers to linkage.
    - Summarize the session, the client's strengths, and agreed-upon next steps.
    - Plan for the next session(s) with the medical provider and/or promotor.

Duration: Each session can take 15 minutes to an hour depending on the purpose of the visit and client needs. The initial welcome visit (intake) can take up to 90 minutes.

Group level intervention

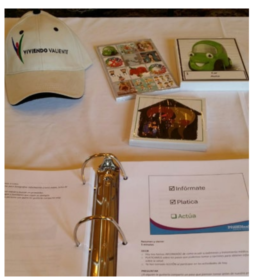
For
-HIV positive
-HIV negative
-HIV status unknown

Purpose: To broaden the awareness of the scope of health and wellness to include HIV prevention and treatment as a component of health and well-being of the Latino community.

Responsible staff: Promotores and program director.
Approved community volunteers who are trained in the provision of the intervention may co-facilitate.

Process: This intervention engages the priority community through small groups of eight to 12 people. This program is made up of four sessions that cover the following topics:

- Session 1: Defining Health & Wellness
- Session 2: HIV/ STI Transmission and Risk Reduction
- Session 3: HIV/ STI Testing & Treatment as a Key Component of Healthcare
- Session 4: Engagement and Retention in Care



Group level intervention curriculum materials

Host sites provide the meeting space and recruit participants who are encouraged to attend all four sessions. In order to ensure trust building due to the nature of the topics discussed, new participants are not allowed in an established group beyond the second session. The program is built on the same three key strategies echoed through the community and individual level interventions: *Inform yourself, talk about it, and take action*. Sessions include educational presentations, group discussions, as well as individual and group level activities to help participants address each strategy.

Tools: The Viviendo Valiente group level intervention curriculum presented as four, two-hour sessions. Consecutive sessions build upon the knowledge provided in the previous session, though each session can stand alone.

For
-HIV positive
-HIV negative
-HIV status unknown

Community level intervention

Purpose: To help recipients of the messages become informed about HIV, test for HIV, and/or link to HIV treatment. This level of intervention intends to engage the priority community through ***Brief Community Education Sessions*** and dissemination of program messaging through ***social media, print media*** and ***radio campaigns***. All engagement efforts are linked by the ***Viviendo Valiente three-point messaging strategy***.

Viviendo Valiente three-point messaging strategy

- **Responsible staff:** Promotores.
- **Process:** The three-point strategy - ***Inform yourself, Talk about it, and Take action*** - can be used regardless of the HIV related goals (e.g., increasing HIV knowledge, getting tested for HIV and/or getting HIV treatment, or individuals' readiness to change HIV risk behavior). A five minute Brief Community Education Session is *tailored* for the Mexican community, presents non-threatening and health oriented messages for the health and well-being of the community, and places a special focus on reducing HIV related stigma in the priority community.
- **Tools:** Messaging provided during individual, group and community level encounters.
- **Duration:** Each message encounter can vary between five minutes (Brief Community Education Session) and/or a two-hour long (group level intervention session).

Brief Community Education Sessions

- **Responsible staff:** Promotores.
- **Process:** The presentation focuses on six topics - 1) Introduction (45 seconds). 2)

How HIV ***is*** transmitted (45 seconds). 3) How HIV is ***not*** transmitted (60 seconds). 4) How to reduce the risk of acquiring HIV (60 seconds). 5) Wrap up, answer questions (60 seconds). 6) Free condom distribution and HIV testing resources (30 seconds).

- **Tools:** Viviendo Valiente's *Brief Community Education Session* script.
- **Duration:** Each session is five minutes long.

Dissemination of program messaging through social and print media, and radio campaigns

- **Responsible staff:** Program director.
- **Process:** The three-point strategy - ***Inform yourself, Talk about it, and Take action*** - is promoted to create awareness of the program, HIV, and HIV resources. Messages include information about how to communicate with the program about HIV and HIV testing.
- **Tools:** Viviendo Valiente developed print and social media messages, and radio campaigns.
- **Duration:** Ongoing.

Description of community partners and roles

Relevant Prism Health North Texas program staff	Provide outpatient HIV medical care and behavioral health services at two clinics: *Oak Cliff Clinic* and *South Dallas Clinic*, onsite and mobile case management and outreach, testing, and other services.
Viviendo Valiente advisory board	Represents the priority population's perspective and informs the design of the program, informs the planning of events, gives ongoing feedback, and provides leadership to help fulfill program objectives.
Viviendo Valiente volunteer health workers	Support the promotores' community and group-level efforts. Volunteer(s) a) must complete assigned trainings related to HIV; b) promote agreed upon health messages; c) help maintain partnerships within the Mexican community; and d) assist with the delivery of programs and events. They must be Mexican born or of Mexican descent, 18 years or older, bilingual in English and Spanish; knowledgeable regarding the local priority community, connected to extensive networks within the local priority community, and able to commit to the volunteer position for a minimum of 18 months.
Stakeholders (community partners)	Stakeholders provide access to priority population networks for dissemination efforts. This strategy allows promotores to leverage the trust that already exists between the partners and the populations they serve which in turn saves promotores valuable time that would otherwise be spent on trust building and recruitment efforts. The program director in collaboration with the promotores presents the program to strategically selected stakeholders. The chief program officer offers critical support in opening doors to key community stakeholders.

Staffing requirements and cost estimates – Intervention staff should be Spanish-speaking Latinos, preferably of Mexican descent. Staff selection should also be based on personal qualities essential to being able to relate empathically to and work collaboratively with the priority population.

Each promotor receives a standardized, minimum level of training to ensure that s/he is able to perform requisite job functions related to each intervention and must demonstrate competence. The required trainings that each Viviendo Valiente promotor receives are detailed below:

- **HIV 101 education.** [Sources: Online courses, literature review, and presentations]
- **Anti-Retroviral Treatment and Access to Services (ARTAS) Training.** [Source: https://effectiveinterventions.cdc.gov]
- **Community Health Workers/Promotor de Salud Certification Course.** [Source: Texas certification provided by the Texas Department of State Health Services]
- **Confidentiality, HIPAA Privacy and Security.** [Source: Prism Health North Texas training]
- **HIV Case Management 101.** [Source: Texas train https://tx.train.org]
- **Motivational Interviewing.** [Sources: Mountain Plains AIDS Education and Training Center (AETC) and the South-Southwest Addiction Technology Transfer Center (ATTC) in collaboration with the Northeast and Caribbean ATTC]
- **Understanding Transnationalism.** [Source: SPNS Evaluation and Technical Assistance Center and literature review]
- **Use of Viviendo Valiente Transnationalism and Cultural Assessment Tool.** [Source: Prism Health North Texas]

Cost estimates are provided in the Intervention Outcomes section.

Program Planning and Development

Start-up steps

The ***core elements*** described below have been essential to the successful implementation of Viviendo Valiente. These components are central to the intervention and must not be altered or left out.

- ☑ *Engage local stakeholders* – Program staff must establish relationships with stakeholders - groups that serve or represent the priority community beginning at the formative stage. Stakeholders should participate in the community assessment by providing feedback through surveys. During program implementation, stakeholders will be valuable as client referral sources and providers of resources and services for clients.
- ☑ *Conduct a local community assessment* – The development and cultural tailoring of the intervention needs to be informed by a multi-tiered needs assessment of the priority community as the first step in designing the intervention. The community assessment should include a review of available literature and local statistics, stakeholder surveys, and focus groups with the priority community.
- ☑ *Follow National Culturally and Linguistically Appropriate Services (CLAS) Standards* - CLAS standards are key to informing the cultural tailoring and messaging of the program.
- ☑ *Deploy full-time promotores* – Promotores must have significant knowledge of the culture and language of the priority community.

- ☑ *Use the* Anti-Retroviral Therapy and Access to Services (ARTAS) *intervention to link persons with HIV to HIV care* – Viviendo Valiente promotores use the ARTAS intervention as part of individual level efforts to link clients to HIV medical care.
- ☑ *Develop HIV/STI messaging and education relevant to the priority community's engagement and retention in HIV medical care* – Viviendo Valiente developed messaging and education for HIV positive clients including basic information related to HIV, HIV resources, and HIV medical care.
- ☑ *Develop a transnational and cultural assessment tool to address sociocultural and structural barriers to engagement and retention in HIV care by considering transnational factors and cultural needs. The tool is* described in greater detail in *the* section entitled *Program Description – The Intervention.*
- ☑ *Provide promotores with a standard level of training and education* – Trainings specific to strength based counseling approaches such as ARTAS and motivational interviewing are essential to the Viviendo Valiente intervention. Please refer to the *Staffing Requirements* section for a detailed list.

Implementation and maintenance

Description and explanation of modifications made to original plan

- Whereas initially the program was designed to place promotores in a highly-focused, time limited role, promotores continued to serve clients for a longer period of time prior to providing a warm hand off to standard of care. Promotores took a more active and extended role by providing both case management services and ongoing support of clients' efforts to ensure retention in HIV medical care and treatment.

Barriers towards implementation

- <u>Enrollment limitations</u> - Enrollment into the Viviendo Valiente individual level intervention is limited to persons of Mexican origin, 18 years and older, living with HIV that are newly diagnosed, know their status but are not in HIV medical care, or those who have fallen out of care for six months or longer in the 24 months prior to referral to the individual level intervention. These limitations prevented the Viviendo Valiente program from serving ***all*** Latinos needing HIV care and assistance with addressing barriers. Clients, who were not eligible, however received standard of care case management and medical care at PHNTX.

Facilitators towards implementation

- <u>Development of partnerships</u> – Viviendo Valiente leverages partnerships with various service organizations – both within and outside of the HIV service arena – to gain access to the priority community.
- <u>Development of referral sources</u> – Viviendo Valiente receives referrals for the individual level intervention from both internal and external sources, with 35 percent of referrals coming from the Dallas County Health and Human Services Early Intervention Clinic. As a result of Viviendo Valiente's partnership development efforts with the Los Barrios Unidos Federally Qualified Health Center (FQHC), the FQHC elected to change its HIV medical service referral of choice from the Dallas County Hospital System to Prism Health North Texas affiliated clinics and to Viviendo Valiente to assist with care coordination and HIV education.

- Integration of cultural elements – Viviendo Valiente integrated cultural elements into the social marketing and recruitment processes, as well as the engagement of the priority community. The marketing processes were very successful in terms of increasing awareness of HIV, as well as about available resources for HIV prevention and treatment.

Ongoing training, staff development and retention strategies – Please refer to *Staff Requirements* for a listing of the standard, minimum level of training provided to each Viviendo Valiente promotor.

Description of how turnover was handled –Viviendo Valiente promotores received a standard, minimum level of training and were cross-trained to provide the same services. If a promotor left the program, client care was provided by remaining staff and the program director and other assignments were similarly addressed.

Cost of Intervention

Approximate cost of the intervention annually (not to include evaluation costs)

Staff Salaries					**$175,000**
Fringe Benefits					**$44,470**
Stipends, community volunteer	--	--	$160	$320	**$240**
Incentives, tangible reinforcements				$340	**$8,885**
Equipment / Supplies	$26,650	$4,280	$3,740	$2,450	**$9,280**
Rent				$16,100	**$19,920**
Other*	$12,300	$63,450	$5,970	$3,000	**$21,180**
				TOTAL AVERAGE (Yr1-4)	**$278,975**

* *Other* - Includes cost of trainings, translation services for intervention materials, media fees, student response system used for the group level intervention, conference registrations and event participation, printing, postage, communication, equipment, event fees, networking.

Lessons Learned

Formation of strategic partnerships – The successful engagement of trusted, local stakeholders takes time. Stakeholders act as important gate-keepers and can open doors for bi-directional referrals to promote linkage to and retention in care. It is important to strategically select trusted, priority community-serving stakeholders and establish mutually beneficial relationships. Ongoing efforts to nurture and sustain these relationships are essential to developing true collaboration in order to ensure that the community is able to benefit.

However, getting even trusted partners to actively engage in referring clients may take time and patience. Even though Viviendo Valiente provided key stakeholders with updates on the individual level intervention and services available for the community served by the stakeholders, it took several reminder phone calls, emails and face-to-face meetings for them to actively engage in the process.

Personalization of partnerships – It is important to research potential stakeholders' missions and community efforts prior to asking to meet with them to introduce services provided by the program. Demonstrating how the intervention can help meet the stakeholders' goals and needs is necessary to honor their work while making the case for collaborative engagement.

Importance of a community advisory board in considering barriers for direct linkage to program – Feedback from internal and external community advisory board members provides valuable insight regarding barriers to care and services faced by the priority population, as well as potential solutions. For example, Spanish-speaking Viviendo Valiente community advisory board members proposed that a designated program phone line would reduce callers' anxiety when they were attempting to follow up on a referral to the program or get in touch. This is especially true if the caller does not speak English, the language in which a call to the agency's main line is initially answered.

Designated phone line for Viviendo Valiente – A designated phone line answered by Viviendo Valiente program staff helped to better connect with monolingual, Spanish speaking individuals who called to connect with program services. Prior to the change, callers connecting through the main agency phone line often would not engage in a conversation because the line was answered in English with the name of the agency rather than "Viviendo Valiente". Program staff received several reports that individuals became confused when they called because they believed they had been given an incorrect phone number and hung up as a result. This led to lost opportunities to connect with potential clients.

Responsiveness and flexibility – Listening to and addressing concerns shared by members of the priority community and being flexible with regard to program implementation has been key to promoting successful outcomes.

References

Añez, L. M., Silva, M. A., Paris, M. & Bedregal, L. E. (2008). Engaging Latinos through the integration of cultural values and motivational interviewing principles. *Professional Psychology: Research and Practice*, 39(2), 153-159.

Center for Substance Abuse Treatment (CSAT) (1999). *Enhancing motivation for change in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99-3354. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (CSAT) (2008). *Enhancing Motivation for Change Inservice Training*. DHHS Publication No. (SMA) 08-4190. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Faist, T. (2000). Transnationalization in international migration: Implications for the study of citizenship and culture. *Ethnic and Racial Studies*, 23(2), 189-222.

Glanz, K., Rimer, B. & Viswanath, K. (2008). *Health behavior and health education: Theory, research, and practice*. New York: John Wiley Sons.

Glick Schiller, N., Basch, L., and Blanc-Szanton, C. (1992). "Transnationalism: A New Analytic Framework for Understanding Migration." Annals New York Academy of Sciences 645: 1-24

Miller, W.R. & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press.

Miller, W. & Rose, G. (2009). Toward a theory of Motivational Interviewing. *American Psychologist*, 64(6), 527-537.

Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivations for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors*, 10(2), 81.

Naar-King, S., Outlaw, A., Green-Jones, M., et al. (2009). Motivational interviewing by peer outreach workers: A pilot randomized clinical trial to retain adolescents and young adults in HIV Care. *AIDS Care,* 21(7), 868-873.

Naar-King, S., Wright, K., Parsons, J., et al. (2006). Transtheoretical model and substance use in HIV-positive youth. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, 18(7), 839-845.

Prochaska, J.O., DiClemente, C.C. & Norcross, J. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist*, 47:1102-1114.

Ryan White Planning Council of the Dallas Area [Ryan White]. (May 2012). 2012 Comprehensive HIV Health Services Plan. Retrieved from http://www.dallascounty.org/department/rwpc/documents/2012_Comp_HIV_Plan.pdf

U.S. Census Bureau. (2010). HISPANIC OR LATINO ORIGIN BY SPECIFIC ORIGIN: *2010 American Community Survey 1-Year Estimates*. https://factfinder.census.gov

University of North Carolina, Chapel Hill

Project Name: Enlaces por la Salud

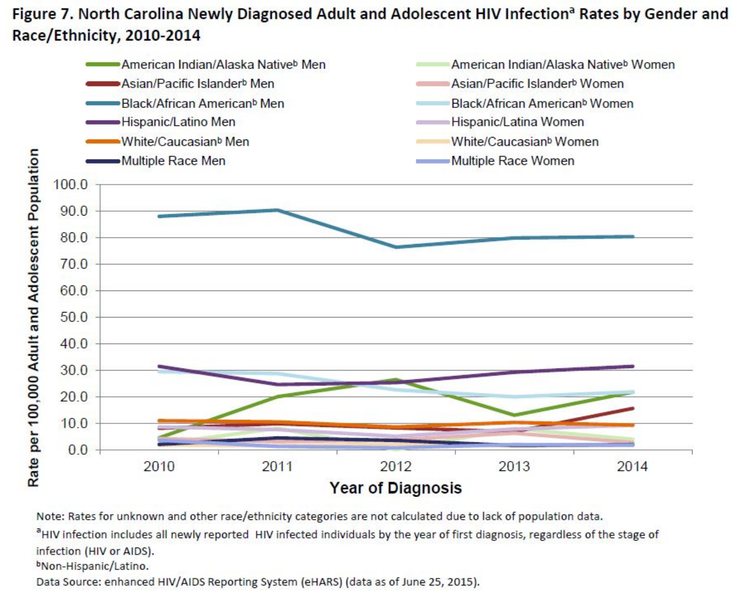
Location: Charlotte and Chapel Hill, North Carolina

Authors: Clare Barrington, PhD; Joaquín Carcaño - Corresponding author: Joaquin_Carcano@med.unc.edu; Lisa Hightow-Weidman, MD, MPH

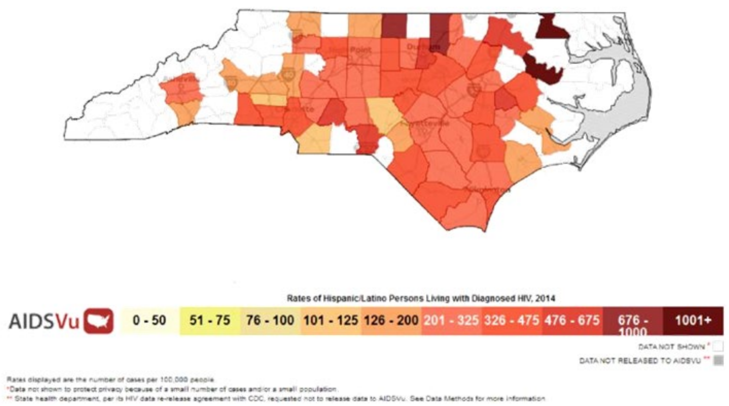
Finding, Linking, and Retaining Mexican Men & Transgender Women in HIV Care

Enlaces staff implementing intervention in Charlotte, North Carolina

Local Epidemiology



North Carolina Newly Diagnosed Adult and Adolescent HIV Infection Rates by Gender and Race/Ethnicity, 2010-2014



North Carolina Rates of Hispanic/Latino Persons Living with Diagnosed HIV, 2014

Latinos are disproportionately affected by HIV/ AIDS in the Southeastern United States (US), where they are the fastest growing segment of the population. With a Latino population increase of 394%, North Carolina (NC) had the largest Latino population growth among all US states from 1990 to 2000.[1] In 2014, NC had the fifth highest proportion of foreign- born Latinos in the nation.2 The majority of Latinos in NC are male and from Mexico. [2,3]

Simultaneously, the number of HIV/ AIDS cases among Latinos also increased dramatically. Latinos accounted for only 1% of newly reported HIV cases in NC in 1995, which increased to 10. 5% by 2016, with a rate of new diagnosis nearly three times higher than non-Latino whites. [3,4] In NC in 2011, prior to the implementation of our intervention, only 17% of Latinos who were estimated to be infected were engaged in care and virally suppressed (NC State AIDS/ STD Director, personal communication) .

Additionally, in 2013 Latinos in NC represented the largest proportion (38. 5%) of late testing cases, defined as receiving an AIDS diagnosis within 6 months of testing positive.[5] The Latino population in particular may test late due to language barriers and limited access to testing and healthcare. In 2013, the highest proportion of unmet need (no evidence of being in care in the last 12 months) was also among Latinos (40. 9%) compared with 24. 3% of non-Latino whites and 25. 8% of black individuals.[5]

Among Transgender Latinas in the US, HIV prevalence has ranged from 14 to 50%.[6-10] The 2011 National Transgender Discrimination Survey showed much higher rates of HIV at 10.9% for transgender Latinos, as compared to 0.08% for all Latinos and 0.6% for the general US population[11]. In NC, data from 2013 indicates that only 0.04% of the testing population was documented to be a transgender person. [5]

Latino men who have sex with men (MSM) and Transgender women (TW) have been particularly affected by the epidemic and yet even less has been done to ensure they are being tested and linked to care. Fifty- eight percent of the new HIV cases among Latino men in NC in 2008 were attributed to male- to-male sex.[12] Traditional HIV testing strategies may not effectively reach Latino MSM/ TW, who may be mobile, socially isolated, and reluctant to use health services.[13] In addition, HIV+ Latino MSM and TW are heavily stigmatized by virtue of their sexual orientation, gender identity, ethnic minority status, and their HIV infection, and are in dire need of culturally appropriate interventions.

The vulnerability of sexual minority Mexican migrants and their sex partners to HIV infection in NC is shaped by a combination of structural and social factors including immigration and labor policies, multiple, overlapping forms of stigma and discrimination, social and geographic isolation, norms around sexual behavior in both their country of origin and in the receiving community, and lack of access to health services.[14-18]

Theoretical Framework

One approach to reaching sexual minority Mexicans to promote HIV linkage and retention in care reflected Parker and Aggleton' s concept of HIV-related stigma as a product of multiple, overlapping forms of stigma related to sexuality, gender, class, and race/ ethnicity.[19] This approach to understanding HIV stigma reflects the intersectionality framework, which is increasingly being used to operationalize the lived experiences of socially marginalized populations that experience20-22 disproportionate burdens of HIV.[20-22] We drew on these approaches to understanding stigma and vulnerability to inform our use of a holistic and integrated response to HIV that recognizes that multiple facets of each individuals' identity.

Building on theory related to stigma and intersectionality, another converging theoretical perspective which guided our intervention was Zimmerman, Kiss, and Hossain' s Migratory Process Framework (MPF) which theorizes about the relationship23 between migration and health.[23] This rights-based, policy- oriented approach considers migration to be cyclical and multi- staged, dividing the process into five phases: 1) Pre- departure, which includes the social, behavioral, and environmental factors affecting migrants before they leave their place of origin; 2) Travel, which addresses the experiences of migrants in transit between their place of origin and intended destination; 3) Destination, with a focus on the conditions of temporary or long- term settlement in a new location; 4) Interception, when applicable, refers to what happens during time spent in detention by immigration authorities; and 5) Return, which focuses on issues faced when migrants go back to their place of origin temporarily or permanently.

The MPF also recognizes the transnational experience of migrants across all stages of the framework. Each of these phases involves distinct health- related risk exposures with cumulative effects over the course of migration, and each also presents distinct opportunities for intervention. For our program, we continued to draw on the MPF as we considered how stages of migration and migration experiences may influence HIV testing behaviors and engagement with care.

The overarching framework which guided the structure and approach of our intervention was transnationalism. Transnationalism considers the experiences and social ties within both country of origin and country of settlement and the ways they are tied in the24 context of an immigrant' s life.[24] Transnationalism is put into practice via modes of communication, social and economic exchanges, travel, and politics which span country borders and allow individuals to be connected, participatory, and influenced by two or more 25 communities simultaneously.[25] The two core communities of an immigrant' s transnational life, in the country of origin and the country of settlement, can provide additional emotional and social support versus one community alone, but can also serve as compounded sources of discrimination and social stigma. The transnational framework provided a foundation from which our PHN could explore the impact of cross- cultural influences upon health and well- being and provide resources and support accordingly.

The Organizational Context

The Enlaces por la Salud research team is based out of UNC-Chapel Hill' s Institute for Global Health & Infectious Diseases (IGHID). Personal Health Navigators (PHNs) and outreach staff are located at two community partners: El Centro Hispano Inc., and the Regional AIDS Interfaith Network (RAIN).

El Centro Hispano is currently the largest grassroots Latino organization in NC. RAIN is one of the largest HIV nonprofit organizations and case management agencies in the Charlotte metro area. PHNS located at both use these sites as their home base and use private office spaces to conduct one- one- one sessions with clients or connect them to other social support services sometimes co-located at the organization.

The geography of North Carolina and the large catchment area of our two community partners create unique needs for transportation and healthcare accessibility. Clients seek HIV care at 11 different clinics, ranging from university clinics to private practices and community health centers, generally located within the Raleigh- Durham-Chapel Hill and Charlotte metro areas. Clients reside in a mix of urban, suburban, and rural areas of the state. Consequently, many clients drive upwards of 2 hours to receive care and staff often travel large distances to meet with clients in their local communities.

Our Goals and Approach

The overall goal of the Enlaces por la Salud program was to increase the number of Mexican men and Transgender women (TW) living with HIV in North Carolina (NC) who are engaged in consistent care.

To achieve this goal, the centerpiece of the intervention involved PHNs who worked intensively one- on- one with clients to deliver an innovative and culturally specific 6-session program promoting linkage and engagement in care and health self- management.

Staff at an Outreach Event in Durham, NC

Operationalization of the Transnational Framework

The client's migration story was the foundation of the PHN-client relationship and informed session structure throughout the intervention. Important questions included:

How are clients still connected to their home country? How does their migration story continue to affect their current life situation? What has been their experience in the US/North Carolina?

Each Session has a Transnational Goal

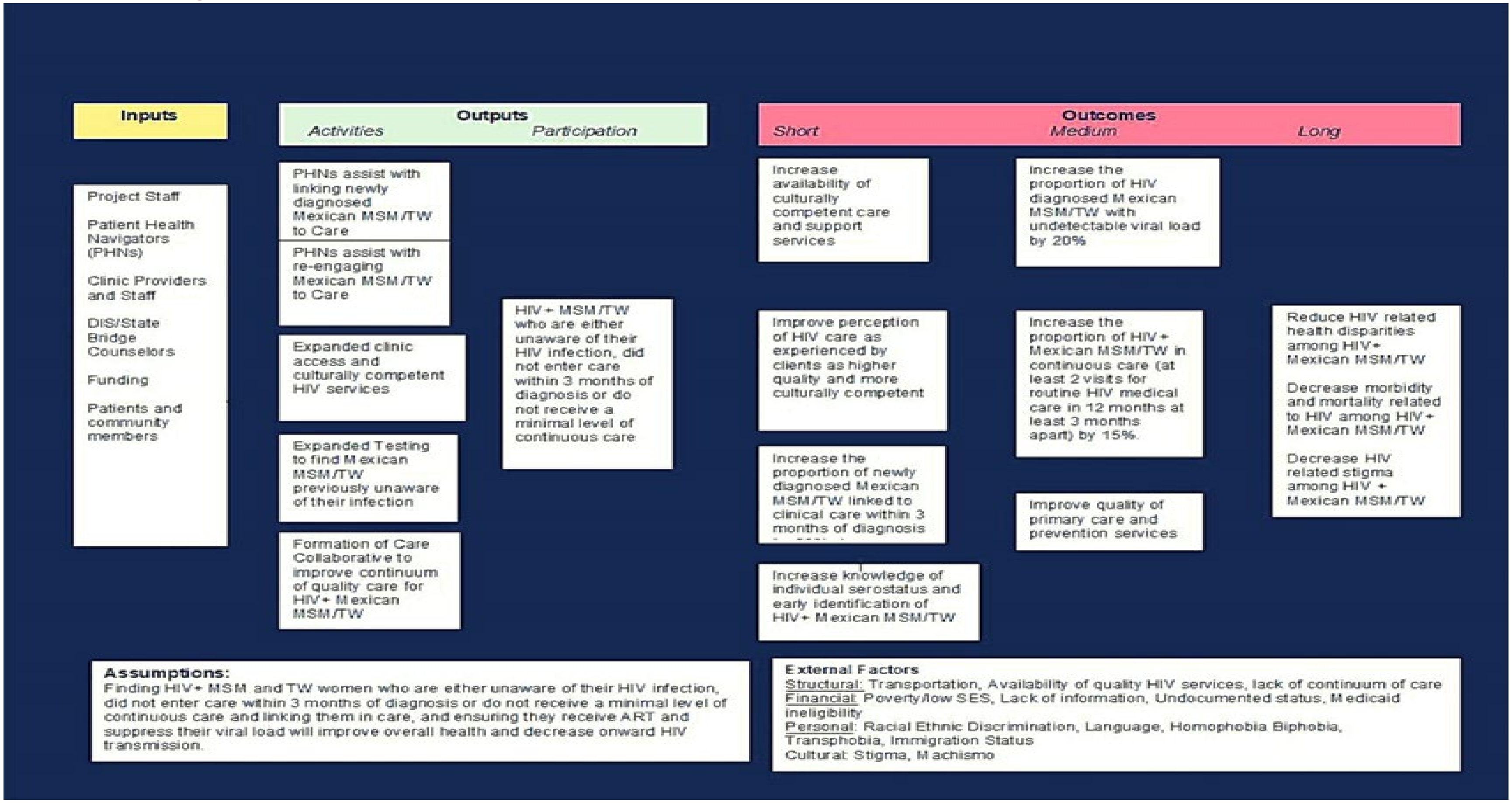
This aided in keeping the structure of the sessions focused on the migratory and cultural influences of the client's life upon their HIV healthcare management

Six intervention sessions with corresponding transnational goals and content outline

Intervention Components

The intervention enrolled individuals newly diagnosed within the last 6 months, those out-of-care for greater than 6 months, or those with inconsistent engagement in care, with eligibility criterion parameters including frequent cancellations and rescheduling, primary use of walk-in hours, and extended gaps between visits. Outreach and recruitment involved collaborative efforts between outreach staff, PHNs, and the Project Coordinator and was a primary focus during the first two years of the study. As a team, we were able to leverage the long standing history and local trust of our community partners to establish referral relationships with area clinics, providers, state HIV personnel, and social service agencies. This process involved visibility campaigns, radio shows, attending regional conferences, presentations to providers, and numerous meetings with area staff to inform them of our services and outline mutually beneficial strategies of referrals and care engagement. Buy-in from HIV providers and state HIV staff was key and allowed direct communication between providers and PHNs which further reinforced client engagement in care.

Intervention Logic Model



Intervention Logic Model displaying inputs, outputs, outcomes, assumptions, and external factors

Linkage and Referrals

North Carolina's Department of Public Health employs Disease Intervention Specialists (DIS) who are tasked with informing individuals of a positive HIV diagnosis and partner notifications, providing initial linkage to care, and pursuing sexual network tracing. The primary role of the DIS is to assure early linkage to care for all newly diagnosed individuals. Supplementing this work, the state also employs State Bridge Counselors (SBCs) who receive out-of-care patient lists from area clinics, locates individuals, and addresses barriers to care to facilitate re-engagement. Informational sessions about the Enlaces intervention were held with DIS and SBC staff assigned to the regions encompassing our two project sites. Once interacting with individuals, determining program eligibility, and receiving consent to share contact information, DIS and SBCs could directly refer individuals to PHNs. Relationships with DIS and SBCs continued throughout the course of the intervention and resulted in a large portion of client enrollments.

Retention

Following enrollment, the PHN provided intensive and ongoing support, including connecting clients to social-support services, and facilitated the 6-session Enlaces intervention to help clients stay engaged in care and treatment to ultimately reach a place of health self-management. Valuable retention strategies included frequent contact with clients through phone calls and text messages and flexibility in regards to scheduling sessions during weekends and evening hours.

Out-of-Care Lists

Following enrollment, the PHN provided intensive and ongoing support, including connecting clients to social-support services, and facilitated the 6-session Enlaces intervention to help clients stay engaged in care and treatment to ultimately reach a place of health self-management. Valuable retention strategies included frequent contact with clients through phone calls and text messages and flexibility in regards to scheduling sessions during weekends and evening hours.

Medical Appointments

The Medical Care Coordination component of routine medical case management (MCM) incorporates support for clients related to preparing for, remembering, attending, and following up on medical appointments. The PHNs provided an enhanced level of service devoted to these activities.

Clients who are newly diagnosed, new to care, and/or re-engaging in care often need particularly intensive support related to their first medical appointment. This support begins with scheduling the appointment. Once the first medical appointment was scheduled, the PHNs worked with clients before the appointment took place to discuss what to expect, identify and help manage potential barriers (e.g., transportation), answer questions, help complete essential paperwork, and offer to accompany clients to their appointments.

PHNs provided emotional support, build rapport, and established relationships. The frequency and number of encounters where these services took place were tailored depending on client needs. Staff often contacted clients once a week before their first appointment, one week before their appointment, the day before their appointment, etc. Some clients benefited from a call or text the morning of the first medical appointment. Others found it helpful for the PHN to meet with them in the hospital or health center lobby to help find the doctor’s office.

PHNs were expected to offer accompaniment to clients to their first medical appointments. Depending on client requests, the PHN accompanied a client throughout the appointment or waited in the lobby or waiting room during the appointment. After the appointment, the PHN worked with clients to debrief about their experiences, review and clarify basic information provided (e.g., regarding HIV disease, HIV medications , HIV lab results, medical instructions , side effect management, resistance and resistance testing, drug and food interactions, etc.), and ask if there were any questions about the visit. For situations in which the PHN accompanied clients to the appointment, the follow-up often took place immediately following the visit. For situations where the PHN did not accompany the client, the PHNs contact the client later that day or the next day to check in and follow up.

The PHN continued offering clients these types of services before, during, and after additional medical appointments for up to 12 months. PHNs also often helped clients coordinate appointments with specialty and primary care providers. Providing reminders about upcoming appointments was an essential activity. PHNs often called or texted clients at one week, one day, and/or the morning of appointments, with the frequency and timing determined based on client needs.

Monitoring appointment attendance and following up with clients after missed appointments was a critical element of PHN service provision. In addition, the PHN monitored the attendance of clients to non-medical project-related appointments. Missed appointments were a warning sign that a client was at a heightened risk for falling out of care and potentially needed additional support. PHNs contacted clients after a missed appointment to check in, offer help rescheduling another appointment; and offered assistance managing barriers to attend the appointment.

Case Management

Enlaces por la Salud services were intended to be an enhancement to routine Medical Case Management (MCM) in that they have an expanded scope and level of intensity. In order to centralize and streamline service provision, clients accessed as many MCM services as possible from the PHN. Therefore, it was expected that the PHN adhere to the same requirements as MCM interdisciplinary teams in terms of service components that they are able to provide or coordinate. These components include Medical Care Coordination, Social Services Coordination, Substance Use Risk Reduction, Sexual Health Promotion. Education and discussion of these topics with appropriate follow-up and linkage to services took place primarily during PHN led intervention sessions.

Medication Adherence

The PHN provided an enhanced level of individual one-on-one adherence support with project clients. This involved working with client provider’s to gain clarification regarding medication regimes and developing tips and practices to encourage medication adherence. For example, a client who was illiterate and needed to take one pill in the morning and one pill in the evening worked with the PHN and provider to match their pills and pill boxes according to sun and moon symbols for an easier-to-follow regime. PHNs also discussed potential or actual adherence challenges with the client and worked with the client to consider options, develop practical plans, and engage in skill-building activities to address these concerns. The PHNs maintain updated information on adherence methods including different types of medication reminders, scheduling strategies, and ways of maintaining privacy and confidentiality.

Core Intervention Staff

UNC-Chapel Hill

Lisa Hightow-Weidman, MD, MPH; Principal Investigator

Clare Barrington, PhD; Co-Principal Investigator

Lynne Sampson, PhD; Quantitative Evaluator

Joaquín Carcaño, Project Coordinator

Community Partners:
RAIN

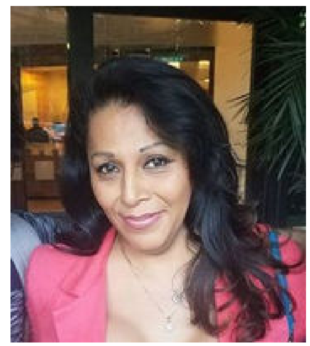
Chelsea White, RAIN Supervisor

Aleida Espinal, RAIN PHN

Roberto Olmo, RAIN Outreach

El Centro Hispano

Maritza Chirinos, ECH PHN



Cristina Morales, ECH Outreach

Staffing Requirements

Personal Health Navigators were responsible for addressing individual and structural barriers to engaging in HIV care by providing culturally relevant Spanish-language health care navigation for HIV+ Mexican men and Transgender women (TW). The PHN was trained in project specific strengths based counseling program in order to deliver a novel 6-session intervention to each client. The intervention was designed to increase a client's knowledge, comfort, and practice with HIV care and support services. The PHN worked closely with their regions' Disease Intervention Specialists (DIS) and State Bridge Counselors (SBC), as well as local HIV providers and support service agencies to assist newly diagnosed/identified or out of care HIV+ Mexican men/TW enter and remain in care, working with these patients from 6-12 months.

Responsibilities

- Building a trusting and effective relationship with the client
- Identifying a client's strengths, needs, and barriers to accessing HIV medical care
- Providing appropriate intervention dependent upon client's needs
- Facilitating the 6-session Enlaces por la Salud intervention 1-on-1 with clients
- Empowering clients through identification of their strengths
- Providing referrals and aiding in consistent engagement of HIV care
- Aiding the client in building positive communication with their medical provider
- Developing individualized care plans for clients which will include training a client to use medication adherence tools
- Providing referrals for social support services such as mental health counseling, substance abuse counseling, housing assistance, legal aid, etc.
- Accompanying clients to medical and other service appointments
- Following-up with clients after a medical care visit

Qualifications

- Spanish/English proficiency
- High school diploma/GED with 2 years HIV or case management working experience. Some college education with 1 year of working experience can substitute.
- Experience working with diverse and target population
- Strong knowledge base of HIV/AIDS
- Ability to communicate well with medical providers and support staff
- Ability to handle multiple tasks
- Ability to work well within the organizational structure

Community Partners

Our two community partners were located in areas of the highest Latino population in the state, the Raleigh-Durham-Chapel Hill and Charlotte metropolitan areas. El Centro Hispano, Inc. (ECH) located in Durham, NC is currently the largest grassroots Latino organization in the state and is dedicated to strengthening the Latino community and improving the quality of life of Latino residents in the Triangle region, and surrounding areas. ECH accomplishes its mission through education, service and community organizing. In June 2012, ECH celebrated 20 years of strengthening the Latino community in NC.

El Centro Hispano

As a member of the Raleigh-Durham-Chapel Hill regional HIV network of care, ECH is the principal agency providing culturally sensitive evidence-based intervention services for the local Latino community.

ECH’s HIV/STD programming includes 4 support groups for the LGBTQ Latino community, with the oldest group now in its 16th year of existence. In January 2013, ECH established the first Latina transgender support group in the state called Entre Nosotras (Between Us). These groups provide a safe space for LGBTQ Spanish-speaking Latinos to meet and receive culturally competent education and support. For the intervention, these groups functioned as both a referral source and as an ongoing community resource.

During the course of the intervention ECH formed an LGBTQ community advisory board, Nuestra Voz, focused on LGBTQ health and well-being and organizing community events such as Pulse Orlando memorials, pride marches, and ECH’s annual Miss Gay Hispanidad drag queen pageant. This contest serves to increase awareness about HIV/STDs, promote visibility and acceptance of the LGBTQ Latino community, and raise funds for the organization's LGBTQ support groups.

RAIN

RAIN, founded in 1922, is located in Charlotte, NC and is one of the largest HIV nonprofit organizations in the Charlotte metro area. RAIN services include medical case management, PrEP navigation, outreach to impacted communities, faith-based training, counseling services, support groups for youth and adults, and volunteers who provide practical support to persons living with HIV/AIDS. RAIN also provides HIV awareness and prevention education programs through community events such as drag bingo, an annual AIDS walk,, art projects, and World AIDS Day programs.

Prior to the implementation of the Enlaces intervention at RAIN, the agency did not have a program dedicated to the Latino community and had no bilingual case management staff. With the addition of the Enlaces services, the agency has recognized the need to serve all affected by HIV in the Latino community, including partners and families. Enlaces staff have helped partners access PrEP services and provided partner and family disclosure, education, and counseling when requested.

Through collaborative efforts between ECH and RAIN and due to ECH's experience in LGBTQ support groups, staff from ECH have been involved in aiding RAIN develop their own LGBTQ support group programming as Charlotte does not have an established LGBTQ center.

Program Development

PHNs and outreach staff members from RAIN and ECH underwent multiple Enlaces specific trainings, which included skills based case management for the intervention. The trainings were kicked off by a webinar by The Latino Commission on AIDS. This training was used to provide project background, relevant research, and an introduction to the cultural context of HIV as well as the HIV healthcare system in North Carolina to further orient the staff to the current health environment. This was followed by a 2 day in-person training again facilitated by The Latino Commission on AIDS. This training focused on the structure of strengths-based case management, how to interact with clients and people of diverse backgrounds, and reviewing paperwork and the process involved in connecting a client to social services. Other highlights included demonstrations and role-plays of the role and responsibilities of the PHN, recognizing the principles of a client centered and client driven approach, goal setting, and establishing effective community collaborations and relationships for seamless linkage and referrals to care.

Staff Support

For the majority of the intervention period, weekly case conference calls were held with the Enlaces core team. This time allowed PHNs to share specific cases, insights, and difficulties and gave an opportunity for the team to strategize and discuss how to address client recruitment and retention issues.

Core staff members were employed for the entirety of the intervention. During Year 1, the RAIN supervisor left her position and Year 2 saw turnover for both outreach positions at El Centro at different points. In these cases, responsibilities were quickly transferred to other organizational staff with prior knowledge of the program and established relationships with the Enlaces team.

Modifications

While the focus of the intervention was initially on Mexican MSM and TW, we recognized that some Mexican men may not identify as MSM or only do so after a period of trust has been established. To ensure we were not excluding clients based on a low level of MSM self-identification, our intervention was broadened to target the wider Mexican male population during implementation in order to achieve maximal uptake.

Barriers to Implementation

An implementation barrier faced involved initial difficulty in building referral networks which included gaining buy-in from providers and clinics and establishing our program's presence and reputation. We encountered staff turnover at area clinics, reluctance to collaborate on a new program which could possibly entail a higher workload, and concern of overlapping geographic areas and the potential impact on clinic/agency funding. Staff had to invest considerable time dedicated to initial and continuous refresher presentations, and consistent communication with referral sources, agencies, and clinics,.

Being a reliable referral source and point of contact for providers during a client's engagement in care aided in building a positive reputation for Enlaces and reinforced our referral networks over the course of the intervention.

Additional frequent barriers encountered specific to client's lives included the large geographic range of client's residences, long spans of time working out-of-state, and difficult work schedules. To combat this, PHNs relied heavily on phone calls and text messages, including the use of WhatsApp, to keep in contact with clients and to facilitate session content when necessary. PHNs would often meet with clients at their home or in other, more accessible locations, often travelling 1-2 hours to meet in-person and facilitating sessions in the evenings or on weekends to accommodate client schedules. Keeping in frequent contact with clients, particularly in-between sessions was vital to engaging the clients in the intervention, staying up=to-date with important life changes, and demonstrating the investment the PHNs had in their overall health and well-being.

Intervention Outcomes

Client Demographics

	ECH	RAIN	Total
Total Enrolled	46	45	91
Men	42	42	84
Transgender Women	4	3	7
New to Care	17	32	49
Out-of-Care	29	13	42
Country of Birth: Mexico	44	38	82
Median Age	39	35	37

84% of clients completed the 6-session intervention

78% of clients completed the 6-month follow-up ACASI Survey

Approximate Annual Intervention Costs

ESTIMATED ANNUAL TOTAL	**$ 6,864**
PHN PHONE PLAN	$ 1,320
PROGRAM + OFFICE SUPPLIES	$ 2,136
STAFF TRAVEL	$ 2,088

The costs listed above exclude evaluation costs, staff salaries, and office space and reflect total costs for two individual sites. A one-time computer purchase for each PHN was budgeted at $2,500. Program and office supplies include printing costs for brochures, flyers, posters, condoms and lubricant, and general office supply needs. Travel costs are largely dependent on geographic range of clients and ability and need to meet in-person at clinics, offices, and/or client's residence. Ongoing staffing would include a Project Coordinator at 50% effort, two Peer Health Navigators both at 100%, and two outreach staff members at each site at 50%. Additionally, each site and geographic location have different costs for operating supplies, salaries, fringe benefits, indirect costs, and rent.

Lessons Learned

Buy-In from clinics, state HIV staff, and providers is key to sustained, consistent referrals

Flexibility with client schedules. Consistent communication via phone calls and text messages were vital to staying engaged with clients as well as evenings and weekend availability.

Transnational holistic approaches to a client's life establishes a deeper level of trust between PHN and client; staff who had similar immigrant experiences to the clients found sharing these stories encouraged trust and vulnerability.

Community partner infrastructure determines approaches to recruitment and establishing referral relationships with community stakeholders.

ECH is a Latino community based organization new to HIV care and support services. This organization structure required the intervention team to invest time establishing relationships with HIV staff for referrals and client support as ECH was not a previous resource for HIV care.

Clients struggled with HIV-related stigma within the Latino community which often prevented clients from interacting with the PHN at ECH and instead preferring to meet in neutral locations.

RAIN is an HIV case management agency branching out to serve the Latino community. Enlaces was able to build on the reputation of RAIN as an HIV support resource which allowed the team to capitalize on previously established referral systems between RAIN and HIV providers. In contrast to ECH, the bigger hurdle was networking and building trust with the Latino community.

References

1. Kochar, R., Suro, R., & Tofoya, S. (2005). The new Latino South: The context and consequences of rapid population growth. Pew Hispanic Center: Washington, D.C. Retrieved March 1, 2013 from: http://pewhispanic.org/reports/report.php?ReportID=50.ln.
2. Pew Hispanic Center. Last accessed January 11, 2018. Available at http://www.pewhispanic.org/.ln.
3. Division of Public Health NC Department of Health and Human Services (2016). North Carolina HIV/STD/Hepatitis Surveillance Report. http://epi.publichealth.nc.gov/cd/stds/figures/std16rpt_rev3.pdf.ln.
4. Division of Public Health NC Department of Health and Human Services. (2011). Epidemiologic profile for HIV/STD prevention and care planning. http://epi.publichealth.nc.gov/cd/stds/figures/Epi_Profile_2011.pdf.ln.
5. North Carolina HIV/STD Surveillance Unit. (2015). 2013 North Carolina HIV/STD Epidemiologic Profile. North Carolina Department of Health and Human Services, Raleigh, North Carolina. P 18, 32-33, 48, 66.
6. Simpan PA, Reback CJ, Bemic CC. HIV prevalence and incidence among male-to-female transsexuals receiving HIV prevention services in Los Angeles County. AIDS 2000:14:2953-5.
7. Clements-Noelle K, Marx R, Guman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. Am J Public Health 2001;91:915-21.
8. Nemoto T, Operarlo D, Keatley J, Han L, Soma T, HIV risk behaviors among male-to-female transgender persons of color in San Francisco. Am J Public Health 2004;94:1193-9.
9. Nuttbrock L, Hwahng S, Bockting W, et al. Lifetime risk factors for HIV/sexually transmitted infections among male-to-female transgender persons. J Acquir Immune Defic Syndr 2009;52:417-21.
10. Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. AIDS Behav 2008; 12:1-17.
11. Grant, Jaime M., Lisa A., Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
12. NCDHHS. Epidemiologic Profile for HIV/STD Prevention and Care Planning: 2009.
13. Sena AC, Hammer JP, Wilson K, Zeveloff A, Gamble J. Feasibility and acceptability of door-to-door rapid HIV testing among Latino immigrants and their HIV risk factors in North Carolina. AIDS Patient Care STDS 2010;24:165-73.
14. Apostolopoulos Y, Sonmez S, Kronenfeld J, Castillo E, McLendon L, Smith D. STI/HIV risks for Mexican migrant laborers: exploratory ethnographies. Journal of Immigrant and Minority Health/Center for Minority Public Health 2006; 8:291-302.
15. Hirsch JS, Higgins J, Bentley ME, Nathanson CA. The social constructions of sexuality: marital infidelity and sexually transmitted disease – HIV risk in a Mexican migrant community. American Journal of Public Health 2002; 92:1227-37.
16. Magana JR. Sex, drugs and HIV: an ethnographic approach. Social Science & Medicine (1982) 1991;33:5-9.
17. Viadro Cl, Earp JA. The sexual behavior of married Mexican immigrant men in North Carolina. Soc Sci Med 2000;50:723-35.
18. Parrado EA, Flippen C. Community attachment, neighborhood context, and sex worker use among Hispanic migrants in Durham, North Carolina, USA. Soc Sci Med;70:1059-69.
19. Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Soc Sci Med 2003;57:13-24.
20. Bowleg L. The problem with the phrase women and minorities: intersectionality-an important theoretical framework in public health. Am J Public Health 2012;102:1267-73.
21. Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: structural racism, intersectionality theory, and immigrant health. Soc Sci Med 2012;75:2099-106.
22. Egan JE, Frye V, Kurtz SP, et al. Migration, neighborhoods, and networks: approaches to understanding how urban environmental conditions affect syndemic adverse health outcomes among gay, bisexual and other men who have sex with men. AIDS Vehav 2011;15 Suppl 1:S35-50.
23. Zimmerman C, Kiss L, Hossain M. Migration and health: a framework for 21st century policymaking. PLoS medicine 2011;8:e11001034.

24. Garnder LI, Metsch LR, Anderson-Mahoney P, et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. AIDS 2005;19:423-31.

25. Glick Schiller, Nina, Linda Basch, and Cristina Blanc-Szanton. 1992. “Transnationalism: A New Analytic Framework for Understanding Migration.” Annals New York Academy of Sciences 645: 1-24.

Philadelphia FIGHT

Project Name: Clinica Bienestar

Location: Philadelphia, Pennsylvania

Clínica Bienestar Philadelphia An HIV primary care clinic for individuals of Puerto Rican descent with a history of injection drug use

Local epidemiology

Substance abuse, sexually transmitted infections (STIs), and HIV infection are major public health epidemics affecting Latin@ communities in the United States. Complications from HIV are the sixth leading cause of death for Latino men ages 25–44, and one in ten deaths among Latin@ adults working-age (20–64) is due to excessive substance use.[2] [3] Substance abuse has been associated with HIV beyond intravenous transmission, with an increase in the likelihood of sexual risk behavior, HIV/STI acquisition, and late AIDS diagnosis.[4]

Addressing HIV continuity of care for Latin@s in Philadelphia requires paying close attention to the opioid epidemic affecting the region.

- In North Philadelphia, the current opioid epidemic is predated by a heroin epidemic dating back to the late 1980s. [5] [6]
- The HIV prevalence rate among Latin@s in Philadelphia is 1,476 per 100,000 population, compared to 660 per 100,000 population among non-Hispanic Whites. Latin@s represented 12.3% of the total population of Philadelphia in 2010, but comprised an alarming 17.2% of new HIV infections that year.[7] [8]
- Since 2009 Philadelphia has seen a 43 percent increase in drug-related overdose deaths representing the highest opioid death rate of any large city in the United States.[9]

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[2] Gant Z, Dailey A, Hu X, Johnson AS. HIV Care Outcomes Among Hispanics or Latinos with Diagnosed HIV Infection - United States, 2015. MMWR Morb Mortal Wkly Rep 2017;66:1065-1072.

[3] Han, B., Compton, W.M., Jones, C.M. and Cai, R., 2015. Nonmedical prescription opioid use and use disorders among adults aged 18 through 64 years in the United States, 2003-2013. *Jama*, *314*(14), pp.1468-1478

[4] Vagenas, P., Azar, M.M., Copenhaver, M.M., Springer, S.A., Molina, P.E. and Altice, F.L., 2015. The impact of alcohol use and related disorders on the HIV continuum of care: a systematic review. *Current HIV/AIDS Reports*, *12*(4), pp.421-436

[5] https://6abc.com/health/emerald-city-ground-zero-of-phillys-opioid-crisis/2978752/

[6] https://www.voanews.com/a/philly-faces-heroin-crisis/4148075.html

[7] U.S. Census Bureau. Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data. Available at: *http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk*

[8] City of Philadelphia. HIV/AIDS Coordinating Activities. HIV Surveillance Report. Available at: https://www.phila.gov/health/aaco/AACODataResearch.html

[9] City of Philadelphia (2017). *The Mayor's Taskforce to Combat the Opioids Epidemic*. Available at: http://dbhids.org/opioid

- Deaths related to Fentanyl, an extremely potent prescription painkiller, have increased more than 300 percent between 2013 and 2014 in Philadelphia.[10]
- Though Philadelphia currently has the highest burden of fatal and non-fatal overdose in Pennsylvania, with 42 deaths per 100,000 people, there are several communities in Philadelphia most impacted by overdose.[11]

The overall evidence strongly suggests that regardless of the amount consumed, substance use: (1) influences short and long-term health behaviors decision-making; (2) significantly increases the likelihood of sexual risk behaviors; and (3) increases the biological vulnerability towards acquiring HIV/STI. The target population for our intervention is:

- 18 years old +
- Puerto Rican Ancestry (Born in PR, or, one or both parents born in PR)
- Spanish-speaking, English-speaking or bilingual
- Men, Women, Transgender women, Transgender men
- Newly diagnosed with HIV or Out of HIV care for more than 6 months
- History or current injection drug use
- History or currently experiencing severe opioid or other substance use disorder

[10] City of Philadelphia (2017). *The Mayor's Taskforce to Combat the Opioids Epidemic*. Available at: http://dbhids.org/opioid

[11] City of Philadelphia (2017). *The Mayor's Taskforce to Combat the Opioids Epidemic*. Available at: http://dbhids.org/opioid

Program description

- ✓ Clinical at individual level
- ✓ Behavioral-cognitive at individual level
- ✓ Organizational level

Intervention priority area

- Retention in HIV care
- Viral suppression within 6 months of linkage to care

Level of intervention implementation cost per client/patient

	$	Low = Educational advertisement, social marketing campaign, social media outreach to large target population
	$$	Low to moderate = One or more of the following: Person-to-person outreach, fixed number of sessions educational group level intervention, or, point-of-referral to clients/patients
	$$$	Moderate = Combinations of the above plus individualized patient navigation
√	$$$$	High = Combination of the above plus onsite provision of HIV medical care
	$$$$$	Very high = Combination of the above plus provision of any of the following: short-term housing, in-patient treatment, or, chronic illness advanced treatment

Program planning and development

Clinica Bienestar Philadelphia is a 5 year demonstration intervention study to increase engagement in each step of the HIV continuum of care (i.e., from HIV testing to HIV viral suppression) among HIV positive injection drug users with moderate to severe substance use disorders, of Puerto Rican ancestry. This multilevel, multipronged intervention combines evidenced-based practices in behavioral and clinical care with a transnational approach to the provision of comprehensive HIV primary care to a highly underserved population. Participants are recruited through near peer outreach, inter-organizational outreach, and inreach within the syringe exchange program and other service programs for substance users at Prevention Point Philadelphia (PPP). FIGHT provides all the primary care services onsite at PPP, thus facilitating integrated management of HIV for our participants. Furthermore, participants receive multiple forms of evidence-based intervention strategies intended to increase linkage and retention in HIV care. The final goal of Clinica Bienestar is to demonstrate that individuals who inject drugs can manage their HIV care effectively, achieve HIV viral suppression within 6 months of linkage (or re-linkage to care for those who have been out of care for more than 6 months within the past 2 years) with supportive services adapted to the transnational needs of the primary service population.

Taking a transnational approach to HIV linkage and retention in care

Clinica Bienestar Philadelphia is the first intervention for HIV positive Latin@s in the region to fully embrace addressing the needs of a transnational "air bridge" population.[12] This means the circular migratory movement between the island of Puerto Rico and cities in the northeast of the U.S. Puerto Rican injecting drug users between the island of PR and Philadelphia as a result of avoiding targeted drug-related violence; seeking better health and human services; and, avoidance of HIV and substance abuse stigmas in in Puerto Rico.

For long-term, US-born Puerto Ricans who are injecting drug users, other critical transnational factors that may have facilitated their engagement in heroin use and HIV infection, may continue to influence their life precluding them from accessing and linking to consistent HIV care.

Taking a transnational approach requires providing services that pay close attention to geographical, cultural and epidemiological contexts.

- ✓ Our clinic is geographically located at the epicenter of the intersecting opioid and HIV epidemics in North Philadelphia.
- ✓ 100% of our staff have demonstrated culturally competent skills in Puerto Rican culture and street-drug culture.
- ✓ 50% of the providers, case-managers and leaderships are racially-ethnically congruent to the target population

Inter-organizational partnership

Clinica Bienestar Philadelphia is the result of the inter-organizational collaboration between Philadelphia FIGHT and Prevention Point Philadelphia (PPP). Philadelphia FIGHT is a comprehensive AIDS service organization providing quality and culturally competent HIV primary care, consumer education, advocacy, social services, outreach to individuals

[12] Deren S, Kang SY, Colón HM, Robles RR. The Puerto-Rico-New York Airbridge for drug users: description and relationship to HIV risk behaviors. Journal of Urban Health, 2007;84(2): 243-254.

living with and at risk for HIV, and access to clinical research and clinical trials. For more information on FIGHT, please visit: https://fight.org. Prevention Point Philadelphia (PPP) is a multi-service public health organization dedicated to reducing the harm associated with drug use and sex industry work. Through education, outreach, advocacy, and direct services, PPP addresses the health and social service needs of Philadelphia's most underserved populations - people who inject drugs and sex industry workers - by providing culturally-sensitive, non-judgmental HIV/HCV prevention and care services. For more information on PPP, please visit: http://ppponline.org.

Unique features of Clinica Bienestar

- Is one of the first sites in the country to provide comprehensive HIV primary care within a syringe exchange program.
- It takes a critical-time approach. Clients receive a medical appointment within 6 days of identification.
- Abstinence from substance abuse is not a prerequisite to receive HIV primary care not HCV treatment.

Evidence-based services provided	*Innovations onsite*
○ ARTAS onsite ○ Syringe exchange onsite ○ Wound care clinic community/onsite ○ Inpatient substance abuse treatment referrals ○ Methadone referrals ○ Social-services case management ○ Emergency housing ○ Housing services assistance ○ Behavioral health onsite ○ Legal assistance onsite ○ Mental health referral ○ Trauma informed services	⇒ Comprehensive HIV primary care ⇒ Hepatitis C treatment ⇒ Cancer early detection screening ⇒ ⇒ STI detection and treatment ⇒ Gynecological testing ⇒ Patient navigation ⇒ Suboxone onsite ⇒ Vivitrol onsite ⇒ HIV peer education ⇒ HIV support group

Stage 1. Testing

In spite of general HIV education efforts, self-motivated HIV testing is not a routine practice among injection drug users (IDUs) where HIV and advanced HIV has been highly stigmatized.[13] The first stage of the Clinica Bienestar intervention is to improve and expand HIV testing services for IDUs of Puerto Rican descent in Philadelphia.

Objective 1.1	Increase access to culturally-appropriate HIV testing for IDUs as part of current organizational activities in drug using communities and venues.
Objective 1.2	Detect individuals with unknown HIV statuses including recently infected IDUs.
Objective 1.3	Identify structurally vulnerable individuals who inject drugs who have been lost to care (as defined by the HIV care continuum) or who have never engaged in HIV primary care.

13 Earnshaw, V.A., Smith, L.R., Cunningham, C.O. and Copenhaver, M.M., 2015. Intersectionality of internalized HIV stigma and internalized substance use stigma: Implications for depressive symptoms. *Journal of health psychology*, *20*(8), pp.1083-1089.

To accomplish the above, our clinic draws from the on-going HIV testing efforts of PPP: a street side clinic, mobile van testing, routine testing as part of syringe exchange program (SEP) services, and general walks-in at PPP. Clinica Bienestar has created a special transnational and culturally-appropriate focus within the above activities to target recent migrants from Puerto Rico. Our clinic uses three markers of success for these activities: (1) # Individual and Organizational outreach contacts; (2) # Testing activities; and, (3) # of HIV care orientations.

Stage 2. Linkage

Before Clinica Bienestar was created, linkage to care for Spanish-speaking Puerto Rican IDUs was the single biggest challenge for the population served by PPP, because patients were referred to other locations to receive services, with little follow-up or support for the patient's transnational experiences.

Objective 2.1	Link the three types of HIV positive Puerto Rican IDUs to HIV care: (a) those who have tested positive in the past 6 days; (b) those who have been diagnosed yet never engaged in HIV care; and (c) those who have been out of care for a period of six months or more within the past two years.
Objective 2.2	Ensure that each newly-diagnosed person meets with Clinica Bienestar's HIV primary care physician (PCP) at within six (6) days of testing or detection during outreach.
Objective 2.3	Ensure that each newly-diagnosed person participates in a case management session within six (6) days of testing or detection during outreach.

To accomplish the above, our clinic provides a comprehensive first primary HIV care appointment, first social case management session, and first medical case management session, each of which gave careful attention to the transnational experience of the patient. The order of these may vary, depending on patient and provider availability. Our clinic uses three markers of success for these activities: (1) # Case management meetings; (2) # Medical appointments; and, (3) # Care navigator communications with participant.

Stage 3. Retention

Clinica Bienestar's retention in care draws on the current assets and strengths of the environments created by PPP, the infrastructure of FIGHT in creating access to services, and, on-going educational and social support activities.

Objective 3.1	Maintain a regularly scheduled HIV clinic with a transnational, empowering environment that motivates staying in care. Participants will have access to medical services at Philadelphia FIGHT on days separate from clinic days at Prevention Point. Participants will be able to participate in case management services during each day of the week.
Objective 3.2	Utilize outreach coordinators in the community and within Prevention Point to retain participants

in medical care and case management services. Support of transportation and medication costs are critical components.

Objective 3.3 Maintain communication with local, state, and federal correctional health services for incarcerated participants . The Institute for Community Justice, a program of Philadelphia FIGHT, will use its prison linkage staff and resources to connect with participants moving through the criminal justice system. This will enable project staff to communicate with medical providers within the prisons and jails to continue patient medication regimens without interruption. With this continuous communication, staff will also know when these participants are scheduled to be released so they can be re-linked into Clinica Bienestar.

Objective 3.4 Maintain internal systems of communications to monitor the health and well-being of participants, reduce excess mortality, and address in a timely manner acute social, mental health, or physical co-morbidities.

To accomplish the above objectives our clinic follows six steps starting at participation in ongoing general PPP activities, complemented by expanded PPP programming that promotes retention in medical care (Step 1) to on-going staff monitoring and coordination of patient/client's care (Step 6). Our clinic uses five markers of success for these activities: (1) # Case management meetings; (2) # Medical appointments; (3) # Case navigator communications with participant; (4) # Activities to promote retention to PPP; (5) # Tailored activities to promote retention to Clinica Bienestar.

Stage 4. Medical therapy

Because Clinica Bienestar's target population is Puerto Ricans, who are born US citizens, we can enroll all of our clients in various forms of health insurance. Furthermore, in the state of Pennsylvania there is no waitlist to receive HIV medications through the AIDS Drug Assistance Plan and the available plans in Pennsylvania cover all medications. Therefore, the PCP can offer comprehensive primary care and medical treatment to patients, and prescription of HIV medications is not a barrier to HIV care among our target population. Clinica Bienestar's prescription intervention activities follow the established standards of HIV care (at PPP and FIGHT) through 6 steps from testing for medication resistance (Step 1) to the PCP educating patients in the progression of HIV treatment (Step 6). Our clinic uses two markers of success for these activities: (1) #Prescription as usual activities; and, (2) #PCP-patient educational sessions as part of medical visit using a transnational approach.

Stage 5. Viral suppression

This intervention addresses dimensions in the lives of individuals who inject drugs that may threaten adherence to medications including improving physical health, mental health, reducing risks related to substance use, and improving the social-structural conditions that contribute to these three areas of IDUs' health and well-being.

Objective 5 Clinica Bienestar's viral suppression objective is to reduce viral load to undetectable among Puerto Rican IDUs within six (6) months of enrollment in Clinica Bienestar.

This objective will be accomplished through: doctor-patient interactions, building social networks of support for engagement in care, and doctor-case management coordination. Our clinic uses three markers of success for these activities: (1) # Interventions on social conditions affecting adherence; (2) #Treatments of co-morbidities including substance use disorder; and, (3) #Provider-patient communication.

Materials needed to replicate intervention

Minimum infrastructural materials	*Minimum human resources for 50-70 clients/patients*
1. Electronic medical records system 2. Staff office space 3. Group activity/educational space 4. Lunch and meals for clients, patients 5. Educational materials (flip charts, audiovisuals) 6. Emergency housing 7. Patient transportation 8. Private medical consultation space 9. Phlebotomy space 10. Clinical materials and equipment for HIV and basic primary care 11. Suboxone, Narcan, and, Vivitrol 12. Private space for mental health, behavioral health and medical case management sessions 13. Waiting room	1. Project director (1) 2. Organizational liaison coordinator (1) 3. Case manager (2) 4. Medical case manager (2), ARTAS Specialists 5. Health educator (1) 6. SNS testing specialists (2) 7. Case manager liaison for in/out correctional facilities (1) 8. Primary care medical provider (1) 9. Drug treatments medical provider (1) 10. Care Navigators (2)

Intervention outcomes

1. To reduce emergency department visits and health care costs associated with late HIV diagnosis and/or treatments of HIV related illnesses/conditions among injecting drug users
2. To reduce costs associated with overdose from opioids or other substances, excess mortality, and excess co-morbidities among injecting drug users
3. To increase quality of life indicators, facilitate pathways for overall wellness and productive years, including substance abuse treatment and effective management of HIV among Latin@s experiencing severe substance user disorders related to injecting drug use

Lessons learned

Working with individuals with severe substance use disorders, injecting drug users and groups affected by transnational barriers in care means adjusting the expectations of the effectiveness of any individual or mezzo level interventions since the factors that shape their vulnerability towards HIV acquisition and treatment require structural level interventions. Clinica Bienestar intervention package does not address macro-structural drivers of HIV vulnerability such as: 1) Hyperincarceration of ethnic minority individuals[14]; 2) Societal stigmas against substance abusers and anti-immigrant sentiments[15]; 3) Housing availability for the poor and working poor[16]; 4) Major disparities in accessing substance abuse services for women due to trauma, domestic violence, childcare barriers[17] [18]; or, 5) Emerging types and rising lethality of street opioids such as fentanyl and black tar heroin[19]. Thus, interventions intended to work with HIV positive with severe substance use disorders confronting transnational barriers to care must prioritize: (1) patient-intensive retention in care techniques, (2) consider the 6 months (as opposed to 12, 18 or 24 months) as a marker of success implementation, and, (3) focusing on reducing excess mortality and overall morbidity as major long-term impact indicators of intervention effectiveness.

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[14] Rios, V.M., 2007. The hypercriminalization of Black and Latino male youth in the era of mass incarceration. In *Racializing justice, disenfranchising lives* (pp. 17-33). Palgrave Macmillan, New York

[15] Szkupinski Quiroga, S., Medina, D.M. and Glick, J., 2014. In the belly of the beast: Effects of anti-immigration policy on Latino community members. *American Behavioral Scientist*, *58*(13), pp.1723-1742.

[16] Aidala, A.A., Lee, G., Abramson, D.M., Messeri, P. and Siegler, A., 2007. Housing need, housing assistance, and connection to HIV medical care. *AIDS and Behavior*, *11*(2), pp.101-115.

[17] Greenfield, S.F., Brooks, A.J., Gordon, S.M., Green, C.A., Kropp, F., McHugh, R.K., Lincoln, M., Hien, D. and Miele, G.M., 2007. Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and alcohol dependence*, *86*(1), pp.1-21.

[18] Amaro, H., Raj, A., Vega, R.R., Mangione, T.W. and Perez, L.N., 2016. Racial/ethnic disparities in the HIV and substance abuse epidemics: Communities responding to the need. *Public Health Reports*.

[19] Roth, A.M., Armenta, R.F., Wagner, K.D., Strathdee, S.A., Goldshear, J.L., Cuevas-Mota, J. and Garfein, R.S., 2017. Cold Preparation of Heroin in a Black Tar Market. *Substance use & misuse*, *52*(9), pp.1242-1246.

Gay Men's Health Crisis

Project Name: Leaders in Networking and Knowledge (Link II)

Location: New York, New York

GMHC
END AIDS. LIVE LIFE.

Local Epidemiology

According to CDC surveillance data from 2010[1], Hispanics or Latinos are disproportionately affected by HIV, relative to other races/ethnicities. The estimated new HIV infection rate among Latinos in 2010 in the United States was more than 3 times as high as that of whites and Hispanics/Latinos accounted for over one-fifth (21% or 9,800) of all new HIV infections in the United States despite representing about 16% of the total US population. Compared with whites, Latinos experience disproportionately higher rates of delayed testing, diagnosis, and entry into care.[2]

More specifically, Latino men accounted for 87% (8,500) of all estimated new HIV infections among Hispanics/Latinos in the United States and most (79% or 6,700) of the estimated new HIV infections among Hispanic/Latino men were attributed to male-to-male sexual contact.

There are several cultural factors that may contribute to the increased risk of HIV infection. Some Latinos may avoid seeking testing, counseling, or treatment if infected because of stigma or fear of discrimination. Traditional gender roles, cultural norms such as *"machismo"* and *"marianismo"*, and the stigma around homosexuality may add to prevention challenges. Numerous socio-demographic and economic factors within the Latino community significantly impact Latinos' engagement and retention in care.[3] These factors include lack of insurance, high rates of poverty, unemployment, lack of transportation, housing instability, low levels of English proficiency, lack of formal education, low levels of health literacy, lack of trust of medical providers, limited numbers of bilingual healthcare providers and lack of bilingual HIV educational resources.[4,5]

GMHC serves more than 3,100 Latino individuals annually (approximately 32% of our entire client base), and of those Latino clients that identify a country of origin, 37% identify as Puerto Rican. Forty-four percent (44%) of GMHC's Latino clients identify as gay or bisexual. We estimate that each year GMHC serves more than 500 individuals who identify as MSM with Puerto Rico as a country of origin.

New York City has a very comprehensive array of services that support individuals living with HIV/AIDS, and these services are coordinated by both public and nonprofit agencies.

However, despite this wealth of services for people living with HIV/AIDS in New York City, there are very few institutions that offer a comprehensive array of services in a single culturally-competent, accepting facility. GMHC is one of only a few HIV/AIDS service providers to have significant experience using social networking strategies to reach difficult-to-engage populations and recruit them for HIV tests. GMHC has unique experience in targeting not only the index client, but also that client's collaterals, including sex and drug-sharing partners. If they meet the eligibility criteria, the client's collaterals may, in turn, become recruiters to target their own social networks.

The LINK II program uses a social networking strategy to identify HIV-positive Latinos who are unaware of their HIV status or who are aware of their status but not engaged in care. This strategy enlists HIV-positive individuals (i.e. recruiters) to encourage people in their network (i.e. network associates) to be tested for HIV, and has shown to be an efficient and effective route to accessing individuals who are infected with HIV, or at very high risk for infection, and linking them to services. The social networking approach, first designed and tested by the Centers for Disease Control in 2003, is based on the idea that individuals are linked together to form extensive social networks, and that HIV is a disease that spreads throughout these networks. In the national CDC Social Networks Demonstration Program operated from 2003 to 3005, a social networking approach yielded a 6% seropositivity rate among all network associates that were tested; this rate of detection is approximately six times higher than the success rate of most traditional HIV testing programs nationally.

GMHC believes that a social networking strategy will be especially effective in overcoming the factors that interfere with identifying Latinos – and specifically Puerto Rican MSM – who are unaware of their HIV status. The personal conversations between peers about the importance of HIV testing will help to overcome some effects of cultural stigma and misconceptions that may impact an individual's reluctance to test for HIV. In addition to addressing the barriers that prevent Latinos specifically Puerto Rican MSM to test for HIV, the social networking strategy takes a more proactive approach than the traditional route of testing which is available to anyone. Traditional testing does not have the added benefit of motivation and encouragement by peers who discuss the benefits and importance of HIV testing from a "relatable" perspective. This addresses another barrier of an individual's initiative to want to get HIV tested, because they are being encouraged by someone in their social group to know their status. Having that "back-up" person, hopes to give the perception to the person seeking to get tested that knowing his status is not just important to him, but to the members of his community (i.e. social network).

Since 2008, GMHC has demonstrated success in using this social networking strategy and this implementation approach to engage hard-to-influence populations that often are not reached by traditional means. During the past five years of its existing social networking strategy program, LINK (Leaders in Networking and Knowledge), GHMC has engaged 138 recruiters, 58% of whom were Latino, to recruit 1,686 network associates for HIV tests. Of these network associates, 5.6% were found to be HIV positive, a higher outcome of seropositivity than from GMHC's traditional outreach alone. In the past year, LINK conducted 548 HIV tests of network associates, with a 4.2% seropositivity rate. The proposed LINK II intervention model will build on the LINK program to identify HIV positive Puerto Ricans unaware of their HIV infection via recruiters drawn from Puerto Rican MSM already part of GMHC's client population.

Target populations:

The target population for this demonstration intervention is Puerto Rican MSM who are ages 18 and older. These individuals are either unaware of their HIV-status or are HIV-positive, but have been out of care for more than 6 months.

Network Associates
N = 1200 NAs Age range: ≥ 18 years
Sample description: Network associates should be HIV- or HIV status unknown adults, or HIV+ positive adults who have been out of care for at least 6months. Both populations must self-identify as Puerto Rican and MSM.

Inclusion for NAs

- Age ≥ 18 years
- MSM
- HIV Negative or newly HIV status unknown
- HIV+ and out of care for > 6 months
- Sent by Recruiter
- Can speak and understand English or Spanish

Exclusions for NAs

- Age < 18 years
- Female
- Sex with women only

Recruiters
Subjects:
N = 120 recruiters Age range: ≥ 18 years

Sample description: Our initial group of recruiters for year 1 of the demonstration study will be HIV+ or high risk HIV- adults who self-identify as Puerto Rican and MSM. As the study progresses (Years 2-4) the demographic description of the recruiter population may shift as we examine the data collected to determine the most effective recruiter characteristics.

Program Description

Goals of the intervention:

GMHC's innovative demonstration intervention model is titled **LINK II (Leaders in Networking and Knowledge)** and utilizes three strategies that will effectively identify and serve individuals in the Puerto Rican MSM community in New York City who are at high risk of HIV infection or are infected with HIV but unaware of their HIV status; are aware of their HIV infection but have never been engaged in care; or who have dropped out of care. These strategies are designed to identify individuals from this target population and provide them with HIV testing and counseling, link them to medical care, and help them remain engaged in medical care.

1. To identify individuals from this target population and provide them with HIV testing and counseling, LINK II employs a social networking strategy that will enlist HIV-positive recruiters from the Puerto Rican MSM community to recruit their network associates for HIV tests. This strategy has proven to effectively and efficiently reach HIV positive individuals in communities that are otherwise hard-to-influence, and will be particularly effective in capitalizing on the

strong relationships that individuals in the Puerto Rican MSM community have with each other.

2. To link those network associates who are HIV positive to care, LINK II employs a Linkage Navigation Specialist from this community to provide customized materials and culturally-nuanced counseling, and a personal escort to Mount Sinai Hospital for an initial medical visit.
3. To help these newly-diagnosed individuals remain engaged in medical care, GMHC will collaborate with Mount Sinai Hospital to offer an array of culturally-sensitive supportive

services in a location that is widely known as being gay-friendly, sex-positive, and outside of the neighborhood where most clients live, to reduce the impact of perceived stigma on engagement in care. The supportive services are offered by bilingual staff and include mental health counseling, support groups, transportation assistance, health insurance and benefits advocacy, and housing assistance.

Overview of Core Phases:

There are four major phases to the Leaders In Networking & Knowledge (LINK) II social networking project. These phases are:

- Recruiter Enlistment
- Engagement (Orientation, Interview, and Coaching)
- Recruitment of Network Associates
- Counseling, Testing, and Referral (CTR)

Recruiter Enlistment

- In this phase, HIV-positive or HIV-negative high-risk persons from the community who are able and willing to recruit individuals at risk for HIV infection from their social, sexual, or drug-using networks are enlisted into the program. To identify recruiters, GMHC approaches our HIV- positive clients and identify additional people through GMHC's existing counseling and testing and other programs.

Engagement (Orientation, Interview, and Coaching)

- After recruiters are enlisted into the LINK II program, they are provided with an orientation session that explains the nature of the program and the social network techniques that might be used to approach their associates and discuss HIV testing with them. Next, recruiters are interviewed to elicit information about their network associates. The period of time needed to elicit information from recruiters is typically brief recruiters may be able to give all of their network information within one - two interviews. Unlike peer outreach workers, recruiters' participation time overall is relatively short and last no more three months.

- Coaching is provided on an ongoing basis throughout the period of the recruiter's participation. Coaching may involve discussion with recruiters on how to approach associates about 1) obtaining HIV CTR, 2) disclosing their own HIV status if they wish to do so, and 3) how to avoid disclosing status if desired. Additionally, the recruitment coordinator seeks to assist the recruiter address any cultural or structural issues their network associates may be facing that creates barriers for HIV testing.

Recruitment of Network Associates

- Recruiters will refer individuals for testing who they have identified as being at risk for HIV infection. All individuals are approached by the recruiter alone, without the involvement of GMHC.

To promote the LINK II project and enlist potential recruiters from the target population, GMHC utilizes a two prong program promotion approach, which includes: in-reach and outreach.

In-reach:

- In-reach is an integral component of the intervention and serves as a means to identify HIV positive individuals who may serve as recruiters as they are more likely to

  have HIV positive individuals, who are unaware of their status or high-risk individuals, within their social networks.

- The recruitment coordinator is responsible for conducting in-reach within GMHC as noted below:

  A. **Meeting & presentations with program staff:** Meetings with other GMHC program staff, within other programs, occurs once and then as needed. The meetings with the staff, from a variety of modalities, enables the recruitment coordinator to inform GMHC staff about the LINK II program, including: (1) goals of the program, (2) target population and eligibility, (3) core phases of the programs & (4) mechanisms for referring to the LINK II program. Meeting with other program staff also creates buy-in from the staff, which increases the likelihood that that the program staff will refer potential recruiters to the LINK II project. Program staff also has the opportunity to ask questions and seek clarification. Staff is provided with a referral form and instructions on how to cement a referral to the LINK II project.

  B. **Presentation to Client Advisory Board (CAB):** The recruitment coordinator also presents annually, and then as needed, at the GMHC client advisory board. The client advisory board consists of GMHC clients, both HIV positive, HIV negative and at-risk who provides feedback on GMHC programs, as well as advocacy on behalf of the client population. The presentation mirrors the presentation conducted for GMHC staff, and includes: (1) goals of the program, (2) target population and eligibility, (3) core phases of the programs & (4) how to become a recruiter for the LINK II Project. During the presentation, CAB members are encouraged to become a part of the LINK II project, if they meet the eligibility requirements. Those CAB members who express an interest in becoming a recruiter for the project are provided with an appointment, within one week of the presentation, to meet with the recruitment coordinator and learn more about the project. Additionally, the recruitment coordinator distributes business cards, to the CAB members, so that they can contact the recruitment coordinator at a later date if they become interested in being a part of the LINK II Project. CAB members also have the opportunity to ask questions and seek clarification.

C. **Intake Department:** The point of entry and access for most of GMHC's services occurs through GMHC's intake department. The intake department is responsible for completing a comprehensive intake and assessment (using program developed algorithms) for all HIV positive clients, identifying service needs and gaps, and ensuring the client is referred to services that address the identified needs and services gaps

As a result of the intake staff promote the LINK II project, to clients presenting for intake services. For those clients who are interested, the intake department contacts the recruitment coordinator to schedule an appointment for the client to meet with the recruitment coordinator to discuss the program further.

Outreach:

In addition to providing culturally competent, specific to Puerto Rican MSM services, promoting the LINK II project, identifying & enrolling potential recruiters for the intervention and providing HIV CTRPRN services to network associates, the additional goals of street-based outreach to the community and community-based organizations are to:

- Increase the accessibility of HIV counseling and testing as a primary prevention tool by deploying a mobile HIV/STI testing unit staffed by trained counselors who will connect both HIV-positive and HIV-negative clients into supportive services.
- Enhance the value of HIV testing as an early intervention tool by providing an easily accessible and comprehensive range of services to enable HIV-positive individuals to learn about and access treatment options and appropriate health care, and obtain entitlement or benefits that will enable them to cover treatment costs.
- Provide at risk individuals an accessible, high-quality counseling and testing program to assist them in their decision to test for HIV or other STI's and access comprehensive supportive services.
- The LINK II Project, a program of the David Geffen Center for HIV Prevention & Health Education at Gay Men's Health Crisis (GMHC), is designed to provide a continuum of sexual health related services integrated with HIV testing that will support continued risk reduction behavior by eligible clients (Puerto Rican MSM). The LINK II Project facilitates access to early intervention information and treatment for those who test positive for HIV. Through the use of a custom designed conversion van, to be used by the outreach team, we are to promote the LINK II project, identify potential recruiters, conduct HIV CTRPN, in the field

(street-based outreach) and at community – based organizations.

- The recruitment coordinator is responsible for identifying and conducting outreach and recruitment activities in the community and at community-based organizations where the target population may congregate, live, or receive services.
- To identify suitable street – based outreach locations, the recruitment coordinator works with members of the testing team/program including the Assistant Director and Offsite Supervisor, as the offsite supervisor is responsible for developing a monthly offsite/outreach calendar of testing locations. The recruitment coordinator will review the calendar and then based on the recruitment coordinators availability and locations (does the location have a high percentage of the target population) determine if he/she will accompany the testing team and conduct outreach to identify potential recruiters for the LINK II project.

A. Outreach locations are determined based on the New York City Department of Health and Mental Hygiene Epidemiological neighborhood profile which details demographical information of the community (e.g. race/ethnicity, age, marital status) as well as HIV incidence and sero-prevalence rates. Outreach is conducted in those areas: (1) with the highest representation of the target population and (2) highest HIV incidence and sero – prevalence rates.

B. In conducting street-based outreach, with the testing team, the recruitment coordinator ensures he/she (1) knows and is able to speak with target populations language & (2) is aware of and sensitive to the community norms, values, and beliefs. The recruitment coordinator approaches potential community residents and asks when was the last time that individual was tested for HIV? This opens up the conversation

C. and enables the recruitment coordinator to (a) encourage the individual to obtain an HIV test, aboard the MTU, and (b) discuss the LINK II project with the individual. Individuals, who opt to receive HIV testing, receive HIV CTRPRN in accordance with the protocol and are screened for eligibility to become a recruiter. Individuals, who opt not to receive HIV CTRPN services, are screened for eligibility, to become a recruiter for the LINK II project. If the individual does not wish to be screened, they are provided with the recruitment coordinators business card, so that if they change their mind, in becoming a part of the project, they are able to contact the recruitment coordinator. During street-based outreach, individuals are also provided with safer sex kits and information on HIV prevention. During the spring and summer months, the recruitment coordinator will also set up a table, outside of the mobile testing unit, that displays safer sex kits, HIV prevention information, and information on the LINK II project.

D. All testing center staff has received crossed training on the LINK II project and protocol. As a result, in the event the recruitment coordinator is unable to accompany the testing team for street-based outreach or at a community based organization, the testing team provides individuals from the target population with information on the LINK II project and contact information to the recruitment coordinator.

Core Intervention Staff

Director of Geffen Counseling and Testing Center, responsible for the support of the testing team in ensuring clients receive quality HIV CTR and prevention services. Specific to the HRSA SPNS contract, the Assistant Director is responsible for the direct supervision and oversight of the recruitment coordinator, ensuring the recruitment coordinator is meeting project goals and deliverables. The Director also provides administrative oversight on the HRSA SPNS contract by providing oversight and performing quality assurance checks of data entry, review of client records (recruiter and network associate) as well as review of additional programmatic forms, including tracking sheets, testing logs, and result logs. The Assistant Director also assists in the completion of necessary HRSA related reports. Participates in the monthly HRSA conference calls to discuss program performance. **Qualifications:** At least five years' experience in the oversight and management of an HIV Prevention Program. Knowledge of Social Networking Strategies (SNS) model, as well as knowledge on ARTAS linkage to care model. Spanish – speaking and extensive knowledge on cultural aspects of PR MSM.

Recruitment Coordinator, responsible for identifying existing GMHC clients who are HIV positive and members of the Puerto Rican MSM community to serve as recruiters. Responsible for screening and conducting orientation for all individuals interested in becoming LINK II recruiters, providing training and coaching for all recruiters, and monitoring the success of each recruiter in engaging network associates for testing. Conduct outreach to identify potential recruiters for the HRSA SPNS project. Attend all HRSA SPNS related meetings and monthly conference calls. This position is also responsible for providing direct supervision to the Linkage Navigation Specialist, to ensure those clients who test HIV positive are linked to medical and support services. Ensures eligible clients complete local and multi-site evaluation questionnaires, as per protocol. Conduct HIV and syphilis counseling and testing. **Qualifications:** NYCDOHMH certified HIV/AIDS Test Counselor Training, High School Diploma, at minimum three years in the conducting HIV testing using a SNS approach. Spanish – speaking and extensive knowledge on cultural aspects of PR MSM.

Linkage Navigation Specialist, responsible for providing immediate counseling to individuals who receive a preliminary positive HIV result at the GMHC Geffen Testing Center. Builds relationships with each individual receiving a preliminary positive and confirmed positive HIV result, and responsible for linking these clients to care at partner medical provider. Conducts all follow-up with clients after medical appointments and contacts all clients who miss medical appointments to address concerns and barriers to care. Refers clients as needed to supportive services at GMHC and referral network to resolve barriers to care. Provides HIV and syphilis testing services. Conducts and documents all engagements into AIRS. **Qualifications:** High school diploma, at minimum 2 years in the provision of linkage to care services utilizing an ARTAS approach. Training in ARTAS. NYCDOHMH certified HIV test counselor.

Program Planning and Development

Staff hiring: The program began the recruitment process shortly after receiving notification that the GMHC was awarded funding. For the recruitment coordinator position, we recruited someone with years of HIV experience and who was from the target population. Being committed to staff development, we identified a well – respected internal candidate for the linkage navigation specialist position as well as for the evaluator position. All other positions were already filled at the point of startup.

Staff Training: All key intervention staff members were trained in HIV counseling and testing, ARTAS (linkage to care DEBI), AIRS Training, cultural competency, as well as HIV confidentiality, and research techniques. Ongoing training occurred annually and included annual HIV confidentiality training, infection control and HIV testing procedures.

Development of partnerships and MOU’s:

A. **Partnerships with Churches:** We routinely partner with community churches, as we understand church is a major cultural aspect in the Puerto Rican community.

B. **Collaborations with Government:** We work extensively with the NYCDOHMH on its Brooklyn and Bronx Knows Testing campaigns. Both boroughs have a high percentage of Puerto Rican MSM and a high HIV incidence and sero-prevalence rates, increasing the opportunity that we will engage the target population, in the LINK II project.

C. **Collaboration with Walgreens/Duane Reade pharmacies:** Ongoing collaboration with both pharmacies, where we conduct targeted outreach and testing each year for National HIV testing day, which allows us to test inside of Walgreens/Duane Reade stores in areas with high concentrations of the target population of Puerto Rican MSM.

D. **Non – traditional venues that cater to Puerto Rican MSM:** Strategic partnerships with several non-traditional venues that cater to the Latino MSM population.

E. **Collaboration with other HRSA SPNS sites:** Riker’s Island and Harlem United.

Implementation and Maintenance:

Modifications: The program faced challenges in identifying enrollees for the project (HIV+ Puerto Rican MSM) utilizing the social network approach. We modified the strategy and we were able to enroll individuals who were from the target audience and were either known positive or were newly diagnosed, but were not a part of the SNS approach. While this approach yielded a few additional enrollees, we did not meet the our initial target of 100 enrollees.

Barriers toward implementation**:** There were two major barriers toward implementing the program. Firstly, the program was not able to enroll participants until year 2 of the project, which increased our annual targets for years 2 – 4. The second barriers was the demonstration requirements for the population itself, in that it was difficult to identify HIV positive (known positive and out of care or irregularly in care, or newly diagnosed) MSM from Puerto Rico.

Lessons Learned

1. Start enrollment into the project as soon as possible.

2. Ensure all evaluation questions, study design, etc. are known and developed early in the process as to not affect when you can enroll clients.

3. Think about target population and while it should be defined, it should be so defined as to affect enrollment. Ensure you have true access to the target population.

4. Train staff fully on model and evaluation metrics, this is vitally important.

References

1. CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. HIV Surveillance Supplemental Report 2012;17(4).

2. Christopoulos KA, Das M, Colfax GN. Linkage and retention in HIV care among men who have sex with men in the United States. *Clinical Infectious Diseases* 2011; 52 (supplement): 214-222.

3. Strategies for engaging and retaining Latinos in HIV Care. Mathematica Policy research, Inc. Web site. http://www.mathematica-mpr.org/publications/PDFs/health/latino_hivcare_ib.pdf. Accessed January 29, 2015

4. Bertolli, Jeanne, R. Luke Shouse, Linda Beer, Eduardo Valverde, Jennifer Fagan, Samuel M. Jenness, Afework Wogayehu, Christopher Johnson, Alan Neaigus, Daniel Hillman, Maria Courogen, Kathleen A. Brady, and Barbara Bolden for the Never in Care Project. "Using HIV Surveillance Data to Monitor Missed Opportunities for Linkage and Engagement in HIV Medical Care." The Open AIDS Journal 2012; 6(supplement 1, M10): 131-141.

5. Mayer, Kenneth Hugh. "Introduction: Linkage, Engagement, and Retention in HIV Care: Essential for Optimal Individual- and Community-Level Outcomes in the Era of Highly Active Antiretroviral Therapy." Clinical Infectious Diseases 2011; 52(S2): 205-207

New York City Health + Hospitals Correctional Health Services

Project Name: "Warm Transitions" for Puerto Ricans after Incarceration

Location: New York, New York

NYC HEALTH+ HOSPITALS

NYC has a large concentration of Latino residents and it is home to some of the largest concentrations of Latino populations in the country including Puerto Ricans.[1] The Bronx alone holds 6% of all Puerto Ricans (298,921) in the US and Brooklyn and Queens also hold significant populations of foreign born Latinos. In addition, there is a high concentration of HIV infection among New York's Latino population. Of all recorded foreign-born HIV cases, over a quarter (27.5%) named Spanish as their primary language, and of all those living with HIV/AIDS in NYC in 2008, 5,258 (5%) were born in Puerto Rico.[2] People incarcerated in NYC jails are also disproportionately Latino, with a high percentage being either HIV-positive or at-risk for contracting HIV. An estimated 1,670 Latinos are incarcerated each month; which translates to about 20,000 each year. In 2011, 653 HIV-infected Latinos were admitted to NYC Jails, and 5,424 (both positive and at-risk) received Ryan White (RW) funded services in 2012. Nationally, Puerto Rican males have triple the incarceration rate (5.1%) of non-Hispanic whites (1.66%).[3] These issues led CHS to identify NYC jails, including Rikers Island, as an epicenter of HIV and to focus on Puerto Rican men and women who are either HIV positive or at high risk of HIV infection to facilitate linkages to community-based primary HIV care and testing. The jail setting provides an opportunity for knowledgeable and empathetic staff to intervene with individuals who may not be stably linked to care.

The primary risk behavior among Latinos in NYC varies depending on ethnic background, and HRSA awarded the SPNS grant to CHS to focus primarily on Latinos of Puerto Rican origin. Compared to other Latino cultures, Puerto Rican men are much more likely to engage in injection drug use, while men from other Latino cultures are more likely to get HIV through unprotected sex.[4] Many Latinos immigrating to NYC are insufficiently informed about HIV/AIDS risk factors, and efforts to reduce risk should be based on the country of origin and family culture.[5] For instance, CHS staff need to understand Puerto Rican norms and culture, and recognize that Puerto Ricans may have a greater need for drug treatment than other Latino cultures.

In addition, it is common for Puerto Rican New Yorkers to travel back and forth between the US and Puerto Rico. Often referred to as an air-bridge, this link demonstrates the close and continued ties between Puerto Ricans in NYC and the island of Puerto Rico. This transitory migration can affect HIV risk: studies of drug users have found differences in norms and behavior regarding drug use and sexual risk taking for those traveling from Puerto Rico to New York in comparison to those traveling from New York to Puerto Rico, though both were found to have high rates of incarceration (88% NY, 75% PR).[4,6] Puerto Ricans on the island were much more likely to use shooting galleries, share syringes and other equipment, continue to use while incarcerated, and they were less likely to access drug treatment during or after release compared with New York participants.[6] Also, Puerto Ricans from the island may move to NYC to access services as they are more readily available. Half of participants in one study moved to NYC from Puerto Rico to be with family, find employment and end drug use.[7]

Latinas have their own unique set of needs when addressing HIV risk behavior and enrollment in care. HIV infection among women, especially Latinas, has been rising more sharply than for any other population.[7] In 1999, Latinas made up 20% of AIDS diagnoses, the majority found among Puerto Rican women. Rates of HIV among Latinas are more than five-times that of white women,[5] and the rates of HIV among incarcerated women are even higher.[8] Most Puerto Rican women who reside in the Bronx believe they are at risk of getting HIV from their heterosexual partner.[9] Despite HIV risk behavior found in Latino communities, especially those involved in the criminal justice system, unprotected vaginal, anal, and oral sex is common for Puerto Rican women, especially during intercourse with their primary partner. Cultural expectations and gender roles may influence a woman's fear of implying infidelity (hers or his) when asking her partner to use a condom and an empathic person familiar with the cultural issues faced by those from her country of origin may be able to make a difference.

Latino MSM and transgender women have their own unique needs for health care and social services. The unique intersection of poverty and race/ethnicity for MSM and transgender women increases the complexity and cost of care. The average MSM living with HIV uses twice as many units of Ryan White Part A services as the average Part A client, resulting in average estimated annual costs of $10,392 for each HIV-positive MSM (compared to $5,196 for PLWHA as a whole). And the recently-completed New York Transgender Project documented both a profound health crisis and a troubling health disparity among 517 transgender women in the NYC area.[9]In that study, 49.6% of transgender women of Latin American origin tested positive for HIV antibodies, while HIV prevalence was 3.5% for white, non-Hispanic transgender women (Prevalence of HIV among participants of African descent was similar to those of Hispanic descent (48.1%).[9] In addition, Latina transgender women are significantly more likely to have Hepatitis C and exposure to syphilis and they are twice as likely to have HIV than Latino MSM.

The ***target population*** for the *Warm Transitions for Puerto Ricans after Incarceration*, are ultimately HIV patients of Puerto Rican origin who are transitioning from NYC jails to the community. The systemwide cultural competency trainings are directly targeted to jail- and community providers who deliver healthcare, support and related services to NYC Puerto Rican HIV patients and indirectly, to their patients. The target population for the PCC-client matching are Puerto Rican HIV patients who are incarcerated in NYC jails. HIV patients are eligible to participate in the multisite study if they are 18 years old or older and self-identify as Puerto Rican.

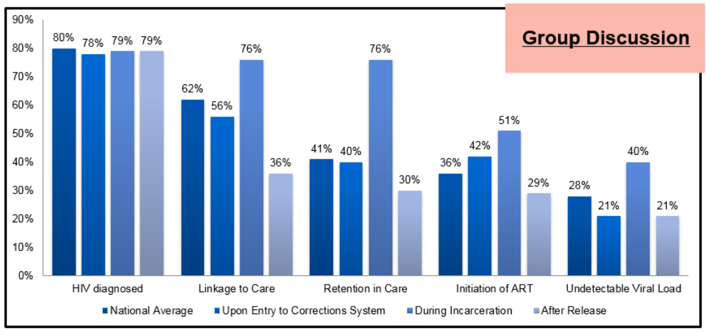
Other data to potentially include:

- HIV Epidemiology in NYC:
    - Source: New York City HIV/AIDS Surveillance Slide Sets. New York: New York City

Department of Health and Mental Hygiene, 2013. Updated February 2015.

- In 2013, approximately 2,832 new HIV diagnoses (33.7 diagnoses per 100,000 people).
- In 2013, approximately 117, 618 persons living with HIV/AIDS (1.4% of NYC population).
- From 2009-2013, Blacks and Hispanics accounted for the majority of new HIV diagnoses
- From 2009-2013, rate of new HIV infection among Blacks and Hispanics were higher than rates of Whites and Asian/PIs.
- From 2009-2013, NYC Neighborhoods with higher levels of poverty had higher HIV diagnosis rates. Source: 1) New York City HIV/AIDS Surveillance Slide Sets. New York: New York City Department of Health and Mental Hygiene, 2013. Updated February 2015. 2) NYC Center for Economic Opportunity. CEO Poverty Measure, 2005-2013. April 2015.
- Neighborhoods with the highest rates of HIV diagnoses are in the South Bronx, Central Brooklyn, Chelsea-Clinton and Harlem.
- The neighborhoods with higher rates of HIV diagnoses are often characterized by: lower access to care, lower rates of insurance, greater housing instability, greater unemployment and underemployment, greater rates of mental health issues, greater rates of substance use, greater exposure to the criminal justice system

- <u>Interconnected epidemics of mass incarceration and HIV</u> are heavily concentrated in specific communities. 1) Velasquz R, Funes S. The Mass Incarceration of Latinos in the U.S.: Looking Ahead to the Year 2050. 2014. 2) AVERT. Prisoners and HIV/AIDS. 2014 3) CDC. HIV in Correctional Settings. 2012. 4) U.S. Department of Justice. HIV in Prisons, 2001-2010. Bureau of Justice Statistics. 2015.
    - Often, the correctional system is the first place where justice-involved persons are diagnosed with HIV.
    - HIV prevalence is approximately 2.4 times greater among justice-involved population than in the general population.
    - Also, New York State, along with California, Florida and Texas, has one of the highest number of HIV-positive justice-involved individuals in the continental U.S. In 2010, approximately 3,200 NYS justice-involved individuals were HIV-positive. Sources: Iroh P, Mayo H, Nijhawan A. The HIV Care Cascade Before, During, and After Incarceration: A Systematic Review and Data Synthesis. American Journal of Public Health. 2015; 105:e5-e16



Latinos and Incarceration

- There are large ethnic/racial disparities among justice-involved individuals in the United States.
- Latinos represent one such group. There are 4.5 justice-involved Latinos for every 1 justice-involved White individual in New York State. Mauer, M. Uneven Justice: States Rates of Incarceration by Race and Ethnicity, The Sentencing Project. 2007.

Latinos in NYC

- A quarter of all Latinos in the U.S. are living below the poverty line. The median income of Latinos in the U.S. is $42,491 compared to $60,256 among Whites. Denavas-Waslt, C. and Proctor, B. D. (2015). Income and Poverty in the United States: 2014. U.S. Census Bureau.
- In 2014, 2.4 million Latinos lived in New York City, comprising 29% of the city population. U.S. Census Bureau Fact Finder: Profile of General Population and Housing Characteristics: 2014

Demographic Profile Data, New York City.

Latino Origin Groups in New York City

Latino Origin Group	% of Total Latinos	Latino Population
Puerto Rican	29.9%	1,095,858
Dominican	22.0%	806,078
Mexican	13.5%	494,290
Ecuadorian	7.6%	278,291
Salvadoran	5.2%	189,201
Colombian	4.3%	156,023
Others	17.5%	642,301

52%

65%

Puerto Ricans, Dominicans and Mexicans comprise nearly 2/3 of the NYC Latino population.

Center for Latin American, Caribbean & Latino Studies. Latino Population of New York City, 2009. City University of New York; Center for Latin American Studies. Mexicans in New York City, 1990-2009: A Visual Database. City University of New York. Source: U.S. Census Bureau, The Hispanic Population: 2011.

Poverty among Latinos in New York City: U.S. Census Bureau. (2013). Poverty Status in the Past 12 Months. 2013. American Community Survey. Fact Finder.

- An estimated 30% of Latinos in New York City are living below the poverty level compared to 12% of the White population.
- Latinos tend to reside in neighborhoods where there are higher levels of poverty.
- Percent of Latinos living in poverty in: Bronx: 39%, Brooklyn: 33%

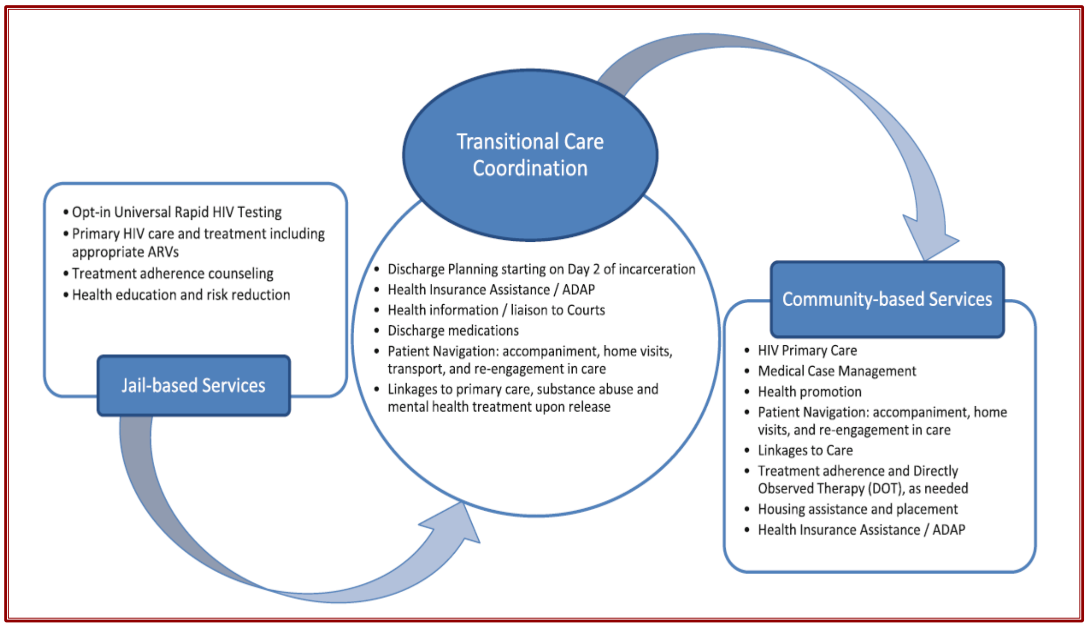
Latinos and HIV with concurrent AIDS diagnosis:

- Latinos account for 30% of all new HIV diagnoses and are more likely to receive a concurrent AIDS diagnosis than any other racial/ethnic group. Karpati A, Kerker B, Mostashari F, Singh T, Hajat A, Thorpe L, Bassett M, Henning K, Frieden T. Health Disparities in New York City. New York: New York City Department of Health and Mental Hygiene, 2004; New York City Department of Health and Mental Hygiene. (2015). HIV Surveillance mid-year report, 2014. Epi Data Brief (2014). Uninsured Adults in New York City. March 2014. No 43.

Program description

New York City Correctional Health Services (NYC CHS), a unit of NYC Health + Hospitals, uses the evidence-informed Transitional Care Coordination (TCC) intervention for people living with HIV, and other chronic health conditions, to support the transition from jail to community health services after incarceration. TCC services include transitional health care planning, assistance with benefits, court advocacy, and referrals to health care and other community-based providers to meet patient survival and basic needs including HIV primary care, substance use treatment, mental health services, housing and ongoing medical case management as needed.

Figure 1: Transnational Care Coordination Model

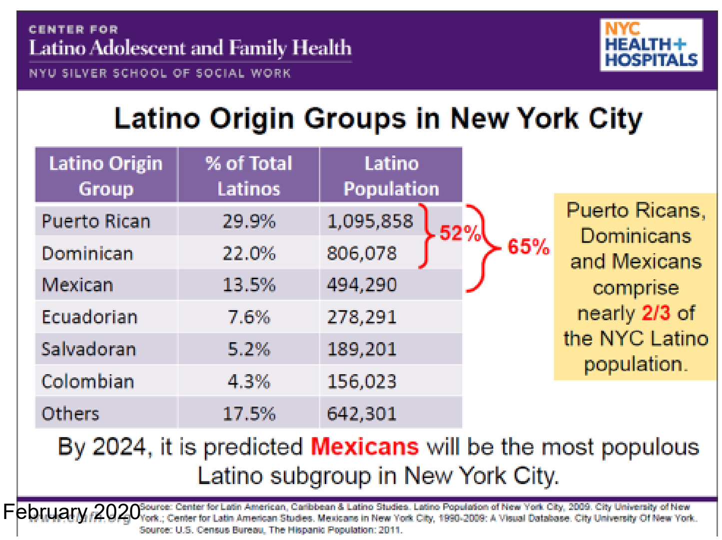


Transitional Care Coordination Intervention

In 2006, NYC CHS developed a population based approach for serving HIV patients incarcerated in NYC jails that spans all stages of the HIV care continuum from HIV testing to viral suppression. The Transitional Care Coordination intervention (see Figure 1. - Diagram of Model) includes universal HIV testing to all persons at jail medical intake, health education and risk reduction sessions, Primary HIV Care and treatment including antiretroviral medications, for all newly diagnosed and self-reporting HIV patients, as well as medication adherence counseling and support, and transitional care coordination that links patients to community-based healthcare and other support services after incarceration (Figure 1). To guide provision of the comprehensive services, NYC set four goals for patients to: 1) know their HIV status prior to release, 2) receive comprehensive health and HIV care, 3) have at least one face-to-face session with a health educator or patient care coordinator prior to release, and 4) be linked to a community health provider within 30 days after incarceration. NYC CHS PCCs are an integral part the TCC intervention as they meet with HIV patients within 48 hours of jail intake, assess their needs related to healthcare and other areas (e.g., housing, substance abuse treatment), and begin the process of linking them to community-based services, benefits, and entitlements. [For a detailed description see https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-dissemination-evidence-informed-interventions; https://nextlevel.careacttarget.org/deii/jails]

Cultural Competency Training

The purpose of the NYC Latino SPNS project is to provide culturally competent care to HIV patients of Puerto Rican origin at all stages of the HCCM. We do this by implementing two interventions; the first intervention is providing system-wide cultural competency trainings to jail- and community-based providers who provide services and health care to people of Puerto Rican origin who are living with HIV. The training, *Culturally Appropriate Engagement and Service Delivery with Puerto Ricans: A Transnational Approach to Enhance Linkage and Retention to HIV Primary Care*, is developed and delivered by New York University's Center for Latino Adolescent and Family Health (CLAFH). Training attendees will include jail- and community-based providers at all levels including clinical (e.g., doctors, nurse practitioners, physicians assistants), mid-level staff (e.g., social workers, nurses and their supervisors), and support staff (e.g., patient care coordinators, medical assistants, patient navigators,



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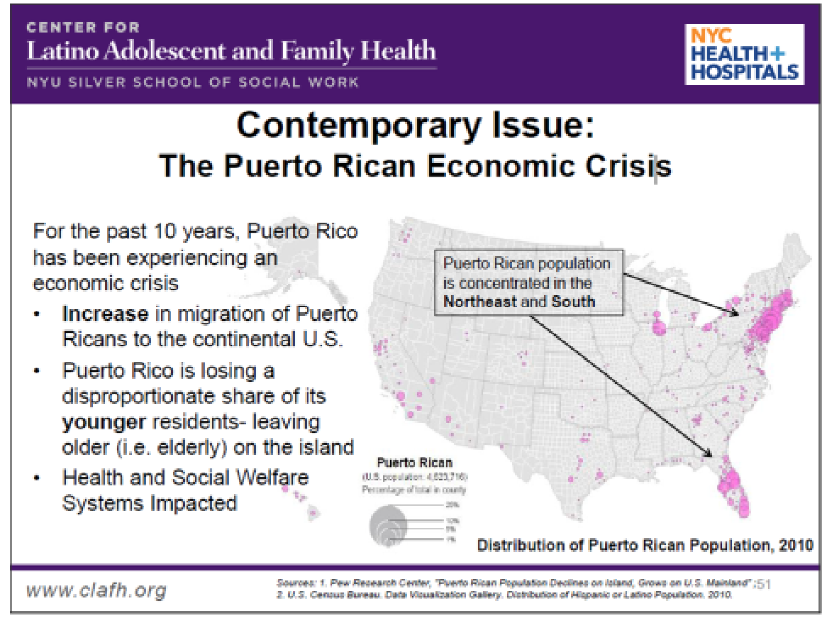
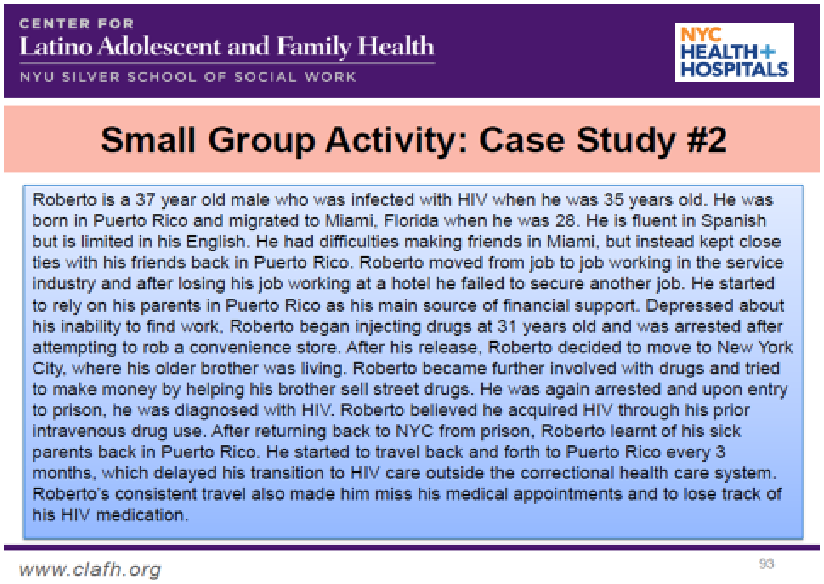
receptionists, residential assistants).





Matching Clients of Puerto Rican Origin to Care Coordinators of Puerto Rican Origin

The second intervention is matching Puerto Rican HIV patients with Puerto Rican patient care coordinators (PCCs) in NYC jails to see if matching by ethnicity improves linkage and retention in HIV primary care. PCCs will work one-on-one with HIV patients using the TCC intervention to connect clients to community-based healthcare and other services after incarceration, and to offer additional support such as medication adherence counseling, assistance with entitlements, benefits, and Medicaid, and transportation for after release.

Core Intervention Staff

Project Manager

The Project Manager coordinates all aspects of the intervention with jail and community-based staff and community partners.

The Project Manager is responsible for:

- Being the point of contact for the intervention and providing oversight of the project;
- Providing administrative supervision to the care coordinators and the data manager;
- Serving as the health liaison to the courts; and
- Serving as the liaison with Department of Corrections (DOC) staff, the Dissemination and Evaluation Center (DEC), and the Implementation Technical Assistance Center (ITAC).

Care Coordinator

The care coordinator has five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care.

Patient engagement during incarceration. The Care Coordinator is responsible for:

- Client engagement and assessment during the client's jail stay; and
- Conducting care coordination with jail- and community-based organizations.

Patient education. The Care Coordinator is responsible for:

- Providing patient education on HIV, including treatment adherence, risk reduction as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.).

Discharge planning. The Care Coordinator is responsible for:

- Assessing client needs;
- Developing a plan with client to address basic needs;

- Identifying resources to facilitate access to community health care; and
- Scheduling initial linkage appointment.

Care coordination for care upon release. The Care Coordinator is responsible for:

- Completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration;
- Arranging discharge medications and prescriptions; and
- Obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts).

Facilitating a warm transition to the community and linking a client to care. The Care Coordinator is responsible for:

- Accompanying individuals who are newly released to appointments to ensure connection to care;
- Coordinating community-based HIV care linkage services;
- Providing home visits, appointment accompaniment, or transportation;
- Conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care;
- Assessing and addressing basic needs like housing, food, clothing, etc.; and
- Facilitating a case transfer for the client to the standard of care after 90 days post-incarceration.

Clinical Supervisor

The Clinical Supervisor is responsible for:

- Participating in case conferencing (as needed);
- Providing monthly (or as requested) individual clinical supervision to care coordinators; and
- Providing monthly group clinical supervision to intervention team (as needed)

Staff Characteristics

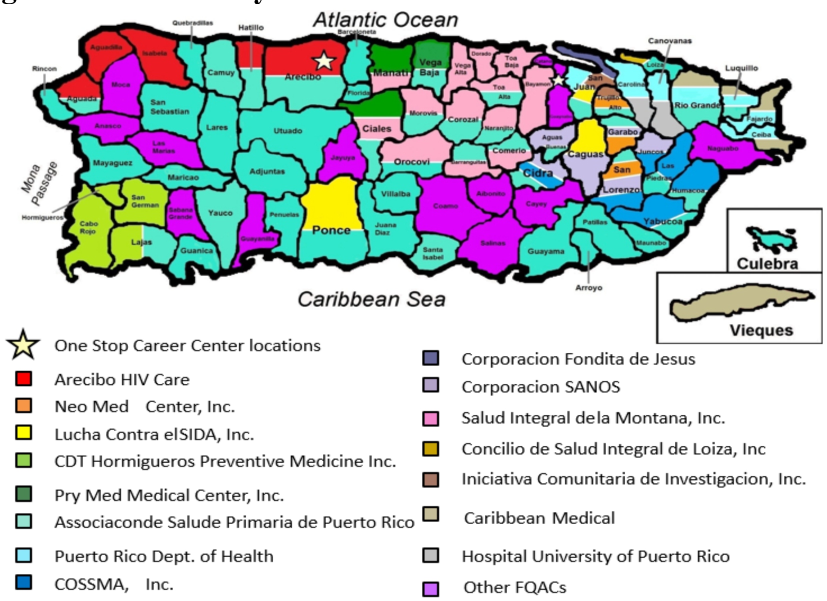
All staff involved in the intervention need to be:

- Able to deliver culturally appropriate services.
- Non-judgmental and demonstrate empathy, professionalism, boundaries around personal philosophy/belief systems.
- Genuinely interested in working with people incarcerated in jails.
- Reflective of racial and ethnic backgrounds of client population with language ability as appropriate to meet client needs (as practicable).
- Able to meet Department of Corrections' security clearance criteria.
- Willing to conform to Department of Corrections' policies and are cognizant of guidelines regarding justice-involved persons working in jail.

Program planning and development

- Startup steps
- Staff hiring, initial training and development, developing MOUs and partnerships, developing administrative and provider support and buy-in as well as recruitment strategies were developed. MOUs were developed across Puerto Rico to facilitate linkages to care for people who may be seeking to return to Puerto Rico after incarceration (see Figure 2. for community health center locations with MOU in place to receive patients after incarceration in Puerto Rico).

Figure 2: Community Health Center Locations



Formative Evaluation: Qualitative Interviews

Formative evaluation helped inform the intervention development. Twenty-four HIV patients of Puerto Rican origin incarcerated on Rikers Island were interviewed using a semi-structured interview guide. Patients were asked questions related to their HIV diagnosis, their healthcare experiences immediately after diagnosis, recent healthcare experiences in the community, and their jail-based healthcare experience including transitional care coordination. Patients were also asked about their history of taking antiretroviral medications, their medication adherence prior to and during the incarceration, and their HIV lab values. Finally, interviewers also questioned participants about whether they've experience stigma in healthcare related to HIV status, Puerto Rican ethnicity, or their history of incarceration, and asked them about their housing situation, social support, and transnational connections with Puerto Rico. Evaluation results were shared with CLAFH as they developed the training curriculum and with PCC to lend insight to their work with Puerto Rican clients.

Curriculum Development

The training curriculum was developed in an iterative process by CLAFH with guidance and input from CHS. First, training needs were identified, including key knowledge areas related to healthcare access among Puerto Ricans, HIV/AIDS among Puerto Ricans, and the interconnected epidemics of incarceration and HIV among Puerto Ricans. Strategies for improving HIV primary care among Puerto Ricans were also identified including the Cultural Formulation framework and the Shared Decision-Making model. The curriculum addresses the import of provider-level strategies and the use of case studies and group interaction/discussion as a learning technique.

Cultural Competency Training

The training workshops have five main objectives: 1) to provide an epidemiological profile of Puerto Ricans and the Latino community with a special focus on HIV, 2) to highlight the interconnected epidemics of HIV/AIDS and incarceration, 3) to review the National HIV/AIDS Strategy, 4) to introduce cultural and transnational frameworks to enhance efficacy of health care delivery, and 5) to discuss strategies to improve linkage, retention, and care coordination in HIV primary care.

The training was delivered in three formats depending upon the target audience and length of the training. The clinical staff (e.g., doctors, nurse practitioners, physicians' assistants) attended an hour and a half grand rounds training, mid-level staff (e.g., social workers, nurses and their supervisors) attended a half-day training, and support staff (e.g., patient care coordinators, medical assistants, patient navigators, receptionists, residential assistants) attended a full-day training. The training covered all workshop objectives regardless of training length or target audience. Onsite training attendees are administered pre- and post-training surveys to evaluate the training. A web-based training is being developed and continuing education units will be offered to attendees to bolster enrollment.

1. GRAND ROUNDS (60-90 minutes)	**2. HALF DAY** (4 hours) *Includes Grand Rounds content*	**III. FULL DAY** (8 hours) *Includes Grand Rounds and Half Day content*
Phase I: Health Care Utilization • Strategies for improving access to primary care – Present Cultural Formulation (CF) model, Transnationalism, DECIDE, and Shared Decision Making (SDM) models	**Phase I: Health Care Utilization** • Brainstorm activities on factors influencing health care utilization • Critical analysis of Cultural Formulation model	**Phase I: Health Care Utilization** • Small group activities and DECIDE role-playing exercise • Phase I closure activity: case study and review
Phase II: HIV/AIDS Among Latinos • The HIV Care Continuum for Latinos • HIV incidence and prevalence rate among Latinos	**Phase II: HIV/AIDS Among Latinos** • Critical analysis and case study incorporating the Cultural Formulation, DECIDE, and Shared Decision Making (SDM) models	**Phase II: HIV/AIDS Among Latinos** • Small group activity on the barriers and facilitators to HIV care • Phase II closure activity and review
Phase III: Incarceration and HIV: Interconnected Epidemics • Epidemiological data on justice-involved Latinos as HIV-positive patients • Contextual factors of incarceration that influence HIV-positive patients in correctional settings	**Phase III: Incarceration and HIV: Interconnected Epidemics** • Critical analysis and case study incorporating the Cultural Formulation, DECIDE, and Shared Decision Making (SDM) models	**Phase III: Incarceration and HIV: Interconnected Epidemics** • Small group discussions on linkages between incarceration and HIV • Inclusion of Phase III review

Intervention Outcomes

In total, CHS delivered 10 trainings titled "Culturally Appropriate Engagement and Service Delivery with Puerto Ricans: A Transnational Approach to Enhance Linkage and Retention to HIV Primary Care."

- 4 grand rounds for doctors, nurse practitioners, and clinical supervisors (60-90 minutes)
- 3 half day trainings for mid-level practitioners including social workers and nurses
- 3 full day trainings for case managers, patient care coordinators, navigators, and other support staff

Trainings were conducted in both jail (n=4) and community (n=6) settings:

- 47% of people trained were jail-based providers
- 53% of people trained were community-based providers

Trained over 450 providers from over 60 community partner organizations

Trainings included materials specific to the transnational approach and to working with people of Puerto Rican origin who are living with HIV.

Training evaluation findings: The curriculum was evaluated with a pre-post design, adapting the Cultural Competence Assessment (CCA) instrument as the primary indicator of curriculum effectiveness. Participants showed statistically significant ($p<.05$) improvements in mean pre-post test scores across four CCA sub-domains:

- Culturally appropriate patient assessment (Mean prepost difference (MD): 1.29 [95%CI 0.68-1.89], d=0.32),
- Cultural knowledge (MD: 0.67 [95%CI 0.43-0.92], d=0.33),
- Capacity to address patient barriers (MD: 0.37 [95%CI 0.13-0.62], d=0.36),
- Use of external resources (MD: 0.85 [95%CI 0.52-1.17], d=0.20).

Lessons Learned

- If others were to try to replicate your program, what are the lessons learned that you would like to share with them?
- There is limited information and resources available for specific Latino groups and generalizations are often not useful when discussing culturally appropriate engagement.
- Cultural appropriateness trainings are beneficial to engagement and linkage to care and treatment.
- Matching patients to staff of similar ancestry / origin is practicable, if given management support and data that shows and positive correlation.