

Intervention: Enlaces por la Salud

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



Content developed by the University of North Carolina, Chapel Hill demonstration site staff with support from the Evaluation and Technical Assistance Center Team at UCSF

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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 comprise 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 larger 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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Acknowledgments

We would like to acknowledge the nine demonstration sites for their contributions to this monograph as well as their dedication to the clients served by this initiative over the past five years.

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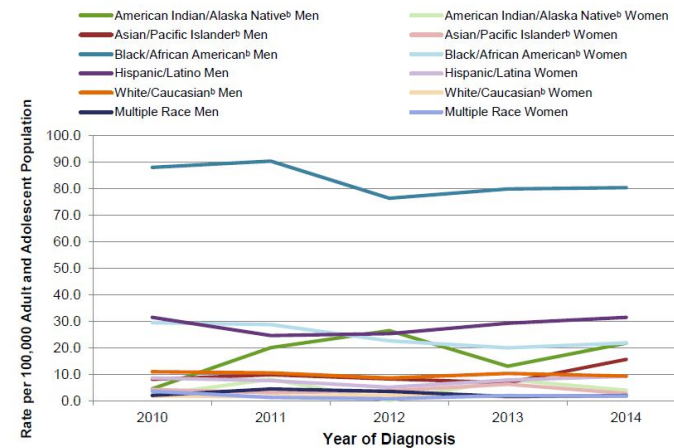
*Finding, Linking, and Retaining Mexican Men & Transgender
Women in HIV Care*



Enlaces staff implementing intervention in Charlotte, North Carolina

Local Epidemiology

Figure 7. North Carolina Newly Diagnosed Adult and Adolescent HIV Infection^a Rates by Gender and Race/Ethnicity, 2010-2014



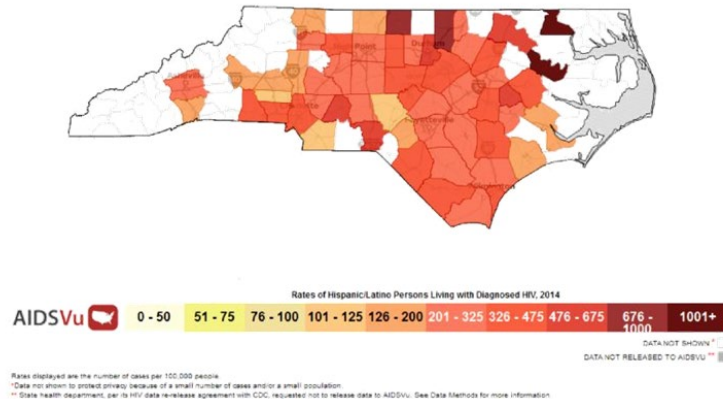
Note: Rates for unknown and other race/ethnicity categories are not calculated due to lack of population data.

^aHIV infection includes all newly reported HIV infected individuals by the year of first diagnosis, regardless of the stage of infection (HIV or AIDS).

^bNon-Hispanic/Latino.

Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 25, 2015).

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 population¹¹. 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 more²⁵ 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

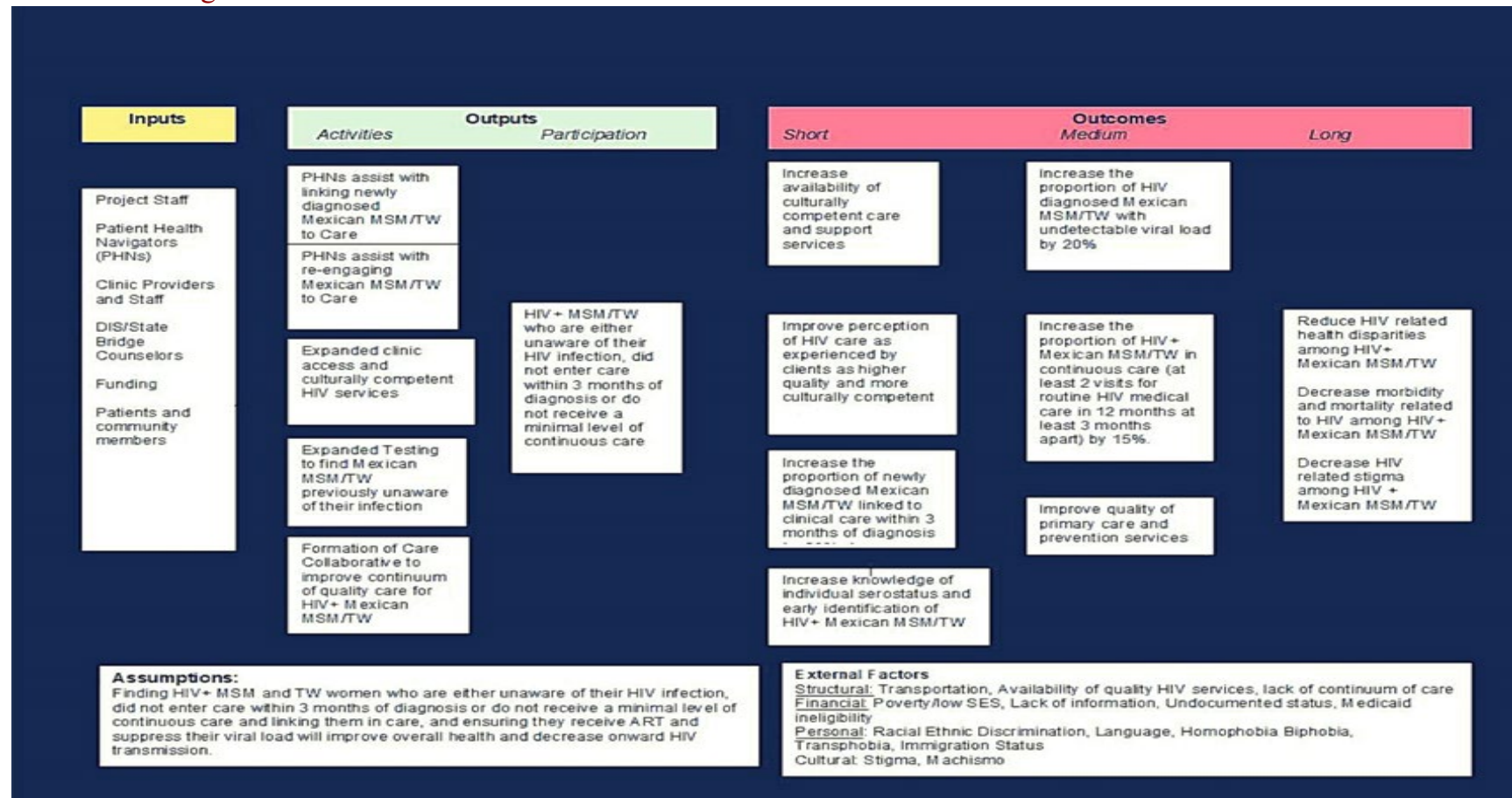


Six intervention sessions with corresponding transnational goals and content outline

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
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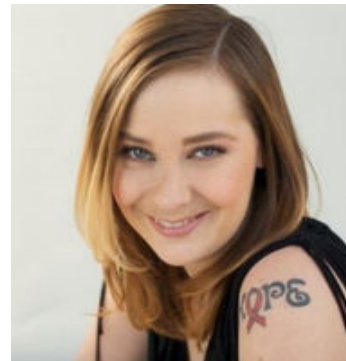


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Staffing Requirements

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.



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.

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