Intervention: Warm Transitions

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

Content developed by the New York City Health + Hospitals Correctional Health Services demonstration site staff with support from the Evaluation and Technical Assistance Center Team at UCSF

Contents

Introduction 2

NY City Health + Hospitals Correctional Health Services 114

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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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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New York City Health + Hospitals Correctional Health Services

Project Name: “Warm Transitions” for Puerto Ricans after Incarceration

Location: New York, New York

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.

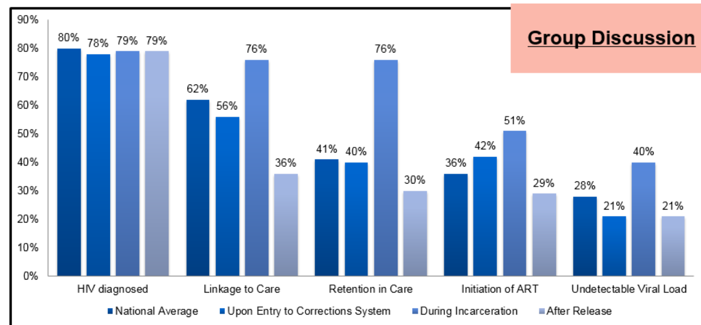
Other data to potentially include:

- <u>HIV Epidemiology in NYC</u>:
    - 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

- Interconnected epidemics of mass incarceration and HIV 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% (Puerto Rican + Dominican); 65% (Puerto Rican + Dominican + Mexican)

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

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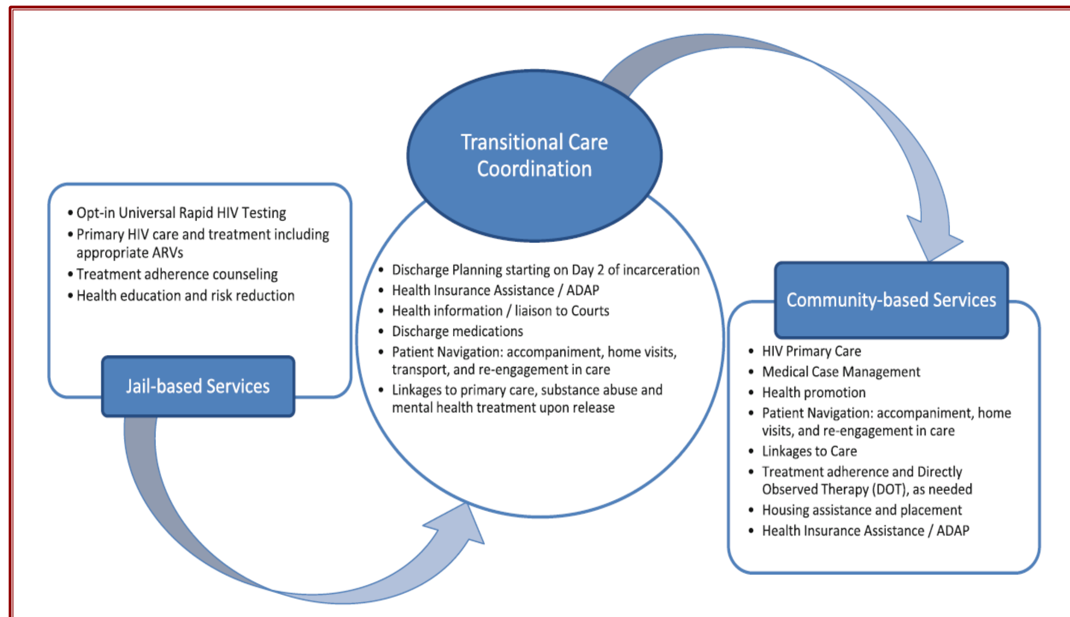
Program description

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, receptionists, residential assistants).

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Latino Origin Groups in New York City

Latino Origin Group	% of Total Latinos	Latino Population
Puerto Rican	29.9%	1,095,858
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Others	17.5%	642,301

52% (Puerto Rican, Dominican)
65% (Puerto Rican, Dominican, Mexican)

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

By 2024, it is predicted **Mexicans** will be the most populous Latino subgroup in New York City.

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Source: 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.

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Contemporary Issue:
The Puerto Rican Economic Crisis

For the past 10 years, Puerto Rico has been experiencing an economic crisis

- **Increase** in migration of Puerto Ricans to the continental U.S.
- Puerto Rico is losing a disproportionate share of its **younger** residents- leaving older (i.e. elderly) on the island
- Health and Social Welfare Systems Impacted

Puerto Rican population is concentrated in the **Northeast** and **South**

Puerto Rican

Distribution of Puerto Rican Population, 2010

www.clafh.org
Sources: 1. Pew Research Center, "Puerto Rican Population Declines on Island, Grows on U.S. Mainland" ;51
2. U.S. Census Bureau. Data Visualization Gallery. Distribution of Hispanic or Latino Population. 2010.

NYC HEALTH+ HOSPITALS

New York City Jail System

Brooklyn Detention Center
Manhattan Detention Center
Vernon C. Bain Center, Bronx

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NYC HEALTH+ HOSPITALS

Small Group Activity: Case Study #2

Roberto is a 37 year old male who was infected with HIV when he was 35 years old. He was born in Puerto Rico and migrated to Miami, Florida when he was 28. He is fluent in Spanish but is limited in his English. He had difficulties making friends in Miami, but instead kept close ties with his friends back in Puerto Rico. Roberto moved from job to job working in the service industry and after losing his job working at a hotel he failed to secure another job. He started to rely on his parents in Puerto Rico as his main source of financial support. Depressed about his inability to find work, Roberto began injecting drugs at 31 years old and was arrested after attempting to rob a convenience store. After his release, Roberto decided to move to New York City, where his older brother was living. Roberto became further involved with drugs and tried to make money by helping his brother sell street drugs. He was again arrested and upon entry to prison, he was diagnosed with HIV. Roberto believed he acquired HIV through his prior intravenous drug use. After returning back to NYC from prison, Roberto learnt of his sick parents back in Puerto Rico. He started to travel back and forth to Puerto Rico every 3 months, which delayed his transition to HIV care outside the correctional health care system. Roberto's consistent travel also made him miss his medical appointments and to lose track of his HIV medication.

www.clafh.org 93

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

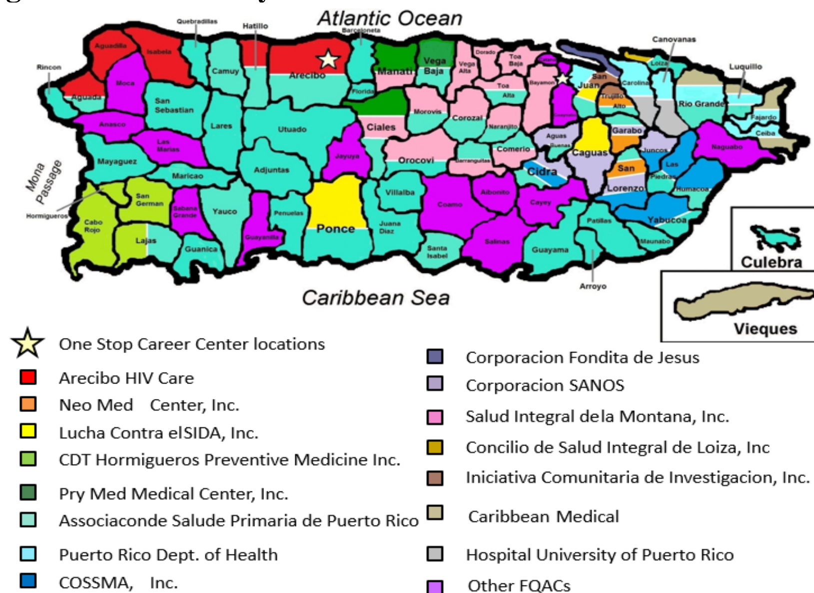
All staff involved in the intervention need to be:

- 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.