

# Intervention: Proyecto Promover

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



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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,<sup>i</sup> they account for 21% of people living with HIV and are infected at a rate three times higher than their non-Latino white counterparts.<sup>ii</sup> 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.<sup>iii</sup> This may be attributed in part to the higher rates of delayed HIV diagnosis and delayed engagement in care among Latinos,<sup>iv</sup> which has been associated with poor health outcomes.<sup>v,vi</sup> Rates of delayed diagnosis and engagement in care are even more pronounced among foreign-born Latinos<sup>vii</sup> 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.<sup>viii</sup>

### 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.<sup>ix,x</sup> 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.<sup>xi,xii</sup> Structural barriers that particularly affect Latinos include lack of bilingual services in Spanish, low rates of health insurance coverage, and lack of transportation.<sup>xii</sup> For Latinos who are not citizens or in the US with official documents, fear of deportation can also reduce willingness to access care.<sup>xiii,xiv</sup>

*Cultural factors* can also result in delays when Latina/os living with HIV, particularly immigrants, enter medical care.<sup>xv,xvi</sup> 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.<sup>xvii,xviii</sup> 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.<sup>xix</sup> 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.<sup>xx</sup>

### 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,<sup>xxi,xxii</sup> 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.<sup>xxiii</sup> As a result, health seeking behavior may be influenced by more than one culture.<sup>xxiv</sup> The transnational framework looks specifically at the social, political, social and cultural ties of an immigrant to their place of origin.<sup>xxiii-xxv</sup> 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

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## 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>1</sup>

The interplay between structural/financial and socio-cultural barriers contributes to health disparities affecting Latino PLWHA.<sup>1,3</sup> 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<sup>1</sup>)

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.<sup>4,5</sup> 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.<sup>4,6</sup> 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.<sup>2,7</sup> 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/mm<sup>3</sup>.<sup>7</sup>

## 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.<sup>8,9</sup> 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).<sup>10,11,12</sup> A diagram of socio-ecological risks and resources is summarized in Figure 1.

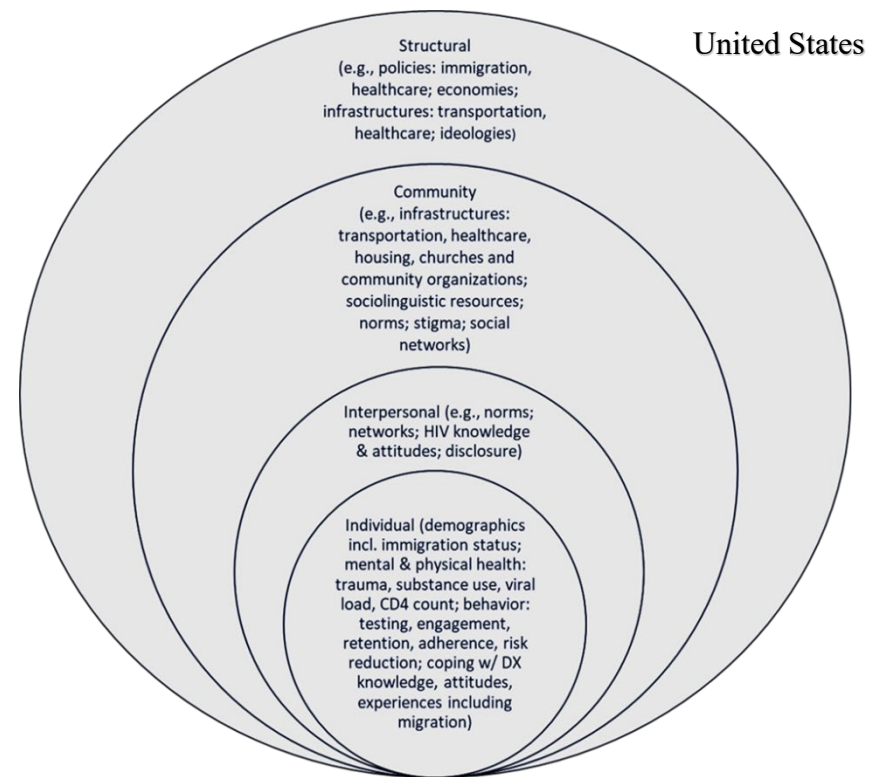


The cultural values of *familismo*, *personalismo* and *respeto* were guiding principles for the key interventionists, Clinical Patient Navigators (CPN), in their efforts to develop rapport and deepen the relationships with patients. *Familismo* is a strong identification and attachment to one's family (nuclear and/or extended).<sup>4,6</sup> 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.

**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

**Figure 1: Socio-ecological framework**



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**



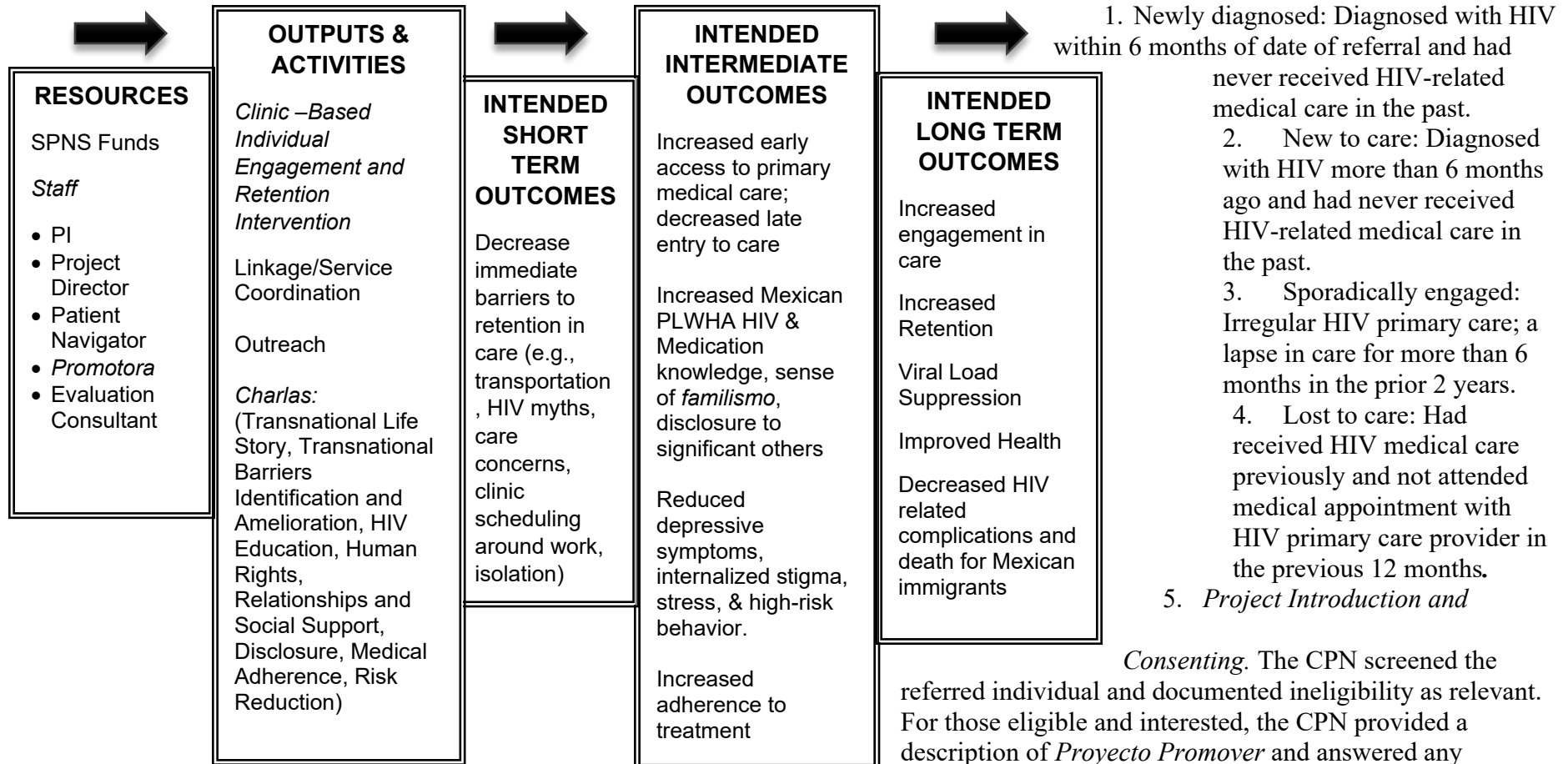
To further understand our participants' transnational lives, we incorporated a migration interview as part of our intervention. The migration interview helped to inform our understanding of our participants' connections to Mexico. Specifically, why and under what conditions they decided to migrate; what 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

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

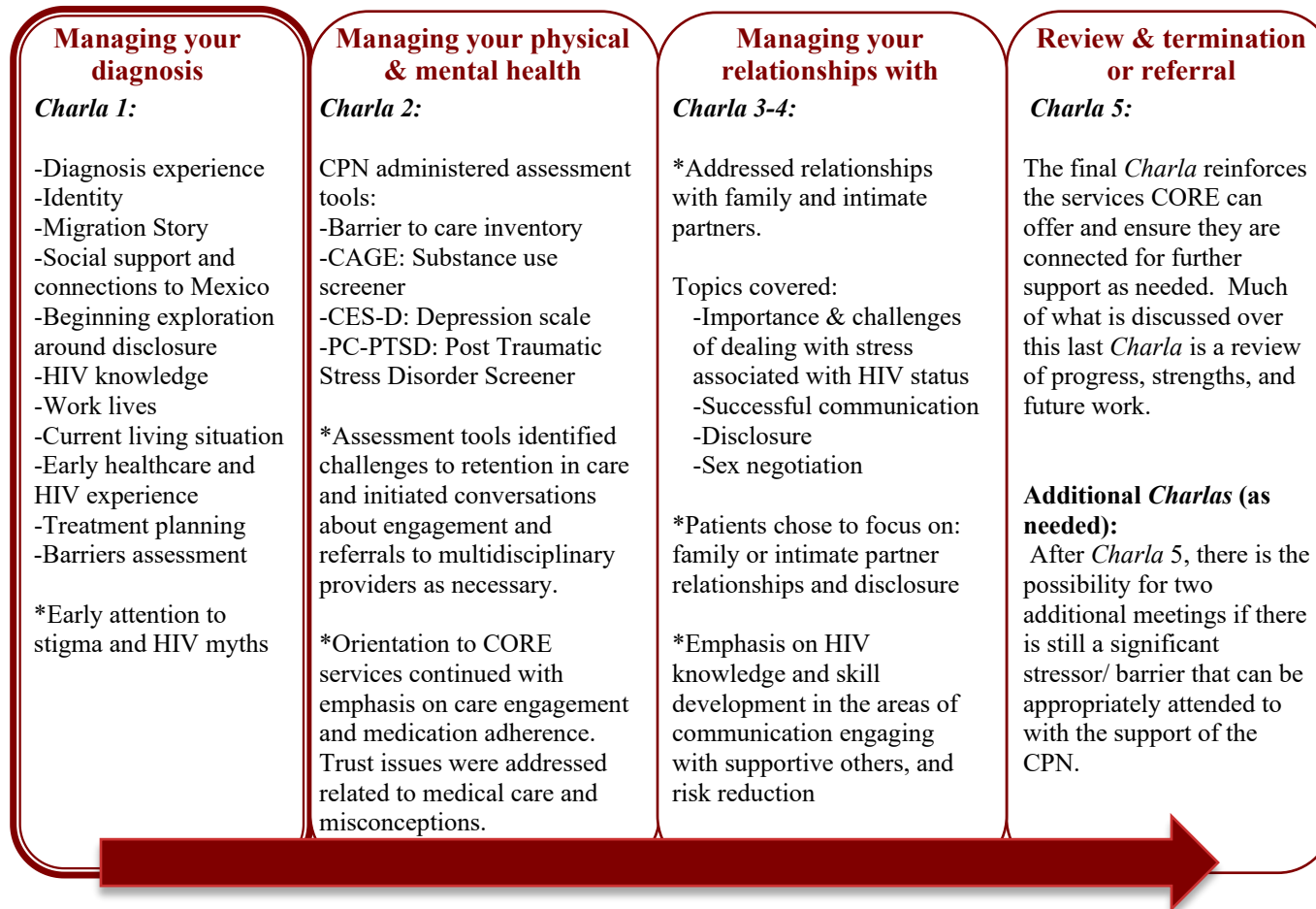
health and substance abuse concerns (*Charla* 2). *Charlas* 1 and 2 focused on managing diagnosis and physical and mental health. Subsequent *Charlas* focused on managing relationships with others. CPNs were prepared to personalize *Charla* topics in the order in which the participant felt was most important.

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**



**Table 1: Summary of *Promover* staff**

Title	Role
<b>Principal Investigator</b>	Provided overall direction and oversight to all aspects of the project.
<b>Project Director</b>	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.
<b>Local Evaluator</b>	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.
<b>Clinical Patient Navigators &amp; Promotora</b>	The clinical patient navigators Took the lead in the implementation of clinic level <i>Charla</i> intervention including: screening, recruitment, engagement and retention of study participants. The <i>promotora</i> 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**



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.



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.

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## 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.

### 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



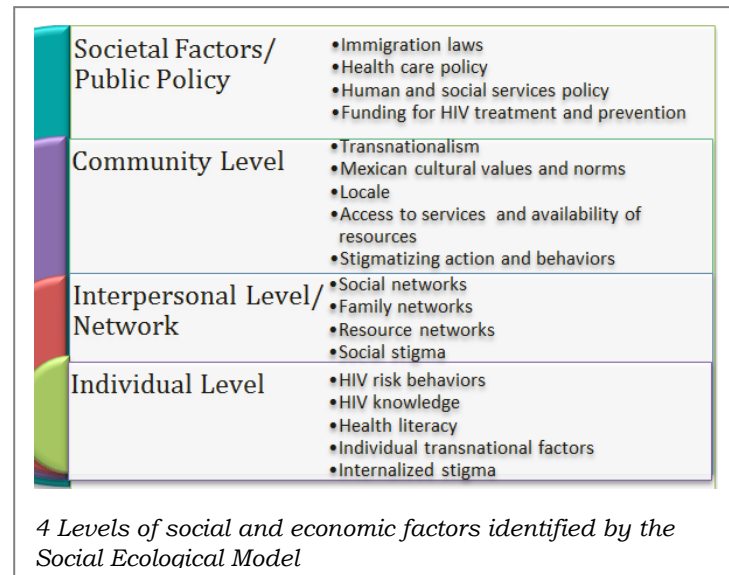
*Prism Health North Texas'*

*Administrative Offices*

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 et 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.



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).

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




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.



 <p>Social</p>	<p><i>Social factors</i> 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.</p>	 <p>Economic</p>	<p><i>Economic factors</i> 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.</p>
 <p>Migrational</p>	<p><i>Migrational factors</i> 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.</p>	 <p>Other</p>	<p><i>Other transnational factors</i> 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.</p>
<p><i>Transnational domains explored by the Viviendo Valiente Program</i></p>			

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

 <p>Cultural Values / Norms</p>	<p><i>Cultural values and norms</i> include holidays celebrated, cultural traditions practiced, rituals performed, and more. Examples include being homesick during holidays and celebrating traditional Mexican holidays such as <i>El Dia de Los Muertos</i> (Day of the Dead).</p>
 <p>Religious/Spiritual</p>	<p><i>Religious and spiritual factors</i> 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.</p>
 <p>Language</p>	<p><i>Language factors</i> 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.</p>
<p><i>Cultural factors explored by the Viviendo Valiente Program</i></p>	

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*

<b>Problem Statement:</b>	People of Mexican origin in Dallas, Texas are not getting tested for HIV and/or accessing HIV medical care.
<b>Intervention Goal:</b>	To link individuals who are HIV positive and who identify as being of Mexican origin to care expeditiously, by reducing barriers to services.
<b>Intervention Objectives</b>	<ol style="list-style-type: none"> <li>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).</li> <li>2. Ensure care access and treatment engagement for those who are HIV positive.</li> <li>3. Remove barriers to HIV medical care.</li> </ol>

	BARRIERS	ACTIVITIES	OUTPUTS*	INTERMEDIATE OUTCOMES*	LONG-TERM OUTCOMES
<b>INDIVIDUAL LEVEL</b>	Lack of HIV knowledge (acquisition, transmission, testing resources, health care options)	<p><b>Encourage</b> individuals at high risk for HIV/STI infection to get tested using appropriate tangible reinforcements</p> <p><b>Promote</b> testing among partners and social networks of HIV positive individuals, using appropriate tangible reinforcements</p> <p><b>Provide</b> risk reduction counseling to individuals</p>	<p><b>X</b> people will be referred for HIV testing</p> <p><b>X</b> HIV positive people will engage in the ARTAS intervention, if appropriate</p> <p><b>Promotores</b> will maintain contact with client based on</p>	<p><b>X</b> people will test for HIV</p> <p><b>X%</b> of participants will successfully complete ARTAS intervention</p> <p><b>X%</b> of those who test HIV positive will be linked to HIV care</p>	<p><b>Increase in # of people that</b></p> <ul style="list-style-type: none"> <li>- test for HIV</li> <li>- engage in HIV care</li> <li>- are retained in HIV care</li> </ul>
	Low perceived risk				

	HIV stigma	<p>at high-risk for HIV</p> <p><b>Assess</b> HIV positive individuals for acuity/need and ongoing engagement in medical care</p> <p><b>Utilize</b> 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</p>	acuity/need level		
	<b>GROUP LEVEL</b>	<p>Lack of HIV knowledge (acquisition, transmission, etc.)</p> <p>Low perceived risk</p> <p>HIV stigma</p>	<p><b>Provide</b> the four-session health education program</p>	<p><b>X</b>, four-session interventions will be conducted</p>	<p><b>X%</b> of participants will identify HIV testing resources</p> <p><b>X%</b> of participants will identify HIV treatment resources</p> <p><b>X%</b> of participants will correctly identify modes of HIV acquisition and transmission</p> <p><b>X%</b> of</p>

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

\*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.
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*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.

### *Individual level intervention*

**For  
- HIV positive individuals**

**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:

<b>Acuity Assessment Categories</b>			
	High Acuity (45+) ↓	Moderate Acuity (29- 44) ↓	Low Acuity (14-28) ↓
<b>Minimum standard contact frequency</b>	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**

**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.

**For**  
**-HIV positive**  
**-HIV negative**  
**-HIV status unknown**

**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.

### *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*.

*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*.

**For**

**-HIV positive**

**-HIV negative**

**-HIV status unknown**

### *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: <i>Oak Cliff Clinic</i> and <i>South Dallas Clinic</i> , 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*

- Enrollment limitations - 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*

- Development of partnerships – Viviendo Valiente leverages partnerships with various service organizations – both within and outside of the HIV service arena – to gain access to the priority community.
- Development of referral sources – 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,

### Cost of Intervention

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

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

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.

\* *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.

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