WEBINAR VIDEO TRANSCRIPT

iHiP Webinar

Culturally Appropriate Interventions of Outreach, Access, and Retention Among Latino[a] Populations

18 June 2019

ANGEL JOHNSON: Good afternoon, everyone. My name is Angel Johnson, and I'll be moderating today's webinar on Improving Health Outcomes—Moving Patients Along the HIV Care Continuum. This is the third webinar in our four-part series being brought to you by the HRSA Special Projects of National Significance, SPNS, program. So as you can see by our agenda for today, I will provide a brief overview about the Special Project of National Significance and the Integrating HIV Innovative Practices project, or IHIP. We will then hear from our presenters, who will discuss their SPNS Latino initiative.

Our first speaker today is Dr. Laura Bamford, MD, with Philly FIGHT, Philadelphia, Pennsylvania. Dr. Laura Bamford is a clinical assistant professor of medicine at the Perelman School of Medicine at the University of Pennsylvania. She is also the medical director of Clinica Bienestar in a staff position at that Jonathan Lax Treatment Center. Dr. Bamford is board certified in internal medicine and infectious diseases. Her specialties are in the areas of engagement in HIV and hepatitis C virus care as well as management of opiate use disorders.

We'll also hear from Dr. Patricia Aguado with Ruth M. Rothstein CORE Center in Chicago, Illinois. Dr. Aguado, PhD, is a bilingual, bicultural social worker with over 15 years of practice and research experience in the field of HIV/AIDS specializing in HIV-positive, Spanish-speaking immigrant populations. She has experience in conducting mental health and substance use assessments, individual therapy, peer and student supervision, and the evaluation of HIV training programs. She is currently an assistant professor at Northeastern Illinois University, a federally designated Hispanic-serving institution and the project director of Proyecto Promover, a HRSA SPNS federal grant focused on engaging and retaining Mexicans in HIV care. Following these presentations, we will open the lines and take questions.

The SPNS program is funded through part F of the Ryan White HIV/AIDS program and provides opportunities for developing, implementing, and assessing innovations designed to meet national goals to end the HIV epidemic and address the evolving nature of our health care delivery system. The SPNS program remains current by addressing emerging issues in HIV care and populations most affected by HIV. There are currently 69 grant recipients providing clinical and support services to over 9,000 individuals living with HIV.
Initially, the SPNS program was challenged by finding ways to effectively disseminate information about successful SPNS models of care and the lessons learned to help other providers replicate these interventions. However, through the IHIP Project, SPNS effectively promotes, markets, and disseminates strategies to support optimal implementation of these models. The IHIP strategies used to disseminate SPNS models include developing tools and resources such as implementation manuals, Intervention guides, and fact sheets to encourage replication, engaging stakeholders to increase reach of these tools, and provide capacity building assistance to support the replication of SPNS intervention models.

So now, without further delay, I'm going to turn things over to today's first presenter, Dr. Laura Bamford with Philly FIGHT. Immediately following Dr. Bamford, you'll hear from Dr. Patricia Aguado with CORE Center. Dr. Bamford.

LAURA BAMFORD: Yes, thank you, Miss Johnson. So I'm very fortunate, today, to present on the work that my amazing team is doing at Clinica Bienestar. And through the SPNS initiative, we were able to start an HIV clinic with those funds for people living in north Philadelphia, particularly those of Puerto Rican descent who didn't have access to this kind of care before Clinica Bienestar. And this is my disclaimer that our project was supported by the Health Resources Service Administration of the US Department of Health and Human Services under that grant number. And that's the funding that we received over a five-year period. And this is the outline of the presentation.

And then on to Clinica Bienestar—so Clinica Bienestar is a clinical collaboration between Philadelphia FIGHT Community Health Centers, which is a federally qualified health center in Philadelphia, and Prevention Point Philadelphia, which is Philadelphia's only harm reduction service center and syringe service program. And again, this clinic was founded with some of those funds from SPNS in an area of Philadelphia in north Philadelphia where, prior to Clinica Bienestar, there were a dearth of services for people living with HIV with a history of injection drug use of Puerto Rican descent.

A little bit of overview—Clinica Bienestar was built on decades of Prevention Point Philadelphia's expertise in harm reduction strategies and established trust in the community that they serve and simultaneously built on decades of Philadelphia FIGHT's expertise in providing high-quality HIV primary care. And again, Clinica Bienestar is located within Prevention Point Philadelphia's harm reduction service center. And this is at the epicenter, in Philadelphia, of the co-occurring epidemics of HIV, hepatitis C, and opioid use disorder. And what Clinica Bienestar has been able to achieve, which makes it so successful, is the collocation of medical services, social services, syringe exchange, and other harm reduction services so that none of our clients need to prioritize one life-sustaining intervention over another. And we deliver all these services in a culturally competent and nonjudgmental manner.

Then our capacity—we enrolled 53 participants living with HIV, of Puerto Rican descent, and a history of injection drug use into our demonstration project. And even though the project targeted individuals of Puerto Rican descent, from the beginning, we did not exclude anyone,
based on race or ethnicity, who needed our services. We now have a population of about 150 individuals living with HIV with a history of injection drug use. And to continue to expand our capacity, our future goals include expanding our clinical services by continuing to add additional clinic sessions to meet the growing need of our clinic and also, in the future, obtain funding for a PrEP program to particularly target individuals who inject drugs to prevent HIV.

How do we implement this project and establish the clinic? So our team includes one medical provider, myself, a nurse, a practice coordinator, and four medical case managers—so really, a small staff. But because we are able to communicate so effectively, it really works for our team. And each of us know what our roles are in supporting our clients. And also, our clients know—because we have this team-based approach, they know who to contact when—to meet their needs.

We have a very flexible scheduling of medical appointments. So both we have scheduled appointments for our patients who are able to keep appointments, but we also have walk-in appointments. We recognize that many of the patients that we see, it's difficult for them to keep track of the day of the week, the day of the month, let alone the time of day. And so we let people walk in when they need to see us. And we try to be as flexible as possible in creating as low a barrier access to our services as possible. And in keeping with our communication, at the end of each clinic day or clinic session, we huddle as a team to review the patients that we've seen that day and go over any outstanding needs and tasks that we need to complete to support our patients. And we also have quarterly staff meetings to discuss any programmatic concerns, and also, sometimes, even patient concerns.

So what were some of the challenges to starting this clinic and implementing this program? And I think one of the challenges and successes is bringing two organizations together in this collaboration. I think the success of that is tapping into the strengths of both organizations. And I think when we think about targeting patient populations that are particularly vulnerable, living with HIV, to engage them effectively in care, bringing together organizations that have expertise in different areas, to target particularly vulnerable populations is really important in the sense we took the clinic to north Philadelphia. So we partnered with Prevention Point Philadelphia from Philadelphia FIGHT and really brought the clinic to their harm reduction service center and into the neighborhood with the greatest need in Philadelphia.

And some of the challenges when you're collaborating with two organizations is getting on the same page about implementation. And I think, over time, again, with our effective communication, we've been able to make that a seamless transition in the same way that establishing—we had to build a clinic from the bottom up. And so we had to establish that the medical infrastructure and the laboratory services. And I think it's a testament to how little infrastructure you really need, physical infrastructure, to start a clinic. And some more of our successes is that we provide—and the goal was really to provide many of the medical services that are provided at Philadelphia FIGHT's main officers in this satellite site. We've really been successful in doing that. And then any services that we don't provide on site at Clinica
Bienestar, we're able to transport our clients to Philadelphia FIGHT's mean offices for things like dental care and nutrition services.

And then, a little bit about the transnational approach—because our goal is to deliver culturally competent care to the patients that we see of Puerto Rican descent. We very carefully modeled our medical and case management staff after the patient population that we are seeing—so many of our staff are of Puerto Rican descent. And many even grew up in the neighborhood that surrounds Clinica Bienestar—to really make patients feel as comfortable as possible. And then, we also helped coordinate medical and case management services for our patients who travel between Philadelphia and Puerto Rico. And then finally, every December, we have a holiday party for our clients. And because so many of them are estranged from family and friends, this is really like one bright light in the middle of the holiday season for them.

And we traditionally—this is sponsored by Philadelphia FIGHT. But we traditionally host a typical Puerto Rican dinner with Puerto Rican music and invite our patients to bring someone who supports them. It doesn't have to be a family or—traditional family member or friend, but someone who is like family to them.

And then, how do we plan to make this sustainable? And the grant funding ended about a year ago. And last summer, in anticipation of that, we were able to bring Clinica Bienestar in under the FQHC umbrella. So it officially became a satellite of Philadelphia FIGHT Community Health Centers, which will make it sustainable for years to come. Also, we participate in 340B drug pricing program. And so the funds that are garnered from that go back into funding directly to support patient care. And like I said before, we're also pursuing opportunities to support our PrEP program for individuals who inject drugs at Prevention Point. And we're hoping to—an answer, an RFP from Gilead Pharmaceuticals to support that in the near future.

Some lessons learned and recommendations for others—I think one of the biggest recommendations is, when you have a particularly vulnerable or hard to reach population to engage in HIV care, thinking about collaborating and integrating the best of different organizations to help target that population, whether it’s, in our case, partnering with a harm reduction service center to try to engage people with a history of injection drug use, or partnering with a methadone maintenance program, or partnering with behavioral health services, going to where people who are the most vulnerable are and not relying on them to come to us for the care. So one of the biggest challenges and, I think, one of the biggest lessons that we learned is to be adaptable and flexible. And almost six years ago now when we embarked on this project, we obviously were targeting people with a history of injection drug use. The opioid crisis wasn't quite in full swing as it is now.

And so as we've watched just the exponential increase in opioid use and opioid-related deaths in Philadelphia, we've really had to relocate our resources from always continuing to engage people in HIV care, but also to scale up naloxone trainings, safer injection practice education for patients, referral to housing and substance use disorder programs, and scale up medication-assisted treatment prescription, both of which we do on site at Clinica Bienestar in the form of
buprenorphine and long-acting injectable naltrexone. In part, because of the opioid crisis—largely in part to that—we have a high prevalence of incarceration amongst our patients. And we really had to scale up our partnerships with individuals who advocate for our patients within the Department of Corrections in Philadelphia. And that's an Institute called the Institute for Community Justice, which is part of Philadelphia FIGHT.

And actually, we've partnered—and that partnership has gotten stronger over the years—partnered with liaisons who visit our patients in the department of corrections, when they're incarcerated, to advocate for them and then help ensure that they come back to us upon discharge. And then finally, again, because of the growing opioid crisis, we're seeing increasing street homelessness amongst our patients, which even further impacts their engagement in medical care—every aspect of their medical care. And we've learned to partner with organizations that provide housing, and really, in housing-first models. Because we know that until people have stable housing, it's really difficult to address any aspect of—other aspect of their medical care.

Some outcomes that we're very proud of—and these our viral suppression rates, retention and care, and linkage to care rates of HIV care continuum for Clinica Bienestar. And so you can see that we have an 88.6% linkage to care rate. And it's defined a little bit different than the traditional linkage to care, because at the time when something came to me, they're essentially linked and then enrolled in the study. So linkage to care is really, for us, if they had a second visit in our clinic—so 88% linkage. And this is during—this is at a year after engagement with us. And these numbers are compared to the numbers from the city of Philadelphia in 2016.

And you can see that our linkage rates are better than that of the city as a whole, and then our retention in care. And that's the same definition that's used by the Health Resource Service Administration—so having an HIV primary care visit—so two and a year, three months apart. And our retention in care rates are 85% compared to 46% for the city of Philadelphia as a whole. And then finally, our viral suppression rates—and we're very proud to have an 83% viral suppression rate. So at a year after enrollment in Clinica Bienestar, 83% of our patients have an HIV viral load less than 200. And that compares to 51% in the city of Philadelphia.

And one other thing that I'd like to point out about this slide is that, as you see with retention—so in Philadelphia as a whole, retention rates are lower than viral suppression rates. And this is really—we see this nationally also. And this is because people, even if they're not being seen by their HIV primary care provider, still do take their meds. And that's why viral suppression rates are higher.

But you can see, with our clinic, our retention in care rates are even higher. And this is really a testament to my wonderful staff, that patients come to see us. And we support them in many ways, even if they're not able to take their HIV meds at any given time. So one, we're interacting with them and supporting them in so many other ways. And also, given the tremendous retention, it's so many opportunities to help support them to take their HIV meds.
And then, these are the resources. So anyone who has additional questions at the end can reach out to me via email. And then there's more information about all of Philadelphia FIGHT's services. That's Philadelphia FIGHT's website, and then also, information about all the wonderful things that Prevention Point Philadelphia does there on their website. And I thank you very much for your time.

PATRICIA AGUADO: Hi, everyone. Thank you for spending a little time this afternoon listening to both Dr. Bamford and myself. My name's Patricia Aguado. And this afternoon, I'm going to briefly talk to you about Proyecto Promover out of the core center in the city of Chicago. This is our disclaimer. Dr. Rosetta Rodriguez is unable to join us this afternoon. But I do think it's incredibly important to give her a shout-out as she was the PI and our project, and really was a tremendous champion in terms of providing oversight and leadership for this project and getting a lot of organizational buy-in. Because as you all know, when you work with large institutions, oftentimes buy-in is incredibly important to being able to implement projects successfully.

Today's outline—I'm going to start with a brief overview and then close out with some recommendations for organizations that might want to duplicate some of this work. You can start a little broadly in terms of Chicago and the landscape there in HIV. As I said, we are housed within the city of Chicago at the Ruth M. Rothstein CORE Center. Currently, the city of Chicago carries the burden of HIV in Illinois. And we're home to about 23,000 folks living with HIV or AIDS.

And as of 2016 census data, we were home to the nation's second largest Mexican immigrant population. And per our Department of Public Health data, historic Latino immigrant ports of entry with high Mexican populations, in our case, like the lower west side, which is where we are located, are disproportionately impacted by HIV and AIDS. And our project, if I hadn't mentioned earlier, Proyecto Promover, focused on Mexican-identified individuals within the Chicago EMA.

The Ruth M. Rothstein CORE Center, again, where Proyecto Promover is housed, is one of the largest HIV/AIDS clinics in the US. We are affiliated with the public health hospital system. We are a safety net health delivery system. And we service about one in four Chicagoans living with HIV. So in 2018, we saw an estimated 4,900 unduplicated patients with at least one primary care visit at CORE. And of our CORE census, about one in four service recipients are of Latino origin, mainly Mexicano.

So broadly, Proyecto Promover's purpose is to serve as a guide for health and social service providers to improve linkage, engagement, and attention to care among Mexican immigrant individuals living with HIV through the creation and implementation of a culturally specific and transnational service delivery intervention. So our overarching broad goals were to reduce HIV-related morbidity, mortality, and to reduce HIV incidence.
How our intervention came to be, our formative research, identifying the needs, we really did a deep dive in the literature to see what had been done, what worked, what didn't work. We convened a cultural advisory board made up of HIV and Latino health experts to help inform and guide some of our work. We convened six different focus groups with Latinos who were living with HIV to try to get a sense, from them, as to what some of the barriers to both testing linkage and then engagement in care were, as well as conducting a series of stakeholder interviews.

So quickly, we developed a two-part intervention. Sadly, I don't have enough time to get into the community aspect of our intervention. I will exclusively focus on our clinic aspect. Our target, as I said, were Mexican-identified individuals of all sexual and gender identities in the Chicago EMA. Fairly broad by design, we wanted to open this up to whomever wanted to participate and could benefit from the support. We came up with what we called charlas. And "charlas" is a Spanish term. And in essence, what it means are checks, informal discussions—soplaticas, for those who may know that word—just really designed to engage with clients in an informal, non-stressful way to develop the relationship. We came up with five intervention sessions focused around support, HIV knowledge, and HIV self-management.

And as you all know, through HRSA, we were charged with developing a transnationalistic framework and figuring out what that looked like within our specific intervention, clearly operationalizing what that might mean. And initially, I think we really had a hard time with operationalizing that within our project. And ultimately, very simply as well, we walked away with this fundamental understanding that all we needed to do was really understand our folks within the context of their lived experience, both in Mexico and the US, trying to hone in on how their experiences, both in Mexico on their trajectory in terms of their journey to the US, and their adaptation to the US, had been in terms of influencing the health care-seeking behaviors.

And to that end, we created something fairly simplistic. But I think it really worked for our client population. I am not going to go over this slide too much, because I don't think I have a lot of time. I'll leave this for recommendations, as it fits in quite well with some of the recommendations. But this is a capacity checklist that we created for sites to consider if they're wanting to engage in this kind of work.

So again, our charlas were five one-on-one 60- to 90-minute culturally tailored discussions over the course of six to 12 months. It varied for folks. Some folks connected fairly quickly and went to our intervention sessions within that six to nine months. And then some folks needed more time. They needed more touches. They needed more support, and may have taken 12 to 18 months, sometimes even 24 months, to fully go through the charlas.

Our intervention was staffed by a clinical patient navigator. She took on the brunt of the work. And she was an MSW getting her clinical licensure hours who had some formative or fundamental training in mental health, and substance abuse, and ultimately, trauma, which is one of the core constructs that we felt like many of our clients had experienced. Each charla
had a transnational goal designed to address and identify structural and psychological barriers to care.

So charlas, what do they look like? In summary, as I said, there were five. Charla 1 was an exploration of our client’s migration history. We developed an open-ended migration interview tool that really sought to understand what our clients lives were like when they were living in Mexico, why they decided to leave Mexico, what their journey was like, and what their lives had been like in the US since settling here. Within that, we also conducted a barriers assessment to try to understand, from clients, what had been the barriers to them, both linking and staying up in care before hooking in with us.

Charlas 2 centered around this structured and unstructured interviewing around substance abuse, mental health, trauma, and violence. We embedded a series of standardized instruments within this charla, not as a means to diagnose. They weren’t diagnostic tools in our eyes, although that’s how they’re utilized oftentimes.

We utilized them as an opportunity to really flag some areas of concern, to do a deeper dive to reflect on. And I think they were incredibly helpful, because it really opened us up to—well, I'll say flags, again, that had the potential to impact our folks' retention and care. And I don't know that we would have assessed it in such a way had we not embedded these tools within that charla. This charla also focused on trying to understand what the health care histories were like for our clients.

Charlas 3 and 4 were an exploration of stigma and really trying to understand the kinds of messages our clients were receiving, both from their communities and support systems that helped support and impede their ability to perhaps staying engaged in the [INAUDIBLE] care. This also did a dive into disclosure and trying to figure out who people had disclosed to, if they wanted to disclose, what that could look like should they want to disclose to someone through role plays of practicing what that could look like. And then charla 5 with sort of a summary, a lessons learned, a reflection on the work together, and an area for discussion about ongoing needs and referrals, both within our institution and outside of our institution.

So in summary, charlas are a combination of personal rapport in a safe, familiar space. They are the identification of cultural strengths and weaknesses. They are the identification, validation. And to the degree possible, it would be amelioration of barriers, discourse with a trusted person, and certainly client-centered. A lot of our folks didn't have anyone to talk to about their living with HIV. Many are immigrants in the US, in Chicago, and had limited support systems. So having a forum where they could be comfortable and have a safe space to talk about what they were going through was incredibly cathartic.

So why did it work? This works because of our migration story, and we didn't anticipate that. This migration interview tool we developed, in essence, as a response to what a transnational framework could look like based on the mandate by HRSA. But ultimately, it really provided us such a rich and profound opportunity to establish rapport with our clients, to develop trust,
certainly to understand barriers to care as a very concrete outcome. But we haven't anticipated how important it would be to the development of the relationship with these interventionists.

And we explored, as I mentioned earlier, the health care seeking practices of our folks in Mexico and the US in migration trauma, their adaptation to the US, what kind of support systems they had here, locally, and back in their countries of origin. I think in large part, this allowed folks a forum to be nostalgic about their lives in Mexico. And anecdotally, oftentimes what we would hear from clients is that I had never shared the story before, and a sense of relief, and even pride in being able to share what they had lived through, which was very powerful.

I think embedding this tool also allowed folks an opportunity to mourn the loss of no longer living in their home country—many can't, or won't, go back to Mexico. And there is a deep sadness associated with that—as well as to reflect on their resiliency in the US by acknowledging their struggle and their perseverance. And even acknowledging that, as immigrants in this country, they have experienced rejection, discrimination, and racism, particularly in this anti-immigrant climate. And utilizing these sources of strength and resiliency as sort of like a mirror or window to folks to say, you have survived so much, and you have been able to thrive—and the same way that you've been able to do so to date, you can also challenge and tackle this HIV illness—so to harness that sense of resilience as immigrants and harness it towards battling their HIV diagnosis.

So our implementation reality, we had two different stories. For folks that were newly diagnosed and recruited into this project, the intervention went as we had envisioned—successful implementation. For those folks that had been old new or lost to care and coming back into care, there were a couple of adaptations. Certainly, it was outreach. We engaged in much higher degree of outreach than we had anticipated, lots of calls, lots of texts, home visits as needed, trying to tap into support networks that had been identified early on with clients to see how we could hook them back in, and then collaboration—collaboration internally with, indeed, providers in our clinic, and then collaboration with outside providers.

As Dr. Bamford mentioned, sometimes work and housing are basic needs. And health, well, that may be a basic need. It falls a little short if our clients are living on the street. And so we had to really strengthen those partnerships in the community to see how we could meet those basic needs before we could then tackle some of these other also basic needs. But in terms of higher-order, health was not a priority if they didn't have food to eat type of thing.

Baseline characteristics—we recruited a total of 114 participants with a mean age of 38. Mean age of diagnosis was 34. 94% of our sample identified as cis male. 93% were born in Mexico with a long range in terms of time in the US. Only about one in five reported traveling back to Mexico. The majority identified as heterosexual, 91%, although 50% of our sample also identified MSM behaviors. The majority preferred speaking Spanish. And as you can see, they had varied educational experiences, although about 40% of our sample had middle school or
less than middle school education. And close to 50% screened positive on the CES-D depression scale.

Further, about 45% of our sample was sporadically engaged. 55% of our sample is newly diagnosed. Many of our clients came from acute care settings—so the hospitals, the ED, and/or nursing homes. And at enrollment, 85% of our sample had CD 4 counts of under 200.

Some perceived HIV care barriers included stigma, as you all know, shame, lack of knowledge across the board about HIV, about where to go to access care, about benefits, et cetera, fear—fear of dying, fear of getting sick, fear of people finding out, fear of rejection—and a generalized sense of hopelessness, and then not feeling sick. What we found in a systematic way was that many of our clients engaged in symptom-driven health care seeking behaviors. So if they didn't feel sick, they weren't going to go to the doctor.

And I will merely direct you to the first set of bars and the last set of bars because of time. Our baseline viral suppression rates overall were 11%. For those that were newly diagnosed, we had a baseline suppression rate of 5%. And those that had been returning to care and entry had a baseline suppression rate of 18%. Now if I direct you to the last set the bars at 12-month depression adjusted—and that was adjusted for folks that completed our intervention—we had an overall suppression rate of 86%, a 94% viral suppression rate for those that were newly diagnosed and a 75% suppression rate for those returning to care.

Now we're incredibly proud of these numbers, but certainly acknowledge that there is more work to be done with those folks that have fallen out of care for whatever reason. And oftentimes, it's some deep-seated, ingrained, psychological, interpersonal stuff that prevents folks from linking in. So I think there's far more work to be done with those individuals.

In terms of sustainability, the CORE continues to have a navigator who meets with clients in the hospital to link them into care that is a point of entry. We continue to work with the administration to modify a migration tool to embed it within the interview intake process for both our Mexican and Central American clients. We were really able to expand our base in terms of the relationships in the community, both to strengthen old partnerships and to solidify new ones. And certainly, there has been a greater emphasis—although there was already one. But this has helped to reinforce the need to be very intentional about trauma-informed care and what it means to be a trauma-informed care institution.

And lastly, some recommendations if you want to do this work—it's definitely to define your audience and secure buy-in. You can't do this work without the support, without the support of people both within and outside of your institution, establishing the transnational approach in your intervention, and utilizing culturally tailored discourse. Hiring staff that reflect, or have a deep regard for, your client population—we had three full-time staff. They were all Mexican origin, identified deep pride and those cultural roots, all Spanish speaking. And while you don't have to be Mexican, you certainly have to have a deep regard and respect for the client population and the culture.
Hiring staff that are skilled in understanding and treating trauma—this is heady stuff. And we can't just probe for what's happened to folks. We have to understand how to help support them in driving and becoming healthy. We don't want to trigger them. Being flexible and accessible, as Dr. Bamford said—the 9 to 5 clinic model, coming 15 minutes before your appointment just didn't work for our population. So whenever they came in, we'd see them. If we had to stay after hours, we stayed after hours. If we needed to meet them in the community, we did so. We didn't want to create this as the barrier to engaging in care. And to that end, also being visible in the community—you have to engender trust with the community organizations that work with these folks.

Lots of follow-up and outreach—we were relentless in our follow-up and outreach. And until someone told us, we do not want you to call us or visit us, we never gave up on people. And then lastly, embedding an educational component, which is looking at the psychological, social, and structural barriers to care. And I really should say gracias. Gracias. We were a team effort. And it was, I think, a labor of love for all of us. And thank you.

ANGEL JOHNSON: Thank you, Dr. Aguado, and thank you also, Dr. Bamford, both of you, for sharing those initiatives. Before we open the lines for Q&A, I want to ask our audience to please make note of the link that you see on the screen and to please give us your feedback on today's webinar. We will also be sending out this link via email to the registered participants following this webinar. So at this time, if you have questions for our presenters, you are free to type those into the chat box. Or you can also ask your question directly.

While we wait for that, Dr. Bamford, can you talk a little bit more about how your services were delivered in a culturally competent manner?

LAURA BAMFORD: Well, yes. And I'm sorry, I think one of my introductory slides was left off. So Philadelphia—65% of Latinos living in Philadelphia are of Puerto Rican descent. And the zip code where Clinica Bienestar is located happens to have the largest percentage of people of Puerto Rican descent in Philadelphia. So one, deciding to open the clinic where most Puerto Ricans are residing, and then also hiring staff members who reflect the population that we're serving, not only of Puerto Rican descent, but also those that actually come from the community—and so really understood what it was to live in that zip code, in that part of Philadelphia.

ANGEL JOHNSON: Thank you. Dr. Aguado, can you respond to the same question?

PATRICIA AGUADO: Well, much like Dr. Bamford, we hired folks that were reflective of the community that we were trying to recruit. They were also born and raised in the community where we did a lot of our outreach intervention—outreach efforts and community intervention aspect of this project. And I think we tried to use some of the cultural constructs that—perhaps stereotypical at times. But we do tend to see through these notions of machismo and how that influences men in their ability to even communicate and engage with other folks. We try to draw on aspects of respeto, meaning respect, and familismo, connecting with folks in a familial
kind of way. And certainly, there's familismo in that engagement and connection with our people that were really bound within this idea of the charlas, these informal talks.

So really focusing in on the relationship, developing that relationship, harnessing that—because we knew that, at the core, that was really where we needed to start in order to build everything else. And again, obviously, everyone in our project spoke Spanish. The majority of our clients only spoke Spanish or felt comfortable speaking Spanish. But yeah, I'm not sure if I addressed that fully.

ANGEL JOHNSON: OK, well, thank you. As we prepare to close, unless we get some final questions, I want to provide you with some information on staying connected to SPNS and IHIP. And if you have questions about any of the information shared during today's webinar or anything related to the replication of SPNS interventions, you can please send your inquiries to SPNS@hrsa.gov. And for additional information on tools and resources, and to sign up for IHIP listserv to receive the latest announcements about IHIP resources and webinar trainings, please visit the Target Center at targethiv.org/ihip. And to learn more about HRSA and sign up for their new e-newsletter, you can visit HRSA.gov.

The next and last webinar in this series is scheduled for July 17, also at 2:00 PM Eastern Time, and will feature a Latino and a workforce initiative demonstration model. Would either of our presenters like to have any closing remarks?

LAURA BAMFORD: There's nothing additional from me. Thank you, Patricia.

PATRICIA AGUADO: Thank you, everyone, for your time and for your interest in learning more about these projects.

ANGEL JOHNSON: Well, thank you all for your participation. And this concludes our SPNS IHIP webinar session. Everyone have a great rest of the day.