

WEBINAR VIDEO TRANSCRIPT

Culturally Appropriate Interventions of Outreach, Access and Retention Among Latino(a) Populations

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ANGEL JOHNSON: Good afternoon, everyone. My name is Angel Johnson and I will be moderating today's webinar on Improving Health Outcomes, Moving Patients Along the HIV Care Continuum. This is the first webinar and a four-part webinar series brought to you by the HRSA Special Project of National Significance Program, or SPNS. OK, and as you can see by today's agenda, I will be providing a brief overview about the SPNS program and the Integrating HIV Innovative Practices Project, or IHIP.

We will then hear from two presenters who will talk about their SPNS Latino initiative, and our first speaker today will be Laura Castillo from Bienestar Human Services in Los Angeles, California. Laura began her work with Bienestar in 2016 where she helped lead the HRSA/SPNS initiative Proyecto Vida, integrating best practices into other Bienestar programming and strengthening comprehensive supportive services. She currently oversees the linkage to care client navigation and housing opportunities for persons with AIDS programs.

Ms. Castillo supervises a team comprised of linkage coordinators, peers navigators, and housing specialists that provide services throughout LA County while also rendering direct client services and mentoring public health students. Ms. Castillo earned her MPH at the University of Southern California with a focus on promotion and education and is a certified health education specialist. We will also hear from Martha Guerrero with Prism Health North Texas and Dallas, Texas. Martha served as the Program Director of the Viviendo Valiente program of Prism Health North Texas.

She earned a BA in French from Austin College, but chose to work in the non-profit sector to serve the Latino community. Her professional experience includes serving as Minority AIDS Initiative and Special Projects Coordinator for the Texas, Oklahoma AIDS Education and Training Center, training behavioral interventions and program development, implementation, and adaptation in both the health and education for Latinos. Ms. Guerrero is certified as a Master Trainer and Community Health Worker instructor in the state of Texas. Following these presentations, we will open the line for questions.

A little bit about the SPNS program. 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. Initially the SPNS program was challenged by finding ways to effectively disseminate information about

successful SPNS model 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, engage stakeholders to increase reach of these tools, and provide capacity-building assistance to support the replication of SPNS intervention model. As I prepare to turn things over to our presenters, I want to share some information on staying connected to SPNS and IHIP.

If you have questions about any of the information you hear during today's webinar, or anything related to the replication of SPNS interventions, please send your inquiries to SPNS@hrsa.gov. For additional informational on tools and resources and to sign up for the 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 e-newsletter, you can visit HRSA.gov. Now without further delay, I'm going to turn things over to the day's first presenter, Laura Castillo, with Bienestar, and immediately following Laura you'll hear from Martha Guerrero with Prism Health. Laura?

LAURA CASTILLO: Thank you. I'm very happy to talk about the work that Bienestar did for this initiative, which is very interesting and rewarding. It allowed us to enhance and strengthen our impact in the community to improve health outcomes and quality of life. And this could not have been possible without HRSA. Bienestar would like to thank you for the wealth of support throughout the five years and overall working together. This presentation will provide a brief overview on our agency, HIV in LA County, key elements to incorporate for successful implementation, what we learned throughout this process, our approach to program sustainability, recommendations to those that would like to do a similar project, and resources readily available.

Bienestar's origin stemmed from the profound need to make accessible services for members of the Latino community living with HIV/AIDS and who did not have an adequate support system. For almost 30 years, Bienestar has been committed to this, as seen by the services listed here which are accessible throughout LA County. We have six service sites in key areas to effectively reach underserved populations. When we look at the landscape here, you can see why we decided to apply for this grant.

LA County is heavily impacted by HIV infections across a large number of cities where Latinos—43%—make up the greatest group of people living with HIV. Only 60% of them are virally suppressed. We were also aware that 84% of new infections among men who have sex with men. Proyecto Vida translates to Project Life. In order to timely link, engage, and retain MSM of Mexican descent, we utilized the seeds of the change to meet them where they were in their readiness to access care.

We understand that not everyone is ready to get into treatment immediately. We also concentrated on their inherent strength, abilities, and resources to highlight their resiliency and empower them. This helped facilitate coming to terms with their HIV diagnosis. As you may know, this initiative is one of the first public health adaptations of a transnational approach. I will cover later what this, since it was the most important key component. Other components incorporated were mobile unit testing to reach inaccessible populations, motivational interviewing techniques, peer navigation—which encompassed patient escort assistance and peer support significantly—and, of course, linkage to care.

Our team was ready to hold their hands throughout their process. Goals and objectives. Individuals were eligible to enroll in Proyecto Vida if they met all of these requirements. They needed to either have been born in Mexico or born in the US and have at least one parent that is Mexican, be newly-diagnosed with HIV, never engaged in care—or have fallen out of care—be over the age of 18, and must be residing in LA County. Our goal was to enroll 100 participants, have an 85% timely linkage to care rate, and conduct at minimum 2,328 HIV tests.

As it pertains to the linkage rate goal, which was the same for both newly-diagnosed and re-engaged to care, the goal was to link newly-diagnosed participants within three months in one month those that needed to be re-engaged back to care. So this is what we had in our toolbox. Due to having multiple offices throughout LA County, we had the capacity to reduce transportation barriers, thus providing participants with multiple options where they can be linked or meet us for peer counseling and support where it was most accessible and comfortable to them.

We recognize that not everybody wants to go to a clinic closest to their homes. Fostering relationships with providers was important for a more efficient and timely linkage as well as medical data extraction, which can be rather frustrating to obtain, especially if every six months. Our program team consisted of two linkage coordinators, peer navigators, HIV testing counselors—which often were also in dual roles as linkage coordinators/peer navigators—and the Program Manager, which was me, under the supervision of the Program Director, Brendan O'Connell.

As I mentioned at the beginning, Bienestar has been around for a long time, addressing the needs of the Latino community through a myriad of services. For this reason, we have the community trust and buy-in. But also when exploring Latino cultural values, we see that building rapport and establishing personal connections before getting down to business is very customary among Latinos. It starts with trust at the individual level with quality interaction and it transcends to trust at the community level, which then translates to service recipients opening up to new experiences and systems such as the medical care system.

We have an in-house research and evaluation team that was able to track our program's success throughout the project. Implementation successes. We were able to surpass all of our goals within the time frame of October 14, 2014, through August 30, 2017. As you can see, we were able to enroll 104 participants. The timely linkage to rate was actually 95%. For HIV tests,

we also exceeded that component, having done 3,710 tests with a 3.0 positivity rate. In case you were wondering, as of current data from 2015, LA County has a positivity rate of 1.11 percent.

This gives you a breakdown of the participants that we were able to enroll. 64 were newly-diagnosed and 40 were re-engaged to care. Successes that we're really proud of are viral suppression. As you can see for viral loads of less than 200 copies of HIV at baseline, 36.4 participants were virally suppressed. But as six months progressed it reached 87.5 with ultimately at 12 months, 92.2. Further breaking it down on the right side, for viral load less than 50 copies of HIV. At baseline only 27.3% of the participants were virally suppressed. At the 6-month mark, 83.9, and 12 months, 86.3.

When we conducted statistical analysis to compare viral loads and following participants from baseline to six months, we also saw a difference that was statistically significant. As you can see, we have for those virally suppressed less than 50 copies of HIV, there is 32%. Preceded by six months, 82%, and ultimately 50% difference thereafter. And here also you can see the baseline 12-month difference when we follow participants from baseline to 12 months. Again, statistically significant.

But we did have some bumps in the road. These are some of the implementation challenges. And keep in mind that it was very hands-on and peer support, and so we also had dynamic interactions as we also explored how to address these issues. Most prevalently was the fact that 69.9% of individuals were uninsured. This is the reason why we feel that a lot were out of care. 69.5, so basically a third, didn't have a social support system. There wasn't really, like, people that could talk about worries that they had with family members. 67.7 lived below the federal poverty level.

And, of course, we also see other concerns like causing instability, substance use, and transportation needs. As far as provider-related barriers, it was pretty difficult to get data from those that had fallen out of care because those individuals had not provided consent to have us contact them, given the fact that they had not signed consent forms and pretty much indicating that they wanted to be part of Proyecto Vida. And something that we didn't foresee was the fact that three clients passed away. This also alerted us that we needed to have mechanisms in place in order to support the staff should this happen.

And how did we adjust to challenges? Well, at the very beginning we only had partnered or identified three providers. We also realized that there were some things outside of our scope. For instance, in developing agreements with other agencies we realized that we could have partnered with legal organizations. Given the political climate, people didn't know what would happen to them and so this would have been a great opportunity to incorporate that given that we do not have a legal department. And transnationalism presented a challenge at first. It took a while to incorporate, but what we did is that we identified key areas utilizing a checklist to better understand and use this approach rather than sporadically incorporating elements throughout the intervention.

Transnationalism can be defined as those activities that take place on a recurrent basis across national borders that require a regular and significant commitment of time by participants. And these activities can be conducted by relatively powerful actors, such as representatives of national governments and multinational corporations or may be initiated by more modest individuals such as immigrants and their home country kin and relations. So basically, that is all to say that transnationalism is a process in which migrants construct connections between the country of settlement and their country of origin. And you can vary by person in my community, by the way.

Some of the transnational practices migrants participate in it may include communication—whether it's electronic, mail, or phone—economic remittances, which we saw a lot in our program participants, and social remittances as well, such as ideas, social norms, and practices, as well as travel. And we really had to think outside the box. How were we going to retain program participants? So what we did is that we incorporated different communication platforms, whether it was doing events at our centers or out in the community. Sustainability. Through HRSA data, we were able to apply for CDC funding so that we can continue linkage to care work with Latino MSM.

Given our successes and our enrollment, we were able to demonstrate that there was a need to continue working with this community. But then it also allowed us to conduct further recruitment activities. Throughout this project, given its length, it really opens up opportunities to publish and also disseminate our findings, lessons learned, and knowledge at national conferences, for instance the Ryan White Conference. Some of the barriers, but all the lessons we've learned, would be that we experienced program staff. Given the fact that this program was very specific, we really didn't have a heavily-staffed program. And also we didn't have the capability to provide the same duration of follow-up.

Because most of the funding at that point was CDC and utilizing an artist intervention, the most that we would be following up participants for and working with them would be up to five sessions. And in having a higher caseload and competing priorities, we saw a decrease in communication with FQHC partners, so we weren't really presenting to them and reminding them of the work that we were doing because we were assisting clients and dealing with complex situations. Recommendations. First, you have to identify what is the most important for clients, whether it be employment or economics.

At times, we would see a lot of our participants having more than one job. So really identifying what that is first, in order to then facilitate the linkage. And community trust—you don't have to be in the community for a very long time, but you can incorporate key components. For instance, hiring bilingual staff, having people mirror the community that you're going to be working with. And if something is working, don't be afraid to modify anything. We had to modify our social networking testing and our social network engagement. That wasn't working, and so what we did is that we were able to double up on efforts for things that were working, such as doing outreach, being seen in the community, and doing mobile unit testing.

And know that participants are going to have many needs. You're not going to have all the resources in-house, so definitely building partnerships but you have external resources. Staff retention is very important. Do the best that you can to retain your staff. Program participants will build relationships with them and sometimes it becomes a reason why they even come to your doors. Don't forget that you have valuable resources that are willing to share a lot of information with you. If you have any questions or you further want to discuss something, Brendan and I can be reached at this contact info and are excited to also share more about the work that we've been doing and have done for a very long time. Thank you. And now, on to Martha.

MARTHA GUERRERO: Thank you very much, Laura. Muy buenas tardes to everyone. On behalf of Dr. Manisha Maskay, Nicole Chisholm, and Prism Health North Texas, it is my pleasure to present to you today, here out of Dallas, Texas. We are grateful to HRSA for their support in allowing us the means to both develop and implement this program for our community. During today's presentation I will be providing an overview of Prism Health North Texas Viviendo Valiente Program, the multi-level interventions and strategies that comprise our program, the role of formative process in outcome evaluation, and some key considerations for those of you looking to implement and sustain a program such as Viviendo Valiente.

A few key points about Prism Health North Texas to better understand the context within which Viviendo Valiente was developed and implemented include that we serve 12 North Texas counties with goals to prevent HIV, test those at high risk for HIV and sexually-transmitted infection, engage and retain people living with HIV in HIV medical care, and help them achieve viral suppression in optimal health. We offer services throughout several sites in Dallas, Texas, and we do so through two health centers that offer primary HIV medical care and integrated behavioral health care—one co-located pharmacy at one site and a second one coming up here in the next few months.

Our clients receive case management, psychosocial support services, testing and risk reduction counseling—either on site or through mobile services—and our HIV Empowerment Center is available for every person living with HIV, thus extending our reach. As for Viviendo Valiente, which in Spanish means living valiantly or courageously, the goal was to link persons of Mexican origin and living with HIV to HIV care expeditiously by reducing barriers to services. In order, of course, to accomplish this, we sought to increase HIV testing and engagement and retention in HIV treatment.

Our program was developed in Dallas, Texas. It was implemented as a unified multi-level intervention. We designed it to identify people of Mexican origin either by birth or descent who were 18 years of age or older, living with HIV, to link them to HIV medical care and to remove barriers to support their retention efforts. Our messaging and strategies were tailored to address our priority populations' concerns and needs related to HIV.

Ideally, organizations best positioned to implement this program will have the following characteristics and, like Prism Health North Texas, have a mission that is inclusive, focused on

addressing needs of diverse populations, it must be committed to providing and advocating for culturally and linguistically appropriate services at each level of care, and offer flexibility to tailor programming and services to address emerging needs of the community. It is also helpful to already have some level of expertise related to engaging the priority population in care and treatment, be able to provide culturally appropriate and relevant care, have a reputation within the priority population as credible and trustworthy, and able to engage stakeholders and community members.

Other important organizational abilities include budgeting for a tangible reinforcement in order to support engagement and retention in care, as well as the ability to support flexibility with work hours of staff members, create and sustain advisory boards that remain active, provide follow-up medical care or work in partnership with a facility that renders the service, and the ability to conduct formative and process evaluation. So what is *Viviendo Valiente*? Well, interventions at multiple levels comprise it as a whole program. It was developed as a multi-level intervention for people of Mexican origin.

At the individual level, we provided ongoing support for people living with HIV to address linkage and retention in care, treatment adherence, and other concerns. At the group level and community level, however, our efforts tended to be general priority community not necessarily already known to be living with HIV. So at the group level, we educated the community about HIV and how to engage in health care through our four session health education course that we developed in house. And at the community level we developed and provided messaging and information through engaging in culturally relevant activities to encourage testing for HIV and STIs.

And some of the messaging strategies that we used included in how we presented ourselves to the community. So even our tag line attached to our name which was developed based on the motivation we knew our community had for testing, which was for the health and well-being of their families and communities. So that spoke directly to their motivation to engage in this highly stigmatized topic. And then there's also the example of our five-minute brief community education session which directly addressed key myths and misconceptions about HIV and AIDS in our community. And through it we were able to model how to speak about it in very public forums, including clinic lobbies that were in partnership with us.

All of our interventions were unified by a three-point strategy—*informate, platica, actúa*: Inform yourself, talk about it, and take action. *Viviendo Valiente* used both theoretical frameworks and models to guide our strategies, and specifically with working at our individual level intervention with people who were already known to be living with HIV, used the antiretroviral therapy and access to services, which is an evidence-based individual level intervention to support clients' efforts to link to appropriate HIV care. We used motivational interviewing, which provides practical guidance for helping an individual to progress through stages of change.

And we used our own transnational and cultural assessment tool, which was developed by our team to identify key transnational factors affecting engagement and retention in HIV medical

care. And Laura did a great job of describing transnationalism as a theory before me. Our activities throughout each one of our interventions were tailored for our priority community to do three things—increase knowledge of HIV in the community, increase perception of risk for HIV, and decrease stigma related to HIV. This slide demonstrates examples moving left to right, from our individual level efforts all through our community level effort.

And as you can see, our messaging even within our [INAUDIBLE] part really reflected the community and their concerns dealing with immigration status and ability to pay. So it let them know that we were established and prepared to help them, regardless of their concerns. In the middle section that reflects our group level intervention and our efforts to educate the community using culturally relevant and culturally respectful strategies that connected to those themes and important connections to our Mexican culture, including the development of a unique [SPANISH], which with our very own Mexican bingo to discuss concerns within the community related to accessing medical care.

And a wonderful telenovela which was already made available by another organization—AltaMed—thanks to CDC funding, which we used to our advantage, which we used to delve into a difficult conversation using the topic of a soap opera that delve into HIV in the Latino community. And then at the community level, all of our messaging through our print and radio campaign spoke directly to the community. We develop scripting that delves into everyday situations in various relationships and how we can bring up the topic of routine testing and the concerns related to HIV and alleviating those concerns, removing the harsh spotlight off of HIV, and making it about health and community.

Outcomes at our individual intervention level were that we served a total of 123 individuals. Our goal had been to enroll 120. We rolled into the study 104 individuals and based on our nine question survey regarding our clients experience at the individual level we had a 97% satisfactory response rate. One challenge and solution that we wanted to really reflect on is that initially at the individual level we were designed as a time-limited intervention, and yet we had to remain a highly-focused over extended period of time intervention through use of promotores de salud, which is Spanish for community health workers.

And our promotores de salud ended up taking a much more active extended role in order to ensure engagement and retention. The two images to the right reflect some of our numbers as far as newly diagnosed vs. previously diagnosed. And one year—very preliminary—one-year outcomes among our participants that met the AIDS definition at baseline. Within our group level intervention, we provided 18 full education courses, thereby engaging over 200 priority community members through each individual session.

The course was submitted to the Texas Department of State Health Services for continuing education consideration for community health workers and their instructors, and we were awarded 14 community units, which is wonderful because for us the big challenge at this level was—how do we engage more people from our community in this dialogue? So we developed connections and partnerships that have given us entry now to the network of certified

community health workers and instructors in the state of Texas. And as you can see from the image on the bottom of the slide, we count several key partners, including the Texas Department of State Health Services, the Office of Border Public Health, and the South Central AIDS Education and Training Center.

At the community level—I know my time is running short—we've reached, engaged, and educated many in our community. 607 have tested as a result of our direct involvement in the community, and we've done a lot of testing, engagement, and reminders. We have seen an increase in Latinos that tested in partnership with *Viviendo Valiente* efforts. As you can see, within the image to the right, in the years prior to *Viviendo Valiente*'s involvement in outreach activities, our testing team tested 376 and 444 Latinos, respectively. And in the years following, it almost doubled in some of the years.

For us very early, our challenge was how to support the third strategy, take action beyond providing education and promoting dialogue. And our solution was to join forces with our testing team as often as possible when working out in the community. As far as sustainability, the mission and as for Prism Health North Texas is about the advancement of health, and it places special emphasis on education prevention and personalized care, all of which are key elements of *Viviendo Valiente*. Sustainability remained at the forefront from conception of our program, and we were challenged from the beginning to consider each one of our strategies fit within the agency scope and whether it was sustainable beyond grant funding.

And this focus on key elements that could be maintained, or could help improve upon our agency standard of care, was seen as vital. Of course sustaining those essential elements requires engagement of stakeholders. Besides looking for collaborative opportunities with as many teams as possible, we developed and maintained active advisory boards for ongoing feedback. And another opportunity involved that of refinement of processes and elements that can be sustained by the organization. And that is where we are now. Five lessons learned and recommendations that we would like to leave with you is to form a strategic partnership at conception and throughout, personalize and nurture this partnership by knowing who you are going to ask for help, being familiar with their goals and with their mission, develop cohesive and consistent messaging that aligns with what you learn from your priority population, inform and maintain active community advisory boards.

We also encourage you to maintain responsiveness and flexibility both within members of your community, your staff, and in regard to program implementation. And with that said, we have a lot that we would like to share and so if you have specific questions about our program, please know that we have multiple resources available to you, and I'm available to speak with you directly should you have questions. And with that said, thank you so much on behalf of our team here at Prism Health North Texas. And that is all for me. Thank you.

ANGEL JOHNSON: Thank you, Martha, and also thank you, Laura, for sharing your program's efforts for your great presentation. So before we open the line for questions, please note the link on the screen, and we would love it if you would use this to give us your feedback on

today's webinar. And then we will also mail this link to anyone who registered to participate in the webinar following the presentation today. So while we're waiting for Stephanie to type her question, I have a question. This is for Laura. Laura, what recommendations can you give to making a program like this sustainable over time?

LAURA CASTILLO: Something that I didn't talk about when I mentioned transnationalism as it pertains to this particular project, was also incorporating Mexican cultural components. Because those really show a correlation in terms of their affect on medical care and experiencing medication. So, for instance, such components like personalismo when I was talking about building rapport, recognizing that there is machismo, religiosity, familiarismo, and fatalism. And then again, something that was very, very crucial was the staff retention.

When you have staff working with participants for a very long time, 18 months, it can kind of create a sense of unfamiliarity with when there is a staff turnover, and it's a lot more effective to be working with one or two people versus, like, six. So I would feel like those are at the forefront for sustainability. And being prepared, for instance, we had some participants that enrolled towards the end of the project, but because we had the CDC funding we were able to transition them over to continue the linkage.

ANGEL JOHNSON: Thank you for that, Laura. So we have questions from—we have a few questions—so we have a question from Stephanie. "Thanks so much for your great presentation. Do results vary in regards to different demographic groups? For example, young adults. At my agency, we have noticed this is a very difficult population to engage." And I imagine this question could be for either of our presenters.

MARTHA GUERRERO: That is an excellent question. And I really think it is about from conception and looking at what your assessment is saying about what is important to your community overall. So there might be varying ways of personalizing a message, say, for my grandparents versus my parents, versus me or my child. What remains consistent for the community is what binds them together. And for us, what came across from our community is that what binds them together is the love for their families and their communities. So we created consistency in our messages that included love and motivation of the community as a whole in the family, rather than creating very individualistic messages.

In our education strategies, we reverted back to what is tried and true in our community, which was the use of games that the community connected to already, which was the use of [SPANISH]. So that was something that could be used with from children to grandparents. And then we also used telenovelas—which in our community is watched by every age group—in order to delve into the topic of HIV in the community. So that was our choice to make very early on, and our experience is that it really did engage individuals at every level. So thank you for your question.

ANGEL JOHNSON: Thank you, Martha. And Laura, did you have any response to that question as well?

LAURA CASTILLO: Yes. I also wanted to go ahead and share that we didn't really notice a difference in terms of engagement successes or linkage as it pertained to demographic groups, but for our end what we really saw played a role were areas like homelessness, poverty, and substance abuse. And it really depended on where they fell in within the federal poverty level. A lot of our participants held more than one job, and so at times it'd be very difficult to find medical appointments where they could go later on in the day, especially if they were just getting linked to medical care where you do have to go earlier on in the day.

So what we try to do for those that say, for instance, have substance abuse problems, when we would engage in sessions with them, coordinating so that they would see the therapist and substance abuse counselor right after. That way we would save them the trip of not having to come again. And with homelessness, you know, then being out of touch, not having a phone, not knowing where we were going to see them again. So really coordinating, working as a team, so that we would know when someone would stop by unexpectedly and be able to readily assist them and be there to support them. So at the demographic level, not something that was very evident. It was more so at the needs level.

ANGEL JOHNSON: Thank you, Laura. So Tom Donahue is asking, "Can you please share how you set up your CAB? Any challenges, facilitators, and were you able to sustain it?"

MARTHA GUERRERO: Thank you, Tom, for that question. We actually had two community advisory boards, one external advisory board and one internal. And we used our staff members who were very active in the community who alerted us to individuals that could be nominated for that advisory board. They were interviewed, they told us about their interests, about their knowledge of the community before they were accepted onto that advisory board.

For the internal advisory board, we really got a great response from our internal team members at Prism Health North Texas that reflected our priority community in their background and that also had many years of experience in serving the community. So across the board, we sought and looked to retain individuals that already expressed and demonstrated a sincere goal of assisting our community through their endeavors. So it was easy for us to maintain them actively involved in providing feedback to us.

ANGEL JOHNSON: Thank you. Any other responses?

LAURA CASTILLO: I also wanted to share that we have a CAB as well. And, although I didn't discuss it as one of the key components, our CAB actually provides feedback or insight throughout the services agency-wide, so not just program-specific. In terms of how we set it up, we really look for community gatekeepers or participant in support groups are the most active and involved and that are just constantly coming to the agency because we know that they have a lot of insight to provide and share with us, knowing how we can improve, how we can enhance quality services and what not. Most of our program participants for the support groups do go to different offices. And as I mentioned, we have six centers. So they are really able to see how we're operating as an agency throughout LA County.

ANGEL JOHNSON: Thank you, Laura. Another question—"What barriers did you encounter when implementing the intervention on an individual, group, and community level, and which intervention was hardest to implement and why?"

MARTHA GUERRERO: For us in Prism Health North Texas, at the community level and at the group level, I wouldn't say that there were barriers. I would say that there were opportunities to really look at what our community assessment told us and to find really not just culturally relevant, but culturally respectful ways of addressing those things that the community assessment told us they were afraid to address, and that was the discussion, the topic of HIV within their families. And so we had to be very creative and thoughtful in how to address that.

And the way we sought to overcome that was by becoming very confident in our discussions about the topic of HIV. And so, in essence, becoming models of how you can address the topic, how it should be discussed, and how to address those things with the people that we love the most. At the individual level, also with me is Dr. Manisha Maskay and she can talk about some of the other things within the prison within the individual level intervention. But it really is about sustainability of being able to spend more time with certain communities in listening to their stories. Oftentimes we have very limited time with them and, as Laura mentioned, the personalismo is really a key element from the beginning that has to be sustained. It is not only important at the beginning, but we really have to take the time to listen to them and to address things in a culturally relevant manner. I wonder if Dr. Manisha Maskay would like to add to that?

MANISHA MASKAY: I think it also was very helpful was that our promotores would meet with our clients at the times that they needed to be met with, and you know, would meet them also at the clinic, even though the clinic is within Prism Health North Texas. It truly helped when our promotores went with them, including to the pharmacy and other places like that. So they provided a lot of advocacy, a lot of support, and a lot of guidance for our patients to be effective consumers.

ANGEL JOHNSON: Thank you, Dr. Maskay and for Martha. So Thomas would love to hear how you use telenovela and "Sin Verguena"? I'm sure I'm not saying that correctly.

MARTHA GUERRERO: That is very close.

[LAUGHTER]

Yes, so we could not have been more thrilled any time we find any activities or resources that have already been developed with a lot of love and a lot of knowledge. We holistically believe in utilizing those resources so that we don't have to reinvent the the wheel. And for us, we found "Sin Verguena", which again was developed thanks to CDC funds by AltaMed, at least the first season was. And, honestly, it was perfect because our sessions that we developed were four, four separate sessions.

And the first season of the soap opera "Sin Verguenza", which means without shame. And it also has a double meaning that means shameless, really, someone who lives without shame. And we were able to tack on those four episodes, all of which were anywhere between five to seven minutes, at the tail end of our session. Because technically our session could stand alone even though we built them so that—or we developed them so that they could be building blocks. So as we took them deeper into the HIV conversation, and we started out from health, which was an easier topic for our community.

And what we did was we injected each one of those telenovela episodes at the tail end, because anyone who's ever watched a good soap opera knows that each episode ends with a cliffhanger. And so what we found was that most individuals returned for each successive session because they wanted to know what happened with that telenovela. And the telenovela dealt specifically with HIV impacting a Latino community. And so it was already something that connected dearly to everyone in our audience. So we're, again, very grateful for those things that are already out in the community, and we found it to be a gem for our group level intervention. Thank you.

LAURA CASTILLO: Martha, I just wanted to say that it was very brilliant that you incorporated "Sin Verguenza" and that also that you were able to adopt this initiative at the community level. It definitely provides a lot of insight, because on our end, at the individual level would be pretty much the way to go and it made complete sense. But I appreciate the shift in perspective and how it can also be adapted to fit the community level needs. So thank you so much for sharing about that and I think that that was phenomenal.

MARTHA GUERRERO: Thank you.

ANGEL JOHNSON: Yes, thank you. And to follow it up, Pedro is inquiring, Martha, "As you implemented these trainings, was there something that stood out from your audience after viewing the novela?"

MARTHA GUERRERO: What we usually are doing when we watch a soap opera or a telenovela is we're really tackling difficult topics through the other, through the other individual that has nothing to do with me. It is some other family that is dealing with this topic. And eventually what we see with telenovelas is that they become more engaged in the storyline. As you start dialoguing after the telenovela, or sometimes through it, you start seeing parts of your own story to that telenovela and relating to it. That is why we engage in those telenovelas, because ultimately it is a reflection of true life.

And what we found as we became more engaged throughout each individual session was that not only were they receiving information which was our three-point strategy—we were providing education, we were engaging in activities that allowed them to then talk about what they were learning and how it related to their fears and concerns and knowledge, and then the telenovela allowed them to take action in some way at the end because it was them really

processing the fears that they had. But it started off slowly with the first episode, again, because they were first being introduced to that topic.

But by the fourth session, they were very engaged. They began to associate their own personal connections with loved ones with people that they knew. We would often times hear about people that they knew that believed would really benefit from that message because they were seen as being high risk or of concern. Some even shared that they knew individuals who were living with HIV. So it really became a moment of relief by the end of our session. Thank you for that question, Pedro.

ANGEL JOHNSON: And thank you, Martha, and Dr. Maskay. I think that's quite interesting. So we have a couple of minutes. We've have so really good questions. If there are any other questions, please feel free to type them in. We may have for maybe one more, or if someone on the line wants to ask a question. That would be great. In the meantime, I just want to let our audience know that both the slide deck and the archived webinar recording will be available at the TargetHIV website, and we ask that you allow about three to four weeks for the material to be posted.

The next webinar in this series is scheduled for next month. We do not have an exact date right at this time, but as soon as it is available we will get that information out to you and hope that you will be able to join us at that time as well. And are there any other questions? Or any closing comments from any of our presenters or anyone else?

MARTHA GUERRERO: I just wanted to thank you for this opportunity. We are very grateful for all of the different efforts that are being made on behalf of our different communities that are impacted by HIV. And we're just grateful for your time in hearing our story, and we look forward to further opportunities to share more about our strategies with you at any time. Thank you.

ANGEL JOHNSON: Thank you.

LAURA CASTILLO: If no one was going to say a question or ask a question, I also wanted to go ahead and thank everyone for really allowing us to share what we've learned. It was truly a remarkable initiative that further enhanced our skill set to better serve the needs of this community. And this has really been transformative in our agency as far as lessons learned and just how to improve our service delivery. This project pretty much kick-started my public health career on high mode, and I just wouldn't be at the place where I am right now and being able to better serve the community without this initiative.

Everything that was discussed, everything that was covered with clients, troubleshooting complex situations which, of course, no material or training can prepare you for. Like, that is life, and so it was a remarkable initiative that really has changed so many lives.

ANGEL JOHNSON: Thank you so much, everyone. And thank you to our presenters, and thank you to our audience. This concludes today's webinar. And if you have additional questions after the webinar, please don't hesitate to contact SPNS@HRSA.gov. So thank you, everyone, and enjoy the rest of your day.