Enlaces Por La Salud

This fact sheet contains highlights from a Ryan White HIV/AIDS Program (RWHAP) recipient on the Enlaces Por La Salud intervention, designed to provide intensive services to help Latino MSM and Latina transgender women link to and stay engaged in care and treatment.

INTERVENTION OVERVIEW: An intervention that uses a transnational framework providing cultural context to support the delivery of intensive services, including one-on-on educational sessions to help Latino men and Latina transgender women link to and stay engaged in care and treatment.

PRIORITY POPULATION: Latino men who have sex with men (MSM) and Latina transgender women of Mexican origin

ORGANIZATIONAL SETTING: Community-based organization (CBO)/AIDS Service Organization (ASO) (North Carolina)

FUNDING SOURCE(S): Health Resources and Services Administration's (HRSA) RWHAP Part F: Special Projects of National Significance (SPNS) "Culturally Appropriate Interventions of Outreach, Access and Retention Among Latino/a Populations" Initiative

INTERVENTION PURPOSE/GOAL: This intervention aims to increase the number of Mexican MSM and transgender women with HIV who are engaged in consistent care.

INTERVENTION SUCCESSES: Enlaces Por La Salud served a total of 91 participants. Of the 91 intervention participants, 50 were new to care and 41 were re-engaging in care. At 12 months:

- 73.6 percent were retained in care
- 81.3 percent had completed all six intervention sessions
- 90.5 percent were virally suppressed
- 85.7 percent had undetectable viral loads

SUSTAINABILITY: When planning for and promoting sustainability, assess organizational capacity to roll intervention activities into existing structures, services, and programs. While implementing the intervention, determine which intervention elements can be sustained, by determining how your organization may be equipped to sustain all or parts of the intervention.

INTERVENTION CORE ELEMENTS:

Identify and partner with CBOs. Identify CBOs with a history of working with people of Mexican descent and people with HIV, who have developed trust within that community. Partner with organizations with the capacity to expand their HIV testing within the Mexican population and to identify MSM and transgender women.

Hire and train staff. Hire staff with the ability to connect with Mexican MSM and transgender women and treat them with dignity and respect. The staff should be able to address issues of relevance to the target population through a transnational framework.

Conduct outreach and establish referral relationships. Conduct outreach to area clinics, health care providers, state HIV personnel, and social service agencies to inform them about the intervention and how it can help keep their

clients engaged in care. Explain the benefits of making referrals to the intervention and the process by which the personal health navigator (PHN) will receive referrals.

Receive referrals. PHNs receive referrals from state HIV personnel, such as the NC Department of Public Health's Disease Intervention Specialists (DIS). After assessing a client's eligibility for the intervention and receiving the client's consent, HIV personnel directly refer clients to PHNs.

Enroll clients. During enrollment, PHNs explain the intervention and expectations for the client. They also assess the client's strengths, needs, and barriers to accessing HIV medical care.

Develop a service and care plan. After the client is enrolled in the intervention, the PHN in collaboration with the client, develops a service and care plan that outlines goals, action steps, and a timeline. The PHN monitors and updates the plan as necessary.

Provide intensive and ongoing client support. The PHN delivers six one-on-one educational sessions, helps with medical appointments, and establishes a relationship with each client by building rapport and providing emotional support. The PHN provides an enhanced level of medical case management (MCM) and provides one-on-one adherence support.

Transition the client to traditional long-term case management with an established partner. The PHN prepares the client for the transition at the beginning of the intervention by delivering services that are intended to be an enhancement to routine MCM. Throughout the intervention, PHNs should provide/coordinate as many MCM service components as possible including linkage to healthcare, psychosocial, and other services. At the end of 12 months, the PHN transitions the client to case management services provided by an established partner.

INTERVENTION STAFFING:

- ***Project Coordinator:*** Oversees day-to-day intervention activities, meets with PHNs weekly, visits community partner sites bi-weekly, and holds case conferences to facilitate the discussion of specific cases, insights, and difficulties among PHNs and ways to address client recruitment and retention with the team.
- ***Personal Health Navigator:*** Builds a trusting and effective relationship with clients, identifies clients' needs, and barriers to accessing HIV medical care; provides appropriate interventions dependent upon clients' needs; facilitates the educational sessions with clients; and empowers clients through identification of their strengths.
- ***Outreach Staff:*** Establishes referral relationships with area clinics, health care providers, and social service agencies.

IMPLEMENTATION CHALLENGES:

Difficulty building referral networks. Local agencies and clinics had concerns regarding serving as a referral source for the intervention. Some believed the intervention to be a duplication of their efforts, whereas others believed it would increase their workloads, and possibly impact their funding. Staff invested considerable time continuously delivering presentations and meeting with agencies and clinics to share how their clients were benefitting from their engagement in the intervention.

Staff turnover at area clinics. Staff turnover required the continuous delivery of presentations about the intervention. Ensure that organizational staff have prior knowledge of the intervention and established relationships with the intervention team.

PHNs were unable to meet with all clients in person. Because clients often spent long spans of time working out of state and had little free time due to work schedules, PHNs had difficulty meeting with clients in person. To address this, PHNs contacted clients by phone and text messages, and delivered the one-on-one educational sessions via phone.

Low recruitment of Mexican MSM. Mexican MSM were initially one of the intervention's priority populations; however, the study team recognized that some Mexican men may not identify as MSM or only do so after a period of trust has been established. To ensure MSM clients were not being excluded based on a low level of MSM self-identification, the priority population was broadened to target the wider Latino male population.

RESOURCES:

Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations Initiative: Intervention Monographs: **https://targethiv.org/sites/default/files/file-upload/resources/Latino-SPNS-Intervention-Monograph-508_0.pdf**

Replicating Innovative HIV Care Strategies for Priority Populations: **https://targethiv.org/library/replicating-innovative-hiv-care-strategies-priority-populations**

HRSA IHIP Enlaces Por La Salud Intervention Implementation Guide: **https://targethiv.org/ihip/enlacesporlasalud**