Intervention: Leaders in Networking and Knowledge (Link II)

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

Content developed by the GMHC demonstration site staff with support from the Evaluation and Technical Assistance Center Team at UCSF

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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 compromise about 16% of the total US population,[i] they account for 21% of people living with HIV and are infected at a rate three times higher than their non-Latino white counterparts.[ii] Along the HIV care cascade, Hispanics/Latinos demonstrate higher percentages of linkage, retention, and prescription of ART as compared to the national population. However viral suppression among the Hispanic/Latino population remains low with only 36.9% of HIV-infected Latinos achieving viral suppression.[iii] This may be attributed in part to the higher rates of delayed HIV diagnosis and delayed engagement in care among Latinos,[iv] which has been associated with poor health outcomes.[v,vi] Rates of delayed diagnosis and engagement in care are even more pronounced among foreign-born Latinos[vii] and those born in Mexico or Puerto Rico have lower survival at 36 months post AIDS diagnosis compared to those born in the U.S. and South America.[viii]

Barriers to linkage, engagement and retention in HIV care

A range of social and structural barriers impedes timely and consistent access to HIV care for Latinos. *Social factors*, such as discrimination and HIV stigma, can negatively affect health seeking behaviors of HIV-infected Latinos/as. HIV stigma has been associated with delayed HIV testing and entry into care and HIV discrimination in the health care setting is also a

strong deterrent to accessing HIV medical services.[ix,x] In addition, many *structural barriers* result from economic disparities affecting Latinos in the US. For example, many Latinos living with HIV struggle with competing needs - such as finding and keeping work and housing - that take priority over health care.[xi,xii] Structural barriers that particularly affect Latinos include lack of bilingual services in Spanish, low rates of health insurance coverage, and lack of transportation.[xii] For Latinos who are not citizens or in the US with official documents, fear of deportation can also reduce willingness to access care.[xiii,xiv]

Cultural factors can also result in delays when Latina/os living with HIV, particularly immigrants, enter medical care.[xv,xvi] Among Latina/os, cultural values such as *simpatia* (politeness and the avoidance of hostile confrontation), *personalismo* (the value of warm personal interaction), *respeto* (the importance of showing respect to authority figures, including health care providers), *familismo* (collective loyalty to extended family and commitment to family obligation) and *fatalismo* (the belief that individuals cannot do much to alter fate) can play a significant role in when they access HIV care as well as influence the decisions they make around issues of HIV care.[xvii,xviii] While these values are generalizations and may not apply to any individual patient, understanding them may help health care providers to understand a particular patient's behavior in the context of lager cultural inclinations.

Among Latinos/as, access to HIV testing and HIV medical care is further influenced by *country of origin and U.S. citizenship.* CDC reports indicate that approximately 55% of Latina/os born in Mexico and 58% of Latina/os born in Central America have a late diagnosis (defined as progression to AIDS within 1 year of diagnosis), compared to 40% of Puerto Ricans and other Latinos born in the U.S.[xix] Although HIV testing is available for all U.S. residents at public health clinics, regardless of citizenship status, accessing these services requires an understanding of how to navigate the health care system, which may be difficult for monolingual Spanish-speakers. Undocumented immigrants may have suspicion or anxiety about visiting health centers for fear that information about them will be released to other government agencies.[xx]

Transnationalism

The application of a standard set of cultural elements to interventions and programs targeting Latinos/as fails to take into account the heterogeneity of Latino cultural practices and values. Because Latino culture and identity often differ between and within countries,[xxi,xxii] it may be beneficial to incorporate a transnational perspective in order to take into account the unique experience of each individual. The transnational perspective takes into account the "duality" of the immigrant experience, exploring the immigrant's process of adapting to their host country while continuing to maintain connection to their country of origin.[xxiii] As a result, health seeking behavior may be influenced by more than one culture.[xxiv] The transnational framework looks specifically at the social, political, social and cultural ties of an immigrant to their place of origin.[xxiii-xxv] Taken together, research around social, structural and possible cultural barriers to care and research on how transnational practices influence care, suggest a need for novel and tailored intervention approaches to improve linkage and retention in care for Latinos living with HIV in the continental US.

This Initiative

Under the Health Resources and Services Administration's (HRSA) Special Projects of National Significance (SPNS) Program **Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations,** nine demonstration sites are developing innovative methods to identify Latinos who are at high risk or living with HIV and out of care or unaware of their HIV-positive status, and improve their access, timely entry and retention in quality HIV primary care. This initiative is one of the first public health adaptations of the transnational approach, with interventions targeting HIV-infected Latino subpopulations living in the US that are specific to their country or place of origin.

This manual describes each of these interventions, including:

- The local epidemiology and unique needs of the populations served
- A description of each organization
- Key components of each intervention including outreach, recruitment, and retention strategies
- A logic model and/or a description of how each key intervention component addressed various stages of the HIV Care Continuum (e.g. linkage, retention, ART adherence, and viral suppression)
- Core intervention staff
- Description of community partners, when appropriate
- Staffing requirements and cost estimates
- Program planning and development needs
- Preliminary programmatic outcomes
- Important lessons learned

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Gay Men's Health Crisis

Project Name: Leaders in Networking and Knowledge (Link II)

Location: New York, New York

GMHC

END AIDS. LIVE LIFE.

Local Epidemiology

According to CDC surveillance data from 2010[1], Hispanics or Latinos are disproportionately affected by HIV, relative to other races/ethnicities. The estimated new HIV infection rate among Latinos in 2010 in the United States was more than 3 times as high as that of whites and Hispanics/Latinos accounted for over one-fifth (21% or 9,800) of all new HIV infections in the United States despite representing about 16% of the total US population. Compared with whites, Latinos experience disproportionately higher rates of delayed testing, diagnosis, and entry into care.[2]

More specifically, Latino men accounted for 87% (8,500) of all estimated new HIV infections among Hispanics/Latinos in the United States and most (79% or 6,700) of the estimated new HIV infections among Hispanic/Latino men were attributed to male-to-male sexual contact.

There are several cultural factors that may contribute to the increased risk of HIV infection. Some Latinos may avoid seeking testing, counseling, or treatment if infected because of stigma or fear of discrimination. Traditional gender roles, cultural norms such as *"machismo"* and *"marianismo"*, and the stigma around homosexuality may add to prevention challenges. Numerous socio-demographic and economic factors within the Latino community significantly impact Latinos' engagement and retention in care.[3] These factors include lack of insurance, high rates of poverty, unemployment, lack of transportation, housing instability, low levels of English proficiency, lack of formal education, low levels of health literacy, lack of trust of medical providers, limited numbers of bilingual healthcare providers and lack of bilingual HIV educational resources.[4,5]

GMHC serves more than 3,100 Latino individuals annually (approximately 32% of our entire client base), and of those Latino clients that identify a country of origin, 37% identify as Puerto Rican. Forty-four percent (44%) of GMHC's Latino clients identify as gay or bisexual. We estimate that each year GMHC serves more than 500 individuals who identify as MSM with Puerto Rico as a country of origin.

New York City has a very comprehensive array of services that support individuals living with HIV/AIDS, and these services are coordinated by both public and nonprofit agencies.

However, despite this wealth of services for people living with HIV/AIDS in New York City, there are very few institutions that offer a comprehensive array of services in a single culturally-competent, accepting facility. GMHC is one of only a few HIV/AIDS service providers to have significant experience using social networking strategies to reach difficult-to-engage populations and recruit them for HIV tests. GMHC has unique experience in targeting not only the index client, but also that client's collaterals, including sex and drug-sharing partners. If they meet the eligibility criteria, the client's collaterals may, in turn, become recruiters to target their own social networks.

The LINK II program uses a social networking strategy to identify HIV-positive Latinos who are unaware of their HIV status or who are aware of their status but not engaged in care. This strategy enlists HIV-positive individuals (i.e. recruiters) to encourage people in their network (i.e. network associates) to be tested for HIV, and has shown to be an efficient and effective route to accessing individuals who are infected with HIV, or at very high risk for infection, and linking them to services. The social networking approach, first designed and tested by the Centers for Disease Control in 2003, is based on the idea that individuals are linked together to form extensive social networks, and that HIV is a disease that spreads throughout these networks. In the national CDC Social Networks Demonstration Program operated from 2003 to 3005, a social networking approach yielded a 6% seropositivity rate among all network associates that were tested; this rate of detection is approximately six times higher than the success rate of most traditional HIV testing programs nationally.

GMHC believes that a social networking strategy will be especially effective in overcoming the factors that interfere with identifying Latinos – and specifically Puerto Rican MSM – who are unaware of their HIV status. The personal conversations between peers about the importance of HIV testing will help to overcome some effects of cultural stigma and misconceptions that may impact an individual's reluctance to test for HIV. In addition to addressing the barriers that prevent Latinos specifically Puerto Rican MSM to test for HIV, the social networking strategy takes a more proactive approach than the traditional route of testing which is available to anyone. Traditional testing does not have the added benefit of motivation and encouragement by peers who discuss the benefits and importance of HIV testing from a "relatable" perspective. This addresses another barrier of an individual's initiative to want to get HIV tested, because they are being encouraged by someone in their social group to know their status. Having that "back-up" person, hopes to give the perception to the person seeking to get tested that knowing his status is not just important to him, but to the members of his community (i.e. social network).

Since 2008, GMHC has demonstrated success in using this social networking strategy and this implementation approach to engage hard-to-influence populations that often are not reached by traditional means. During the past five years of its existing social networking strategy program, LINK (Leaders in Networking and Knowledge), GHMC has engaged 138 recruiters, 58% of whom were Latino, to recruit 1,686 network associates for HIV tests. Of these network associates, 5.6% were found to be HIV positive, a higher outcome of seropositivity than from GMHC's traditional outreach alone. In the past year, LINK conducted 548 HIV tests of network

associates, with a 4.2% seropositivity rate. The proposed LINK II intervention model will build on the LINK program to identify HIV positive Puerto Ricans unaware of their HIV infection via recruiters drawn from Puerto Rican MSM already part of GMHC's client population.

Target populations:

The target population for this demonstration intervention is Puerto Rican MSM who are ages 18 and older. These individuals are either unaware of their HIV-status or are HIV-positive, but have been out of care for more than 6 months.

Network Associates

N = 1200 NAs Age range: ≥ 18 years

Sample description: Network associates should be HIV- or HIV status unknown adults, or HIV+ positive adults who have been out of care for at least 6months. Both populations must self-identify as Puerto Rican and MSM.

Inclusion for NAs

- Age ≥ 18 years
- MSM
- HIV Negative or newly HIV status unknown
- HIV+ and out of care for > 6 months
- Sent by Recruiter
- Can speak and understand English or Spanish

Exclusions for NAs

- Age < 18 years
- Female
- Sex with women only

Recruiters

Subjects:

N = 120 recruiters Age range: ≥ 18 years

Sample description: Our initial group of recruiters for year 1 of the demonstration study will be HIV+ or high risk HIV- adults who self-identify as Puerto Rican and MSM. As the study progresses (Years 2-4) the demographic description of the recruiter population may shift as we examine the data collected to determine the most effective recruiter characteristics.

Program Description

Goals of the intervention:

GMHC's innovative demonstration intervention model is titled **LINK II (Leaders in Networking and Knowledge)** and utilizes three strategies that will effectively identify and serve individuals in the Puerto Rican MSM community in New York City who are at high risk of HIV infection or are infected with HIV but unaware of their HIV status; are aware of their HIV infection but have never been engaged in care; or who have dropped out of care. These strategies are designed to identify individuals from this target population and provide them with HIV testing and counseling, link them to medical care, and help them remain engaged in medical care.

1. To identify individuals from this target population and provide them with HIV testing and counseling, LINK II employs a social networking strategy that will enlist HIV-positive recruiters from the Puerto Rican MSM community to recruit their network associates for HIV tests. This strategy has proven to effectively and efficiently reach HIV positive individuals in communities that are otherwise hard-to-influence, and will be particularly effective in capitalizing on the

strong relationships that individuals in the Puerto Rican MSM community have with each other.
2. To link those network associates who are HIV positive to care, LINK II employs a Linkage Navigation Specialist from this community to provide customized materials and culturally-nuanced counseling, and a personal escort to Mount Sinai Hospital for an initial medical visit.
3. To help these newly-diagnosed individuals remain engaged in medical care, GMHC will collaborate with Mount Sinai Hospital to offer an array of culturally-sensitive supportive

services in a location that is widely known as being gay-friendly, sex-positive, and outside of the neighborhood where most clients live, to reduce the impact of perceived stigma on engagement in care. The supportive services are offered by bilingual staff and include mental health counseling, support groups, transportation assistance, health insurance and benefits advocacy, and housing assistance.

Overview of Core Phases:

There are four major phases to the Leaders In Networking & Knowledge (LINK) II social networking project. These phases are:

- Recruiter Enlistment
- Engagement (Orientation, Interview, and Coaching)
- Recruitment of Network Associates
- Counseling, Testing, and Referral (CTR)

Recruiter Enlistment

- In this phase, HIV-positive or HIV-negative high-risk persons from the community who are able and willing to recruit individuals at risk for HIV infection from their social, sexual, or drug-using networks are enlisted into the program. To identify recruiters, GMHC approaches our HIV- positive clients and identify additional people through GMHC's existing counseling and testing and other programs.

Engagement (Orientation, Interview, and Coaching)

- After recruiters are enlisted into the LINK II program, they are provided with an orientation session that explains the nature of the program and the social network techniques that might be used to approach their associates and discuss HIV testing with them. Next, recruiters are interviewed to elicit information about their network associates. The period of time needed to elicit information from recruiters is typically brief recruiters may be able to give all of their network information within one - two interviews. Unlike peer outreach workers, recruiters' participation time overall is relatively short and last no more three months.

- Coaching is provided on an ongoing basis throughout the period of the recruiter's participation. Coaching may involve discussion with recruiters on how to approach associates about 1) obtaining HIV CTR, 2) disclosing their own HIV status if they wish to do so, and 3) how to avoid disclosing status if desired. Additionally, the recruitment coordinator seeks to assist the recruiter address any cultural or structural issues their network associates may be facing that creates barriers for HIV testing.

Recruitment of Network Associates

- Recruiters will refer individuals for testing who they have identified as being at risk for HIV infection. All individuals are approached by the recruiter alone, without the involvement of GMHC.

To promote the LINK II project and enlist potential recruiters from the target population, GMHC utilizes a two prong program promotion approach, which includes: in-reach and outreach.

In-reach:

- In-reach is an integral component of the intervention and serves as a means to identify HIV positive individuals who may serve as recruiters as they are more likely to

  have HIV positive individuals, who are unaware of their status or high-risk individuals, within their social networks.

- The recruitment coordinator is responsible for conducting in-reach within GMHC as noted below:

  A. **Meeting & presentations with program staff:** Meetings with other GMHC program staff, within other programs, occurs once and then as needed. The meetings with the staff, from a variety of modalities, enables the recruitment coordinator to inform GMHC staff about the LINK II program, including: (1) goals of the program, (2) target population and eligibility, (3) core phases of the programs & (4) mechanisms for referring to the LINK II program. Meeting with other program staff also creates buy-in from the staff, which increases the likelihood that that the program staff will refer potential recruiters to the LINK II project. Program staff also has the opportunity to ask questions and seek clarification. Staff is provided with a referral form and instructions on how to cement a referral to the LINK II project.

  B. **Presentation to Client Advisory Board (CAB):** The recruitment coordinator also presents annually, and then as needed, at the GMHC client advisory board. The client advisory board consists of GMHC clients, both HIV positive, HIV negative and at-risk who provides feedback on GMHC programs, as well as advocacy on behalf of the client population. The presentation mirrors the presentation conducted for GMHC staff, and includes: (1) goals of the program, (2) target population and eligibility, (3) core phases of the programs & (4) how to become a recruiter for the LINK II Project. During the presentation, CAB members are encouraged to become a part of the LINK II project, if they meet the eligibility requirements. Those CAB members who express an interest in becoming a recruiter for the project are provided with an

appointment, within one week of the presentation, to meet with the recruitment coordinator and learn more about the project. Additionally, the recruitment coordinator distributes business cards, to the CAB members, so that they can contact the recruitment coordinator at a later date if they become interested in being a part of the LINK II Project. CAB members also have the opportunity to ask questions and seek clarification.

C. **Intake Department:** The point of entry and access for most of GMHC's services occurs through GMHC's intake department. The intake department is responsible for completing a comprehensive intake and assessment (using program developed algorithms) for all HIV positive clients, identifying service needs and gaps, and ensuring the client is referred to services that address the identified needs and services gaps

As a result of the intake staff promote the LINK II project, to clients presenting for intake services. For those clients who are interested, the intake department contacts the recruitment coordinator to schedule an appointment for the client to meet with the recruitment coordinator to discuss the program further.

Outreach:

In addition to providing culturally competent, specific to Puerto Rican MSM services, promoting the LINK II project, identifying & enrolling potential recruiters for the intervention and providing HIV CTRPRN services to network associates, the additional goals of street-based outreach to the community and community-based organizations are to:

- Increase the accessibility of HIV counseling and testing as a primary prevention tool by deploying a mobile HIV/STI testing unit staffed by trained counselors who will connect both HIV-positive and HIV-negative clients into supportive services.
- Enhance the value of HIV testing as an early intervention tool by providing an easily accessible and comprehensive range of services to enable HIV-positive individuals to learn about and access treatment options and appropriate health care, and obtain entitlement or benefits that will enable them to cover treatment costs.
- Provide at risk individuals an accessible, high-quality counseling and testing program to assist them in their decision to test for HIV or other STI's and access comprehensive supportive services.
- The LINK II Project, a program of the David Geffen Center for HIV Prevention & Health Education at Gay Men's Health Crisis (GMHC), is designed to provide a continuum of sexual health related services integrated with HIV testing that will support continued risk reduction behavior by eligible clients (Puerto Rican MSM). The LINK II Project facilitates access to early intervention information and treatment for those who test positive for HIV. Through the use of a custom designed conversion van, to be used by the outreach team, we are to promote the LINK II project, identify potential recruiters, conduct HIV CTRPN, in the field

(street-based outreach) and at community – based organizations.

- The recruitment coordinator is responsible for identifying and conducting outreach and recruitment activities in the community and at community-based organizations where the target population may congregate, live, or receive services.
- To identify suitable street – based outreach locations, the recruitment coordinator works with members of the testing team/program including the Assistant Director and Offsite Supervisor, as the offsite supervisor is responsible for developing a monthly offsite/outreach calendar of testing locations. The recruitment coordinator will review the calendar and then based on the recruitment coordinators availability and locations (does the location have a high percentage of the target population) determine if he/she will accompany the testing team and conduct outreach to identify potential recruiters for the LINK II project.

  A. Outreach locations are determined based on the New York City Department of Health and Mental Hygiene Epidemiological neighborhood profile which details demographical information of the community (e.g. race/ethnicity, age, marital status) as well as HIV incidence and sero-prevalence rates. Outreach is conducted in those areas: (1) with the highest representation of the target population and (2) highest HIV incidence and sero – prevalence rates.

  B. In conducting street-based outreach, with the testing team, the recruitment coordinator ensures he/she (1) knows and is able to speak with target populations language & (2) is aware of and sensitive to the community norms, values, and beliefs. The recruitment coordinator approaches potential community residents and asks when was the last time that individual was tested for HIV? This opens up the conversation

  C. and enables the recruitment coordinator to (a) encourage the individual to obtain an HIV test, aboard the MTU, and (b) discuss the LINK II project with the individual. Individuals, who opt to receive HIV testing, receive HIV CTRPRN in accordance with the protocol and are screened for eligibility to become a recruiter. Individuals, who opt not to receive HIV CTRPN services, are screened for eligibility, to become a recruiter for the LINK II project. If the individual does not wish to be screened, they are provided with the recruitment coordinators business card, so that if they change their mind, in becoming a part of the project, they are able to contact the recruitment coordinator. During street-based outreach, individuals are also provided with

safer sex kits and information on HIV prevention. During the spring and summer months, the recruitment coordinator will also set up a table, outside of the mobile testing unit, that displays safer sex kits, HIV prevention information, and information on the LINK II project.

D. All testing center staff has received crossed training on the LINK II project and protocol. As a result, in the event the recruitment coordinator is unable to accompany the testing team for street-based outreach or at a community based organization, the testing team provides individuals from the target population with information on the LINK II project and contact information to the recruitment coordinator.

Core Intervention Staff

Director of Geffen Counseling and Testing Center, responsible for the support of the testing team in ensuring clients receive quality HIV CTR and prevention services. Specific to the HRSA SPNS contract, the Assistant Director is responsible for the direct supervision and oversight of the recruitment coordinator, ensuring the recruitment coordinator is meeting project goals and deliverables. The Director also provides administrative oversight on the HRSA SPNS contract by providing oversight and performing quality assurance checks of data entry, review of client records (recruiter and network associate) as well as review of additional programmatic forms, including tracking sheets, testing logs, and result logs. The Assistant Director also assists in the completion of necessary HRSA related reports. Participates in the monthly HRSA conference calls to discuss program performance. **Qualifications:** At least five years' experience in the oversight and management of an HIV Prevention Program. Knowledge of Social Networking Strategies (SNS) model, as well as knowledge on ARTAS linkage to care model. Spanish – speaking and extensive knowledge on cultural aspects of PR MSM.

Recruitment Coordinator, responsible for identifying existing GMHC clients who are HIV positive and members of the Puerto Rican MSM community to serve as recruiters. Responsible for screening and conducting orientation for all individuals interested in becoming LINK II recruiters, providing training and coaching for all recruiters, and monitoring the success of each recruiter in engaging network associates for testing. Conduct outreach to identify potential recruiters for the HRSA SPNS project. Attend all HRSA SPNS related meetings and monthly conference calls. This position is also responsible for providing direct supervision to the Linkage Navigation Specialist, to ensure those clients who test HIV positive are linked to medical and support services. Ensures eligible clients complete local and multi-site evaluation questionnaires, as per protocol. Conduct HIV and syphilis counseling and testing. **Qualifications:** NYCDOHMH certified HIV/AIDS Test Counselor Training, High School Diploma, at minimum three years in the conducting HIV testing using a SNS approach. Spanish – speaking and extensive knowledge on cultural aspects of PR MSM.

Linkage Navigation Specialist, responsible for providing immediate counseling to individuals who receive a preliminary

positive HIV result at the GMHC Geffen Testing Center. Builds relationships with each individual receiving a preliminary positive and confirmed positive HIV result, and responsible for linking these clients to care at partner medical provider. Conducts all follow-up with clients after medical appointments and contacts all clients who miss medical appointments to address concerns and barriers to care. Refers clients as needed to supportive services at GMHC and referral network to resolve barriers to care. Provides HIV and syphilis testing services. Conducts and documents all engagements into AIRS. **Qualifications:** High school diploma, at minimum 2 years in the provision of linkage to care services utilizing an ARTAS approach. Training in ARTAS. NYCDOHMH certified HIV test counselor.

Program Planning and Development

Staff hiring: The program began the recruitment process shortly after receiving notification that the GMHC was awarded funding. For the recruitment coordinator position, we recruited someone with years of HIV experience and who was from the target population. Being committed to staff development, we identified a well – respected internal candidate for the linkage navigation specialist position as well as for the evaluator position. All other positions were already filled at the point of startup.

Staff Training: All key intervention staff members were trained in HIV counseling and testing, ARTAS (linkage to care DEBI), AIRS Training, cultural competency, as well as HIV confidentiality, and research techniques. Ongoing training occurred annually and included annual HIV confidentiality training, infection control and HIV testing procedures.

Development of partnerships and MOU's:

A. **Partnerships with Churches:** We routinely partner with community churches, as we understand church is a major cultural aspect in the Puerto Rican community.

B. **Collaborations with Government:** We work extensively with the NYCDOHMH on its Brooklyn and Bronx Knows Testing campaigns. Both boroughs have a high percentage of Puerto Rican MSM and a high HIV incidence and sero-prevalence rates, increasing the opportunity that we will engage the target population, in the LINK II project.

C. **Collaboration with Walgreens/Duane Reade pharmacies:** Ongoing collaboration with both pharmacies, where we conduct targeted outreach and testing each year for National HIV testing day, which allows us to test inside of Walgreens/Duane Reade stores in areas with high concentrations of the target population of Puerto Rican MSM.

D. **Non – traditional venues that cater to Puerto Rican MSM:** Strategic partnerships with several non-traditional venues that cater to the Latino MSM population.

E. **Collaboration with other HRSA SPNS sites:** Riker's Island and Harlem United.

Implementation and Maintenance:

Modifications: The program faced challenges in identifying enrollees for the project (HIV+ Puerto Rican MSM) utilizing the social network approach. We modified the strategy and we

were able to enroll individuals who were from the target audience and were either known positive or were newly diagnosed, but were not a part of the SNS approach. While this approach yielded a few additional enrollees, we did not meet the our initial target of 100 enrollees.

Barriers toward implementation: There were two major barriers toward implementing the program. Firstly, the program was not able to enroll participants until year 2 of the project, which increased our annual targets for years 2 – 4. The second barriers was the demonstration requirements for the population itself, in that it was difficult to identify HIV positive (known positive and out of care or irregularly in care, or newly diagnosed) MSM from Puerto Rico.

Lessons Learned

1. Start enrollment into the project as soon as possible.

2. Ensure all evaluation questions, study design, etc. are known and developed early in the process as to not affect when you can enroll clients.

3. Think about target population and while it should be defined, it should be so defined as to affect enrollment. Ensure you have true access to the target population.

4. Train staff fully on model and evaluation metrics, this is vitally important.

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