Intervention: Salud y Orgullo Mexicano

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

Content developed by the AIDS Foundation of Chicago 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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AIDS Foundation of Chicago

Project Name: Salud y Orgullo Mexicano

Location: Chicago, Illinois

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Local Epidemiology

As of 2015, there were approximately 24,000 people living with HIV/AIDS in the Chicago eligible metropolitan area with a disproportionately large representation of Latino and African American men who have sex with men (MSM) living in Chicago's South and West side neighborhoods.[1] Chicago is a racially segregated city, with most of the South and West Side neighborhoods being predominately made up of African Americans and Latinos. Chicago's linkage to care and retention in care rates are generally much better than the national rate, at 78% and 61% respectively. However, people living with HIV/AIDS (PLWHA) of color in Chicago continue to struggle with engagement in care relative to their white counterparts.

According to the Chicago Department of Public Health, Chicago Latinos' risk of acquiring HIV is elevated: their HIV infection rate (23.6 per 100,000) is 20% higher than that of Latinos elsewhere in the US and it is 50% higher than the overall US rate (Ref: Chicago DPH). [2] The local burden of the HIV/AIDS epidemic has been growing; in Chicago, AIDS diagnoses among Latinos rose 16% between 2003 and 2009. While the highest rates of new HIV infection remains among MSM in Chicago, the rate has decreased among white MSM while continuing to increase among Latino and Black MSM. Nationally, among Latinos (in general) and also specifically for Mexicans, the predominant mode of transmission is through sex among men; Sexual transmission among MSM accounted for 78% of HIV infection among Latinos living in Chicago diagnosed with HIV in 2009. This corresponds to a significant population in Chicago considering that, as of the 2010 census, Latinos comprise 29% of the city's population; 80% of that Latino population is Mexican, accounting for the fourth largest Mexican-origin population in the United States.

The disproportionate burden of HIV in Chicago's Latino community is apparent not only in infection rates but in retention in care. While Latinos in Chicago who were diagnosed with HIV in 2010 were 3% more likely to have been initially linked to care than their non-Latino white counterparts, Latinos were significantly less likely (17%) to be retained in care than non-Latino whites. Among Mexican-American men, low retention-in-care rates are attributable in part to structural, financial, and cultural barriers to accessing medical care. These barriers include lack of health insurance, lack of experience navigating the American healthcare system,

and a lack of culturally competent healthcare facilities.[3] Their access to HIV primary care is further complicated by fear, stigma, and the economic reality that men of Mexican descent tend to have less education and lower incomes.[4, 5]

Program Description: The SOM Intervention

The Organizational Context

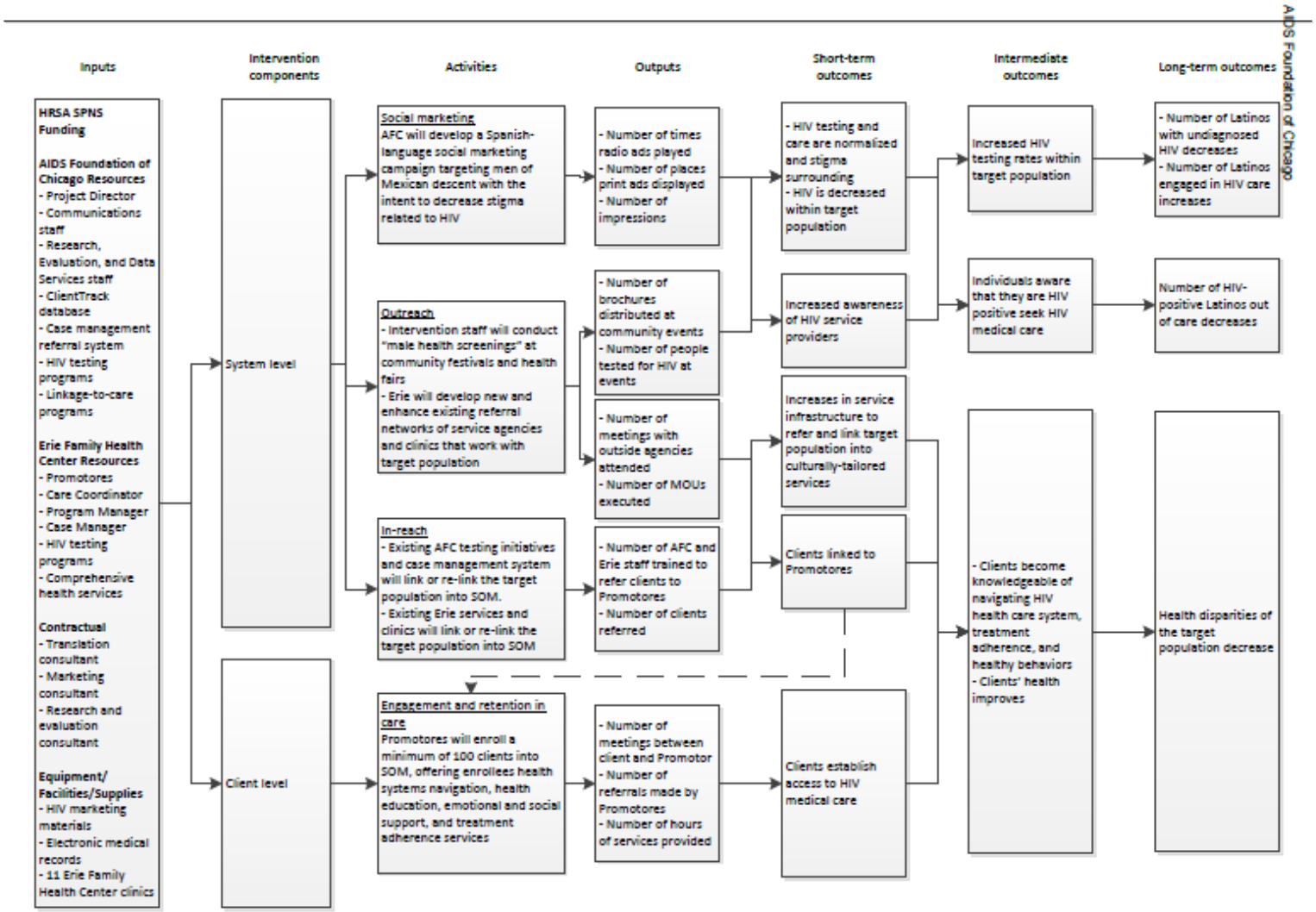
Informed by a transnational framework, and funded through this HRSA/SPNS initiative, Salud y Orgullo Mexicano (SOM), which means "Mexican health and pride," was developed to identify men of Mexican descent who are HIV positive and then engage and retain them in HIV primary care. SOM was managed by the AIDS Foundation of Chicago and principally executed with a clinical partner, Erie Family Health Center.

Theoretical Framework

The overall conceptual model for the SOM intervention was grounded in the Stages of Change theoretical framework within the transtheoretical model; this model assesses an individual's readiness to act on a new, healthier behavior and provides strategies to guide the individual through various stages of change to the point they are ready to take action and maintain that change.[12] As such, the strategies of SOM consider each person's current life circumstance and level of need and do not provide a "one-size fits all" approach, considering that within the Stages of Change framework, clients may move through the following stages when deciding whether to be tested for HIV or to participate in HIV medical care: pre-contemplation, contemplation, preparation, action, maintenance, and sometimes relapse. The Stages of Change framework has been applied in Latino-focused social marketing campaigns and HIV community health worker programs, and is easily compatible with SOM's transnational approach detailed below.[6,7]

The SOM Promotor intervention was chiefly based on two previous service delivery experiences: ARTAS and our linkage initiative from Bristol Myers Squibb/Positive Charge funded by AIDS United entitled Project IN-CARE. [8,9] Together these programs demonstrate the effectiveness of both active linkage to care accompanied by strengths-based case management and peer navigation services for HIV-positive clients.[9,10] The ARTAS intervention provides a recently diagnosed individual with strengths-based case management over multiple sessions in a time-limited period to effectively link them to care; this strengths-based case management approach encourages a client to identify and use his personal strengths, create goals for himself, and develop an effective, working relationship with a Linkage to Care Coordinator. Two completed ARTAS studies showed that participants who received the ARTAS intervention had higher levels of linkage to primary care than participants who did not receive the ARTAS intervention[11,12] SOM Promotores utilize a session-limited, strengths-based model to work with men of Mexican descent that include strengths based interviewing, a fixed number of sessions, and 180 days to work with individuals. In the SOM project this period was extended from 90 days to 180 days. While the intervention is based on the ARTAS and Project IN-CARE models, the peer training is based on the People-to-people training curriculum, an intensive three session training for peers/Promotores de salud.[13]

Salud y Orgullo Mexicano Logic Model



Additionally, SOM was informed by peer health navigation interventions, particularly those targeted at minority men and MSM. These interventions employ navigators who come from the same community as their target population, making them uniquely qualified to help clients navigate population-specific barriers to care. In 2013, the AIDS Foundation of Chicago (AFC) completed its IN-CARE project, which targeted minority MSM; this intervention successfully linked 87% of male participants to HIV primary care through its peer health navigation services.[9] Lourdes Campero's recent research based in Mexico demonstrates, peer social support helps men improve their quality of life and seek medical care after an HIV diagnosis.[14] The elements of the IN-CARE project incorporated into SOM include this use of HIV-positive peer navigators in the form of SOM Promotores, an intensive supervision structure, and the expectation of on-going contact requirements beyond the initial six-month linkage period to engage and retain participants.

Peers Adapting a Transnational Framework

The SOM intervention was specifically developed with a transnational approach stitched into its education sessions with clients. As part of formative work to develop the intervention, SOM created an advisory board of community experts who work in the HIV Latino community. This advisory board was comprised of six members representing Mexican men from different organizations including faculty at the University of Illinois at Chicago, the National Latino Commission, Midwest AIDS Training and Education Center and several community-based organizations, discussed the intervention and provided input regarding the needs of the Chicago HIV-positive Latino community and what type of intervention would benefit newly diagnosed individuals or patients who are out of care. They also identified the barriers that affect this population's medical care and adherence to treatment. Barriers identified by the community advisory board were synthesized thematically and informed intervention content creation. Staff then completed 13 qualitative interviews where "near-peer" participants (e.g., participants similar to our intervention population but ineligible for the program) were asked questions about barriers, ties to family and Mexico, work, stigma, immigration, confidentiality and transnationalism. With the information gathered from the qualitative interviews, the intervention was updated to address a peer-led intervention emphasizing HIV education, where the Promotor shares more about his own life experience regarding his HIV diagnosis; navigating HIV care and treatment; disclosing to family members and friends; and engaging in romantic relationships, sex, and dating. Consistent with the Transnational Framework, the identities, practices, and social engagement opportunities of Mexican immigrants to Chicago are shaped both by experiences in their home countries and by their new lives in Chicago and in the United States. They often maintain a number of cross-border practices and activities including ongoing communication with loved ones in their home countries, traveling back and forth from their home country and host country, sending remittances back to people in their country of origin, and sustaining political and social affiliations/activities that span countries.

Dr. Hector Carillo, an expert in transnational approaches to public health interventions particularly as they relate to the Latino and Mexican population, suggests that interventions incorporating a transnational framework consider a client's cultural points of reference, sources of information, sources of emotional and practical support, sources of discrimination and

social stigma, sources of beliefs about health, and access to healthcare and health practices. [17, 18] As an HIV/AIDS intervention with Mexican-American men, transnational considerations for SOM include;

- Helping participants determine how they can share their HIV status and seek social support from family and friends in their country of origin,
- Helping to offer participants social support through Promotores here in their country of settlement,
- Helping participants adapt their healthcare beliefs and behaviors to the available U.S. HIV healthcare model when a participant's point of reference about healthcare is his place of origin,
- Assessing a participant's level of transnational identity and cross-border practices and determining to what degree that shapes his retention in care,
- Navigating cost-effective HIV care and seeking supportive services, given the added expense of remittances to their families,
- Addressing cultural norms that might shape a participant's engagement in healthcare, including;
  - *Machismo:* a pride in and responsibility towards identifying with and displaying traditional, often dominant, masculinity. This can influence men's perception of their sexuality and their willingness to engage care,
  - *Familismo*: a strong orientation and commitment towards the family in Latino culture, especially as it relates to marriage, childbearing, and familial obligation,

Fatalismo: a sense of powerlessness to effect change or resignation to a perceived inevitability that might prevent some Mexican MSM from seeking HIV care.

SOM Goals and Objectives

Program Goals

1. Conduct a multi-year social marketing campaign to raise HIV/AIDS awareness, encourage HIV testing and recruit HIV-positive men of Mexican descent into HIV primary care.
2. Enroll 100 HIV-positive men of Mexican descent.
3. Provide Promotor services to link and retain all clients in HIV primary care at Erie Family Health Center or their clinic of choice.

Components of the SOM Intervention

The intervention consisted of two main strategies:

- A Community **Social Marketing Campaign** to raise HIV/AIDS awareness, encourage HIV testing and recruit HIV-positive men of Mexican descent into HIV primary care.

- **Peer Navigation Services**, including standardized SOM intervention education sessions (outlined below), provided by Promotores to link and retain clients in HIV primary care at Erie Family Health Center. Promotores' main role was to provide peer education about HIV care; resources are also provided to the clients when appropriate. In the scenario where the participant is in need of more services or referrals, the Promotor refers the participant back to the patient's Ryan White case manager that the client is assigned whether that be at Erie or another of our case management agencies.

Client-Level Measurable Outcomes:

Outcome 1: Clients establish access to HIV care
Indicators:
1. Clients attend two medical appointments within 12 months
2. Clients have their CD4 count and viral load drawn twice a year
3. Eighty five percent of clinically indicated clients begin medications

Outcome 2: Clients' health improves
Indicators:
1. Eighty percent of clients report an improved or maintained perception of health
2. Eighty percent of clients achieve viral suppression within 12 months of initiating antiretroviral therapy
3. Clients' utilization of emergency rooms and number of hospital stays decreases by 50%

Recruitment and Referral Goals:
1. Screen no less than 50 individuals per year for years two through four? five of the project.
2. Refer no less than 75% of all eligible clients who wish to receive their primary care at Erie to SOM.
3. Enroll no less than 25 individuals per year for years two through four? five of the project.

Target Population and Eligibility Criteria

SOM targeted men whose country of origin is Mexico; are HIV-positive, and are over age 18. Eventually due to the need for targeting our recruitment efforts we narrowed eligibility to men who have sex with men. In addition:

Long-Term Program Objectives:
- Increase retention in HIV medical care for newly diagnosed individuals living with HIV and individuals living with HIV who have been lost to care.
- Increase client knowledge of HIV disease and treatment.
- Improve client self-sufficiency.
- Increase the number of individuals living with HIV who are virally suppressed.

Short-Term Program Objectives:
- Client adheres to regular HIV primary care appointments during first year (engaged or re-engaged in care).
- Client increases independence and transitions to self-management or case management.

Promotores de Salud work with three client populations:
1. Newly diagnosed: clients first diagnosed with HIV during the previous 180 days.
2. New to Care: clients previously diagnosed with HIV infection but not previously linked to HIV medical care.

Out of Care: clients with fewer than four medical appointments with a provider with prescribing privileges in the last 24 months, OR client has experienced a gap greater than six months between HIV-specific medical appointments within the past 24 months.

Promotores de salud, or peer community health workers, who come from the same community as the target population facilitate clients' timely entry, engagement, and retention in HIV primary care at EFHC by providing a culturally adapted intervention that consists of systems

navigation, health education, and peer counseling. Prior research has shown that Promotores are effective at improving healthcare service utilization by HIV-positive men of Mexican descent by helping participants overcome obstacles to accessing care.[17, 18, 19] As peers who, like the clients, are HIV-positive men of Mexican descent, the Promotores are well-suited to helping clients address their structural, financial, personal, and cultural barriers to accessing medical care. EFHC and AFC worked together to select the Promotores for SOM. The ideal candidate is open about sharing his HIV life experience such as coping with HIV, disclosing HIV status, experience with dealing with HIV stigma barriers and history of HIV treatment.
Some of the key navigation services Promotores provide to foster consistent engagement in care include: individualized general health education; skills building around patient-provider; communication; referrals and coordination of services with Ryan White case managers; accompanying participants to medical or other service appointments; reminders to participants of upcoming medical visits; build problem-solving skills for navigating housing, substance use, and employment issues.

The SOM intervention sessions include information on PrEP for partners, immigration, harm reduction, and disclosure of HIV status. The sessions encourage the Promotor to ask the participants questions and to allow a peer-to-peer dialogue on HIV/AIDS and are completed in the order requested by the client. Although numbered the sessions are not linear. The sessions' contents are detailed in Figure 2.

Staffing requirements

Project Director Responsible for the overall planning and coordination of the SOM project's daily operations, oversees contact with all collaborating agencies.

Program Manager Responsible for receiving all referrals to the program at AFC. Oversees daily operations and works closely with the Promotores.

Clinical Site Supervisor Responsible for all supervisory functions of the Promotores, in close consultation with the Project Director.

Promotores Responsible for education session delivery and primary interaction with program participants. Based on our

FIGURE 2

Session One
- HIV 101 (transmission and viral life cycle)
- Importance of primary care
- Strategies to improve appointment adherence
- Strategies for how to talk to doctor/medical provider

Session Two
- Medication readiness assessment
- Medication adherence assessment
- Demonstration of how HIV medications act against the virus
- Medication beliefs discussion

Session Three
- Understanding lab values
- Tracking your lab values and their impact in your health
- Discussion of co-morbid conditions (diabetes, hypertension, etc.)

Session Four
- Assessment of HIV risk behaviors
- HIV risk reduction
- Impact of STI's and HIV disease

Session Five
- Disclosure
- A social support assessment
- Maintaining your care while traveling to Mexico
- Immigration

project recruitment goals our program planned a client to promotor ratio of 1:50. Due to lower than anticipated recruitment we hired one promotor at Erie and a promotor at AFC.

Agency Backgrounds

The AIDS Foundation of Chicago (AFC) mobilizes communities to create equity and justice for people living with and vulnerable to HIV and related chronic diseases. Today AFC oversees case management services for nearly 5,000 clients in the Chicago area through its case management cooperative of nearly 30 agencies.

Erie Family Health Center (EFHC) provides high-quality, culturally-sensitive, bilingual healthcare to more than 70,000 medical patients in Chicago, serving a population that's nearly 72% Latino. In addition to offering free rapid HIV-testing six days a week at their location in Humboldt Park, a Chicago neighborhood that is nearly half Latino. This Humboldt Park site houses the Lending Hands for Life program which offers comprehensive HIV medical care and support services that are designed to meet the Mexican MSM community's specific needs and was the service delivery site for SOM.

SOM Activities, Procedures and Policies

Training Promotores

SOM Promotores are trained in various stages. The first stage of training involves a four-day People-to-People training facilitated by AFC. People to People is a peer-to-peer education program that supports individuals living with HIV/AIDS. People to People is intended to improve the health of those living with HIV/AIDS by providing trained, qualified peers to the community and building local organizations' capacity to use peers. The program targets HIV-positive individuals who reflect the epidemic in each local area. Training modules includes HIV transmission, disease progression, treatment adherence, and clinical preceptorships to address identified needs. As a peer-oriented popular education program, this training captures crucial elements of AFC's Project IN-CARE by informing peer navigation services for Promotores. [20]

Promotores were required to attend at least six professional development/training sessions per year to stay updated on new trends in HIV/AIDS and remain grounded in the best approaches for reaching our specific body of participants. Examples of those trainings included: The Face of ACA, Ready, Set, PrEP, HIV and STI's update, and HIV Treatment Update. In addition, the SOM Program Manager was onsite at Erie Family Health Center to help train the Promotores and serve as a resource for them. The role of the SOM Program Manager at EFHC was used to provide day-to-day training on program-related subjects like immigration, STI/HIV transmission, disclosure, and management of HIV medications.

Promotores are also trained by the Project Director on several modules not included in the People to People training, such as cultural competence, ethics and boundary setting, ClientTrack data collection procedures, program evaluation expectations, and the general ARTAS-inspired structure of the SOM program. The Project Director incorporates materials from various online cultural competence/cultural humility trainings online. Also, the Promotor viewed the Northeastern Illinois HIV/AIDS Case Management Collaborative's "Ethics and Boundaries" online training module that was developed for its case manager orientation. In addition, the Project Director delivered an ARTAS-inspired session based on the CDC's service delivery model.[21]

Participant Recruitment and Referrals

The SOM initiative's client recruitment took place through three strategies: 1) a targeted social marketing campaign; 2) in-reach through existing programs of AFC and its clinical partner, EFHC; and 3) outreach to agencies working with the target population and to clients at health fairs and community festivals.

Referrals through community testing and other linkage to care initiatives

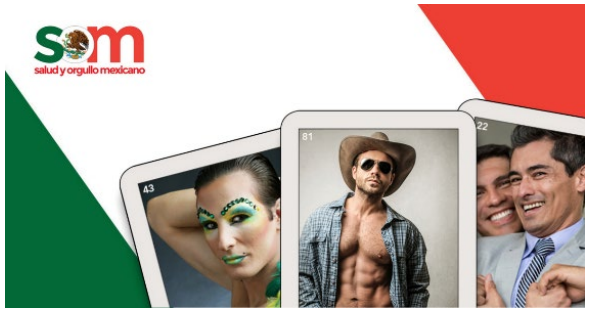
Referrals through the HIV-VIP Program, aimed at linking newly diagnosed men living with HIV into HIV primary care. Clients were screened for eligibility by the staff from the pool of individuals who test positive during outreach testing. All eligible clients were referred via telephone referral to the Promotor

Referrals through the Case Management system at AFC

All clients requesting case management services through AFC were screened for eligibility for the SOM project by the Intake and Referral Staff on the Care team during their initial telephone screening for case management services.

Referrals through online outreach

Internet outreach targeting MSM's living with HIV was conducted by creating profiles on sex-seeking websites. Adhering to an online policy and procedure manual, the SOM Program Manager spent an average of two hours a week on sex-seeking websites for recruitment purposes. All outreach was conducted by AFC staff using the AFC secure online network.



Online outreach website

EFHC recruitment procedures:
Clients for the SOM project were recruited through outreach via the following mechanisms:

- Health fairs and public events
- Referrals of HIV-positive patients from all Erie locations to the SOM Site Supervisor
- Newly diagnosed patients eligible for the program are referred to the Promotor via a warm handoff directly after

their intake to the HIV program. The Promotor meets with the patient to discuss SOM and schedules a time for intake.

Recruitment through relationships with outside agencies

Outreach meetings are frequently held with community agencies to increase awareness of the SOM project and to establish Memoranda of Agreement with organizations that provide HIV testing or other services that may reach eligible clients. SOM staff meets with agency representatives to provide background on the project, highlight project goals, and establish whether a collaboration with the agency would feasibly result in the recruitment of eligible SOM participants. If the collaboration seems agreeable, a Memorandum of Agreement is signed. Erie and the signing agency maintain a minimum of monthly contact to answer questions and to provide support and information.

Intake Assessment and Action Plan Development

A brief intake assessment occurs during an initial meeting with the client. During intake the Promotor explains the scope of SOM services and expectations for client participation in the program. The Promotor gathers information on the client's immediate barriers to care. The client signs an agency-specific service agreement to indicate enrollment in SOM services.

Barriers to engagement in medical care identified by the client and/or Promotor during assessment are prioritized and translated into an action plan that defines specific action steps to address barriers. The Action Plan serves additional functions, including: focusing client and Promotor on priorities; providing a tool to the Promotor to know how to tailor the intervention to meet the participants' needs; assisting clients in negotiating service delivery systems.

The majority of the Promotor's work occurs through the implementation of the action plan, which involves completing the education sessions with the participant and addressing identified issues. Activities performed during implementation are individualized and vary based on the barriers to care identified by the client; however, all action plan implementation requires scheduling of HIV medical appointments, preparing clients for medical appointments, attending medical appointments, and coordinating efforts with the client's care team. The care team includes the Promotor, the primary care provider, and the case manager when the client is enrolled in case management.

Ongoing Action Plan implementation includes:

A. Scheduling HIV Medical Appointments

- Promotor assists the client in scheduling the first and second HIV medical appointments while explaining and modeling the process to the client, and providing reminders for those appointments.
- The client independently schedules third and subsequent appointments.

B. Preparing the Client for HIV Medical Appointments

- Promotor discusses what the client can expect during the visit.
- Promotor assists client in preparing a list of questions they want to ask the provider.
- Promotor encourages the client to fully participate in the medical appointment.
- Promotor confirms plans for transportation and meeting with the client for the appointment.

- Promotor contacts the client before their appointment to remind the client of appointment date and time, if the Promotor has this information.

C. Attending HIV Medical Appointments

- With the client's consent, the Promotor attends the first medical appointment with the client, if getting medical care at EFHC.
- Promotor attends the second and third medical appointments if the client requests, if getting medical care at EFHC.
- At the appointment, the Promotor acts as a support and advocate and leaves the exam room when requested to do so by the client or medical provider, if getting medical care at EFHC.

D. Coordination with the Client's Care Team

- Promotor is responsible for introducing themselves to the care team and explaining his role, if client is getting medical care at EFHC.
- Promotor maintains a minimum of quarterly contact with appropriate members of the client's care team, if getting medical care at EFHC.

SOM action plans are updated as action steps are completed or as the client's life circumstances change. Due to the time-limited nature of SOM services, informal plan reviews occur regularly between the Promotor and client. Formal reviews between the Promotor and Promotor supervisor occur at regularly scheduled intervals.

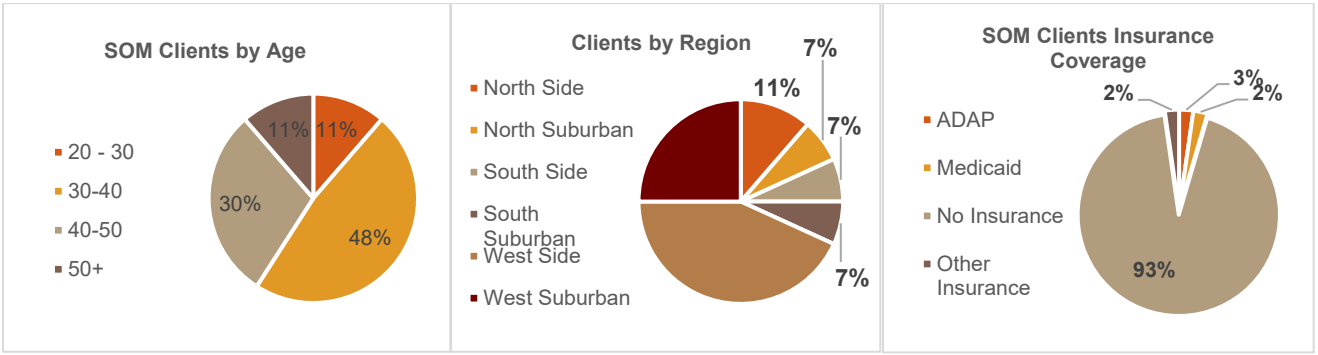
SOM Education Sessions

The Promotor schedules and engages clients in five education sessions to be completed ideally within the first six months of the individual's enrollment in the SOM project, approximately one education session per month. These standardized education sessions are negotiated with the client to help them meet their needs and are documented in the client's chart and in ClientTrack. The Promotor should explain to the participant the time commitment of the program and discuss the best way to schedule the session and that the participant can complete the education sessions during normal business hours of EFHC and/or once a month on Saturdays. In addition, sessions two, three, and four can be done over the phone or skype. If the participant is not able to go to EFHC, the Promotor should coordinate a phone meeting date and ask for the patient when is a good time and date to complete the session over the phone. Since all education sessions may be conducted at any setting, the client can coordinate with the Promotor to get them done at their medical home or over the phone, if they are not getting their medical care at EFHC. If that is the case, the Promotor should also confirm the address that was collected during enrollment and ask the participant if it's okay for them to get mail. If the patient agrees, the Promotor is to mail the participant the education sessions. Once the patient has received the education sessions, the Promotor is to complete the education sessions over the phone.

Participant Intervention Characteristics

The Salud y Orgullo Mexicano project screened a minimum of 90 clients per year between years two and four of the project. The majority of clients screened were ineligible to participate due to having seen an HIV provider within the last six months. Clients were interested in participating in the program to obtain culturally specific programming and/or access additional resources. A total of 44 participants were deemed eligible and enrolled in SOM. Participants were between the ages of 26 and 67 years old with an average age of 38 years; 52% of clients

were newly diagnosed (HIV diagnosed in the previous six months) and 48% had not seen an HIV provider within the past 6 months ("lost to care"); 63% of participants were receiving their primary medical care at EFHC; and 98% of our clients were born in Mexico. The program participants represented diverse geographic areas of Chicagoland with 39% living on the West side of the city (near EFHC). Finally, participants faced challenged in obtaining medical insurance with 93% reporting they were uninsured. Participants reported and ranked barriers to their retention in HIV care, the top reported barriers were medical mistrust, stigma and immigration status. The flexibility of the SOM intervention allowed Promotores to personalize intervention content to address individual client barriers. The most frequent topics discussed by the Promotores outside of the education sessions include: emotional support, HIV education, and medication adherences support. The intervention sessions were well attended with 84% of participants completing all 5 education sessions.



Education Sessions

The approximate cost of the intervention, including all efforts at recruitment and project staffing, is an annual estimate of $203,198.

Annual intervention costs include a reduced staff allocation in Years 1 and 2 of the 5 year project to pay for costs related to the planning, creation and implementation of a public bus shelter advertising campaign and radio ad creation and dissemination. Through years 3 and 4 the program utilized a digital marketing campaign that cost approximately $30,000 yearly utilizing the content created in Year 1. Year 2 expenses include additional staff effort at AFC for recruitment, and testing staff at Erie. Year 2 also saw the hiring of the Promotores at both Erie and the AIDS Foundation that continued through Year 5 with no funds for the marketing and recruitment campaigns, but staff for the evaluation and dissemination of program finding

Lessons learned

For purposes of replication and program sustainability, it is imperative to review lessons learned. Below are some of our program wide lessons:

- of the same struggles as participants and this may impact effective boundary setting.
- A large amount of training is needed for peer health workers, which pays off in terms of skills developed and participant outcomes in the long view. Having a peer with a similar Mexican background as clients helps facilitate relationships and trust.
- In developing a culturally appropriate intervention it is important to be flexible and adaptable.
- Our program team conducted three rounds of qualitative research with various audiences to refine our intervention and define the education sessions. We also learned that including a wide range of topics in education sessions allowed clients to focus on what was important to them, rather than having project staff dictate what is important.
- Finally, it is crucial to ensure the target population is accessible to project staff. Our team tried multiple recruitment strategies and expended a lot of effort to recruit, however, the target population proved to be largely inaccessible. We believe that two factors may have negatively affected our recruitment: stigma remains a very strong deterrent for Mexicans to seek testing and seek care, additionally we feel the socio-political environment of the last three years has led to fear and concerns of deportation that inhibit Mexicans from seeking care.
- In developing and implementing a peer-based navigation program it is critical to ensure proper start up time and staff supervision structure. This includes strong training and ongoing review of healthy boundary setting between the Promotores and their participants. This is particularly true as staff may be encountering many

Top 10 Topics Discussed with Promotores
• Education Session 1 – 100% • Education Session 2 – 80% • Education Session 3 – 80% • Education Session 4 – 84% • Education Session 5 – 76%
• Food and Nutrition Issues- 5% • Medication Readiness- 5%

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