



Responding to Needs

Common Barriers to Care

Provider Strategies

Evaluating the Results

RESPONDING TO LATINO HEALTH NEEDS

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) recently completed a study of 10 HIV services providers treating predominantly Latino(a)/Hispanic clients (referred to hereafter as Latinos). The resulting research report, *Responding to the HIV/AIDS Epidemic Among Latinos: Latino Best Practices*,¹ provides an outline of effective approaches to addressing barriers to care experienced by Latinos throughout the United States.

The timeliness and necessity of this work, which took place in diverse parts of the Nation, cannot be overstated. Although Latinos represent just 14 percent of the U.S. population, they account for 17 percent of diagnosed HIV/AIDS cases^{2,3} and nearly 1 in 4 Ryan White HIV/AIDS Program clients.⁴ The Ryan White HIV/AIDS Program is dedicated to increasing the engagement and retention of Latino populations in HIV primary care. This issue of *HRSA CAREAction* summarizes the findings presented in the HRSA study.

The HRSA study found that multilevel interventions that take the following factors into account have the greatest likelihood of success:

- *Patient-level factors:* Patient's background, such as language, country of origin, acculturation, income level, insurance coverage, HIV risk factors and serostatus, co-occurring mental illness and substance abuse, low health literacy, and fear of HIV disclosure and deportation
- *Clinician-level factors:* Cultural and linguistic competence, provider biases, clinic schedules and hours, and familiarity with HIV disease and treatment
- *Organizational-level factors:* Availability of care, client privacy and confidentiality, translation services, acceptability by community,

DID YOU KNOW?

- ▶ Latinos are a diverse population encompassing many subgroups, all of whom have slightly different risk factors for HIV. These subgroups may include Native populations from Central and South America who do not speak Spanish as a first language.
- ▶ Latinos in the U.S. have been disproportionately affected by HIV since the epidemic began, and today account for nearly 20 percent of all diagnosed HIV/AIDS cases.^{2,3}
- ▶ Nearly one-fourth of all Ryan White HIV/AIDS Program clients are Latino.⁴
- ▶ Providers that have culturally and linguistically competent clinicians on staff and create a familial atmosphere in their clinic are more likely to retain Latinos patients in care.



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For over 20 years, the Ryan White HIV/AIDS Program has implemented cutting-edge strategies to engage all people living with HIV disease into care. Although we have saved tens of thousands of lives during that time, some populations, including Latinos, continue to face significant challenges regarding retention.

This issue of *HRSA CAREAction* provides an overview of the report, *Responding to the HIV/AIDS Epidemic Among Latinos: Latino Best Practices*, which highlights results from a recent Health Resources and Services Administration, HIV/AIDS Bureau, study about Latinos and HIV service delivery. It examines the many barriers to HIV care experienced by Latinos, and the successful strategies implemented by 10 different Ryan White providers nationwide to engage this population in care.

Although Latinos represent myriad subgroups with different HIV risk factors, they share common cultural norms that, when respected by providers, make them more likely to stay in care. Each site has exercised its cultural and linguistic skill sets differently, according to the needs of the Latino populations served. Some sites have focused on creating a familial space that features comfortable furniture and patient-made artwork, whereas others have created special social support groups targeting this population. All, however, have engaged translation hotlines or hired bicultural and bilingual staff to facilitate communication with patients and ensure the continued dedication of the Ryan White HIV/AIDS Program to offering culturally competent care.

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Publisher

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Prepared for HRSA/HAB by Impact Marketing + Communications

Photographs

Cover: A couple at Boriken Neighborhood Health Center in Harlem.
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and affordability of HIV core medical and support services

- *System-level factors:* Policies that determine eligibility for services, availability of funding for support services, policies limiting undocumented clients to services, Latino-oriented service providers, and care coordination across providers
- *Community-level factors:* Issues such as stigma related to HIV and homophobia, cultural beliefs, awareness of HIV treatment services, and subgroup HIV incidence and prevalence (Table 1).

Margaret Hargreaves, senior health researcher at Mathematica Policy Research, who assisted in the study, says that each of the 10 providers profiled in the study demonstrated a sophisticated facility in addressing the barriers their clients face in accessing care. She explains,

The clinics we visited for this study found a way to address their patients' barriers to care at every level. Though several targeted these barriers in a systematic fashion, others did so through more organic, intuitive, and adaptive approaches. For instance, if patients said they did not want to go down a certain hallway because they feared that part of the hospital, the provider dealt with it, adapting the services to a more inviting space.

Providers across the study found ways to work around systematic and organizational issues, reduce stigma at the community level, and ensure that patients overcame their personal issues to stay in care. Although Latino clients in this study were more likely than non-Latinos to have progressed to AIDS, be under the age of 45, or living at or below the Federal Poverty Level, the care they received at Ryan White-funded sites was found to be comparable to that received by non-Latino clients.¹

LATINOS: DIVERSE POPULATIONS, COMMON BARRIERS TO CARE

Each site participating in the study developed interventions appropriate to its region and the Latino subgroups it serves. Latinos are the largest and fastest growing ethnic group in the United States. Latinos are also one of the most diverse groups; the many subgroups, who speak a variety of Spanish dialects, include Puerto Ricans, Cubans, Mexicans, and South Americans. English often is a second language. A growing number of U.S. Latinos from Central and South America are members of indigenous communities and often speak only their native languages.

HIV incidence and transmission factors vary among Latino subpopulations as well. For instance,



TABLE 1. CONCEPTUAL APPROACH TO EVALUATING EFFECTIVENESS OF INTERVENTIONS TO IMPROVE ACCESS TO AND RETENTION IN HIV/AIDS CARE AMONG LATINOS¹

BARRIERS TO ACCESS AND RETENTION IN CARE	INTERVENTIONS TO IMPROVE ACCESS TO AND RETENTION IN CARE	SHORT-RUN OUTCOMES
<p>Community issues related to</p> <ul style="list-style-type: none"> • Stigma associated with HIV and gay, lesbian, and transgender people • Discrimination against Latinos, including new immigrants • Lack of knowledge of HIV prevention and treatment • Population and subpopulation characteristics • HIV incidence and prevalence <p>System issues related to</p> <ul style="list-style-type: none"> • Limited care coordination and service linkages • Limited eligibility for publicly funded programs <p>Organizational issues related to</p> <ul style="list-style-type: none"> • Limited access, availability, acceptability, and affordability of HIV core medical and support services • Limited organizational support for culturally and linguistically appropriate services (CLAS) • Lack of race/ethnicity data, • Limited program evaluation and quality management capacity • Limited resources for translation and interpreter services <p>Provider–client interaction issues related to</p> <ul style="list-style-type: none"> • Lack of frontline provider HIV clinical expertise and linguistic and cultural competence • Cultural, linguistic, and gender provider–client discordance • Lack of Spanish-speaking providers and interpreters • Communication and trust between provider and client <p>Client characteristics</p> <ul style="list-style-type: none"> • Demographics (age, gender, language, country of origin, immigration, acculturation, rurality) • Financial (poverty, lack of insurance, education, health literacy, housing) • HIV risk factors and HIV serostatus • Co-occurring mental illness, addiction, and chronic diseases • Psychosocial (fear of disclosure of HIV status, deportation) 	<p>Community issues related to</p> <ul style="list-style-type: none"> • Social marketing campaigns to change social norms • Partnerships with community organizations to address stigma issues • Culturally relevant, gender-specific HIV education via local media • HIV education in social networks through lay health advisors • HIV testing initiatives <p>System issues related to</p> <ul style="list-style-type: none"> • Accessible HIV care through one-stop centers, family-centered care, youth-friendly services, and networks of HIV care in rural areas • Network of client referrals from Latino-serving organizations <p>Organizational issues related to</p> <ul style="list-style-type: none"> • Rapid or same-day intake and initial clinical assessments • Effective scheduling and reminders to reduce missed appointments • Clinic finding for clients lost to care • Medical case management to increase care coordination <p>Provider–client interaction issues related to</p> <ul style="list-style-type: none"> • Use of HIV-positive peers or near-peers for outreach, education, navigation, advocacy, translation, and psychosocial support • Medical care integrated into outreach through mobile units • Organizational support for and evaluation of CLAS practices • Improved provider communication with patients about health care, cultural beliefs, traditional medication, and so on • Bilingual English- and Spanish-speaking, bicultural staff • More providers trained to provide culturally competent care • Production of client education materials in English and Spanish <p>Client characteristics</p> <ul style="list-style-type: none"> • HIV education, health literacy, and life-skills training • Early intervention services tailored to special populations • Assistance with basic needs that compete with HIV care • Facilitation of entry to care for special populations (postincarceration, youth aging up to adult services, pregnant women) • Gender-specific support groups for HIV-positive Latinos 	<p>Reduced HIV/AIDS health care disparities for Hispanics and Latinos</p> <ul style="list-style-type: none"> • Increased knowledge and awareness of HIV prevention and treatment • Reduced HIV stigma • Reduced barriers to HIV/AIDS health care • Improved access to and use of HIV care • Increased retention and engagement in HIV health care • Increased HIV immune system and resistance monitoring • Increased use of HAART and other HIV-related medications • Reduced morbidity and mortality • Enhanced quality of life



Environmental Factors Economic conditions, structure of safety net system, geographic location, Medicaid and other public insurers, Ryan White HIV/AIDS Program sunseting, Federal immigration policies, and Federal health care reform legislation

Puerto Ricans are more likely than other Latino subpopulations to be infected through injection drug use. They also are more likely than members of other Latino subgroups to see themselves as being at risk for HIV, perhaps because of attention given to Puerto Rico's high HIV prevalence in recent years. The territory currently has one of the highest HIV incidence rates among all U.S. States and territories.³ Transmission among men who have sex with men (MSM), however, is higher among Latinos of Mexican, Cuban, and Central and South American descent. High-risk heterosexual contact appears to be common across subgroups.⁵

Precarious living situations often make Latinos living with HIV at higher risk for progressing to AIDS, contracting HIV comorbidities like hepatitis, and falling out of care.

Many Latinos, particularly those eligible for services through the Ryan White HIV/AIDS Program, live on the margins of society. They are much more likely than members of other racial and ethnic groups to live in poverty and to be highly mobile. Language differences, limited education attainment, and heavy work schedules make accessing services daunting, particularly when doing so requires a person to fill out paperwork and present identification. One study participant reported that their intake form is more than 40 pages long and sometimes must be completed more than once. Such paperwork could dissuade anyone from accessing care, particularly clients who have limited facility with English or experience navigating the U.S. health care system, as is the case with many Latino clients.

These factors can pose intimidating roadblocks to care for Latinos, who generally test for HIV later than other racial and ethnic groups. They are also more likely to progress to AIDS within a year of their HIV diagnosis, experience delays in initiating highly active antiretroviral therapy (HAART), drop out of care, and have worse clinical health outcomes than people living with HIV/AIDS from other communities.^{5,6}

The following sections examine issues related to migrant workers and undocumented immigrants, cultural norms, and other issues identified in the HRSA report as significant barriers to care for many subpopulations of Latinos in the United States. The sites' strategies for breaking down these barriers and bringing Latinos into care, as well as their approaches to evaluating their success, are reviewed as well.

Migrant Workers and Undocumented Immigrants

Migrant workers and undocumented immigrants living with HIV are at particular risk for progressing to AIDS, contracting HIV comorbidities like hepatitis and tuberculosis, and falling out of care. Much of this risk stems from their precarious living

situations. They often reside in rural areas with limited access to health care information and transportation. Many live in densely populated group quarters; one provider reported that their patients share cooking and bathroom facilities with at least 25 to 30 other people.

Most undocumented immigrants work long hours and are extremely vulnerable to their employers, because they are not protected by U.S. labor laws and therefore do not have health insurance or earn minimum wage. Applying for services can be difficult for this subgroup. Many do not have the means to get to a clinic or cannot provide the documentation of citizenship, employer letter, or Social Security number sometimes required for Federal and State assistance programs, such as Medicaid, food stamps, the Ryan White HIV/AIDS Program, and pharmaceutical company medication services.

In addition, migrant workers and undocumented immigrants tend to be wary of health care facilities because of their perceived resemblance to government offices, which are heavily associated with immigration officials and police. Some people fear that accessing care may label them a "public charge" and put them at risk for deportation. Those fears have been heightened in recent years, particularly along the U.S.–Mexico border region and in the southern United States, where many local police forces have received special qualifications to enforce U.S. Immigration and Customs Enforcement law.¹

Consequently, some Latinos have to wait a long time for services, if they can access them at all. Those who do obtain care can be difficult for providers to track because of their frequent travel across State and national borders. Restrictions set by the Health Insurance Portability and Accountability Act of 1996 often make it difficult to share information. Incarceration may complicate care for this group even further, because Latinos in prisons and jails are likely to fall out of care and are more difficult to recruit and retain into care after their release.¹

Cultural Norms and Stigma

Many Latinos share culture related to religion, family, gender, and health that can pose significant barriers to HIV care. For instance, Latinos often believe in *fatalismo*, the idea that God ordains certain events to occur. HIV infection is often considered a judgment that only God can heal, a belief that can complicate treatment adherence. Others engage in *curanderismo*, the practice of traditional folk healing carried out by *curanderos*, or spiritual healers. Specific groups, including many Cubans and Puerto Ricans, also may practice *Santeria*, a religion that emphasizes holistic medicine and, often, *limpios* (cleansings), whereas Mexicans often use herbs and traditional remedies.

Latinos engaged in traditional healing may keep their practices secret from clinicians, especially if they see the clinicians as outside authority figures rather than caring partners dedicated to improving their health. Although *curanderismo* practices are often benign, doctors need to know about them because some treatments, such as ingesting fish oil, may

inhibit the metabolism of HIV medications. Some healers also have been known to communicate conflicting messages to patients living with HIV, telling them that it does not exist or that traditional practices can cure AIDS by “freezing” the virus from the body. These patients are at risk for dropping out of care, developing drug resistance, and increasing their chances of transmitting the virus to others.¹

Latinos diagnosed with HIV also face stigma—primarily because of the disease’s association with homosexuality, which runs counter to notions of *machismo*, an exaggerated form of masculinity based on sexual prowess, dominance, and aggression. The study quotes a California provider explaining that much of the stigma attached to HIV stems from ignorance about the disease: “In the Latino community, [homosexuality] is not accepted and HIV has an even worse stigma associated with it. As a result, clients do not go and get care and they do not want to be seen getting care.”

Latino men may not disclose their HIV status to family and friends due to fear of rejection.

Latino men diagnosed with HIV fear disclosing their status, because doing so may mean rejection by their family and friends, a situation that can encourage them to leave care. Hargreaves notes that “AIDS is very hidden in the Latino community, and it can be hard to come out [as HIV positive], especially if you are gay and have HIV.”

Machismo also can undermine the health outcomes of Latina women, who are expected to live up to the ideal of *marianismo*, which dictates that women be submissive to men, particularly to those in their family and their husbands. They generally cannot access HIV testing and care, and negotiating safer sex practices in marriage is almost impossible. Although many Latina women who contract HIV do so from their husbands, they are blamed for “bringing AIDS into the home” and are at considerable risk for domestic violence. In addition, providers participating in the HRSA study reported that their HIV-positive Latina patients delay or fall out of care as a result of the demands of the *familismo*—the tradition of multiple generations living together—whose needs they often put ahead of their own.⁷

Provider-Level Issues

Latinos tend to wait until they are already ill before seeking care, and they are often diagnosed with AIDS. Many also struggle with comorbidities, such as substance abuse and mental health issues, which carry a great deal of stigma as well. Despite their need for assistance, Latino patients often are wary of being seen at a clinic, fearful that they may be spotted by people they know or that clinic staff will disclose their diagnoses to their family and friends.

Much of this distrust stems from organizational and systemic issues. Funding cuts have made it difficult for many providers to recruit culturally and linguistically competent staff. Agencies with limited budgets cannot compete with the compensation and benefits offered by larger organizations and hospitals. Those that do have the resources often find themselves unable to find qualified staff as a result of workforce shortages in the health care arena. Moreover, the number of minority clinicians available in the United States has become even smaller in recent years. As a result, agencies serving Latinos often experience high rates of staff turnover, which can be unnerving to patients, who may feel abandoned. Patients dealing with staff unfamiliar with Latino culture and unable to speak Spanish may become frustrated and drop out of care if they cannot discuss their health concerns in their own language with someone who understands their concerns.

Other barriers include the strict appointment schedules found at many clinics. Latino clients often miss appointments because they work long hours and may not be accustomed to scheduling and keeping appointments. Limited space at many clinics can fragment primary and specialty care services into different parts of a hospital or other locations. This structure can inhibit providers’ ability to deliver services expediently and may cause longer wait times as well as longer time between appointments. Navigating such a system can be difficult for patients who are fearful of immigration officials, speak little English, or are reticent about accessing services in the first place. As one provider cited in the HRSA report explained, “Latino clients, who are reluctant to seek mental health services due to cultural norms, might be less likely to seek care if they have to go to another service provider with which they are less familiar.”¹

Study participants also reported that some patients had histories of poor patient–provider relationships that stemmed from a lack of provider communication and cultural competency. When providers demonstrate that they are putting their patients’ needs first, it facilitates trust and respect. Patients, in turn, are more likely to follow their clinicians’ advice.^{1,8}

PROVIDER STRATEGIES ADDRESS LATINO BARRIERS TO CARE

Many evidence-based strategies that have worked with other populations have proven effective in serving Latinos. Those strategies include enlisting Latino peer, near-peer, and non-clinical health navigators and counselors; supportive case management; appointment reminder calls; use of pill boxes; directly observed therapy; literacy lessons; and use of referral to mental health and substance use counselors. Latinos, however, have a unique set of cultural norms that must be taken into account; in many instances, study participants used approaches with this population specifically in mind, such as recruiting Spanish-speaking care teams and taking steps to understand the cultural differences among Latino subgroups. Many providers have translated materials into the dialect of

At the clinics themselves, staff invite patients and their families to serve as *promotores de salud* (health promoters), who serve as a bridge between the local community and clinic. The *promotores de salud* use various means of breaking down stigma, such as participating in local gay pride events and parades.

Spanish spoken by their clients and are aware of their clients' religious beliefs and practices, particularly as they relate to traditional medicine and even food.

Although commonalities exist across sites, location has played a role in some strategies. For instance, study sites near the U.S.–Mexico border have implemented cross-border strategies to improve care coordination. Other sites focus specifically on the subpopulations within the Latino community they serve, developing approaches addressing the unique needs of women, incarcerated clients, MSM, transgender clients, youth, migrant or seasonal workers, documented and undocumented immigrants, substance users, and injection drug users. All 10 study sites offer patients assistance in completing applications and securing documentation for participation in programs such as Medicaid, Social Security, and the AIDS Drug Assistance Programs. Additionally, providers refer patients to social support services (e.g., food and housing assistance, legal aid, immigration services) when they are not offered in-house, and they offer targeted services for Latinos, such as support groups, within their clinic when possible.

The providers in the HRSA study also have access to fluent Spanish speakers through interpreter lines and bilingual staff. In many instances, clinicians and staff members are themselves Latino, which helps facilitate effective communication between providers and patients and ultimately leads to a higher quality of care. It also assures patients of the organization's dedication to their needs. The providers understand the power of creating a warm, welcoming environment to engage and retain clients in care and keep their families at ease. Patients in these environments are more likely to adhere to treatment and stay in care. A majority of study participants also offer transportation assistance such as vans and fare cards or tokens for trains or buses. In a few instances, providers offer home delivery of HIV medications by pharmacy or clinic staff.

To further encourage people to access HIV prevention, testing, treatment, and care, many provider sites in the study promote their medical services and disseminate HIV messages to Latino populations in their communities. They target businesses with large numbers of Latino employees, such as farms and processing plants, and advertise on Spanish-language radio stations and television programs. They also tailor their messages to specific subgroups. Slang is used to address youth, but more formal Spanish that demonstrates *respecto*—the tradition of showing respect for others, particularly elders and authority figures—in messages geared to older Latinos. Another strategy is to educate local businesses and organizations about HIV, raising their awareness about

the disease and encouraging them to promote the HIV provider services. At the clinics themselves, staff invite patients and their families to serve as *promotores de salud* (health promoters), who serve as a bridge between the local community and clinic. The *promotores de salud* use various means of breaking down stigma, such as participating in local gay pride events and parades.

Many providers have set up non-health-related support groups at their clinics, such as knitting circles, which have created a sense of community and engender *simpatía*, the desire to maintain harmony, politeness, and respect in relationships. Participants may discuss health issues such as HIV, but they are not required to do so. Some providers further foster a family atmosphere, like that created through the tradition of *familismo*, by recruiting patients to create art that reflects their culture or home country and decorating the clinic with it. Waiting-room furniture and medical posters often are replaced by couches and patient artwork. Finally, several clinics have organized theater groups, in which staff and clients write, produce, and act in plays and skits with HIV messages targeted to local audiences. These activities not only make the clinics less institutional but also create a sense of camaraderie, rapport, and family among staff and the community and help to bolster the self-esteem of the clients.

"Patients were helping to create the space or environment they wanted to come to; that felt more like a community and less like a medical intervention," explains Hargreaves. "You might not think of knitting as a part of quality health care. However, it can give folks, some of whom are immigrants away from home or shunned by their families, the support they need to remain patients at the clinic."

Medical staff members communicate a sense of home in their interaction with patients as well. Depending on their location, clinic staff consciously dress in a manner that differentiates them from immigration officials and police, making clients feel more at ease. Staff also engage in ongoing training in providing culturally competent care to Latinos. The training emphasizes the importance of conversation that avoids loaded language (e.g., "mental health" and "psychiatry") that could alienate patients. To further ensure patient comfort, most study clinics have instituted "universal screenings" designed to destigmatize HIV, substance use, and mental health assessments by making them a routine part of the primary care intake process.

Several sites have hired staff who work specifically with new clients to set up initial appointments and identify any barriers to care, such as transportation, insurance, family issues, and

work schedules. Follow-up takes place on subsequent visits to ensure that the patients remain in care. These approaches are particularly important within Latino subgroups, including formerly incarcerated persons, women, MSM, and heterosexual men, who are difficult to recruit and retain in care.

Providers also ensure that staff members understand the stigma around HIV in Latino communities and the necessity of patient confidentiality. The participating sites only call patients at home if granted permission to do so, and they leave only generic voicemail messages. In addition, some providers have given their clinics discreet, non-HIV-focused names, such as “Clinic 7,” and have secured space in locations such as back hallways and side buildings to ensure patient privacy.

Staff members receive training on the importance of Latino cultural values and communication styles, particularly around the notions of familismo. For patients who are alone in the United States or are isolated from their families, issues of trust and even touch are of great importance. They often view the clinic through the lens of *personalismo*, the desire for close, intimate relationships. For many patients, the clinic becomes a second home and the clinicians are like family. It is not uncommon for staff to visit clients in the hospital. Most of the sites provide newly diagnosed patients with treatment and site orientations and assign a staff member to accompany them to their appointments at outside specialists. They also provide assistance with completing and submitting intake forms and other paperwork. Approximately 70 percent of HRSA study participants offer home visits or hospital visits and provide long-term follow-up as part of their retention efforts.¹

The report observes that the sites’ success depends on the efforts of every staff person, from nutritionists to nurses, working together as a team and sharing patient information. Communication is accomplished in many ways, including morning huddles and meetings, patient briefings, daily e-mail summaries of clinic activities, and other shared communication. Ongoing communication ensures that patients’ needs are met and that care is coordinated as seamlessly as possible. Most of the sites also have instituted more sophisticated and centralized information systems that enable all clinical staff to track medication use, office visits, lab results, and clients’ contact information.

Information systems also allow physicians to quickly see whether clients are missing appointments and tests or are not treatment adherent, helping them reengage patients in care as quickly as possible. These systems also lend themselves to systematic “in-reach” strategies, in which patients who have fallen out of care are reengaged. Several sites have established partnerships with clinics in other States to help track patients who move often. In this way, providers can track their clients’ care efficiently and effectively.

The providers in the study offer patients multiple appointment options to ensure that they stayed in care; options include evening, rapid-intake, and walk-in appointments. Most clinics collaborate with and have created partnerships

SPANISH TERMINOLOGY OF LATINO VALUES

Collectivism: The tendency to think of collective well-being over individual needs.

Curanderismo: Practice of traditional folk healing carried out by curanderos (healers).

Familismo: The significance of family as the primary unit within Latino culture.

Fatalismo: Sense of fatalism; may convince some Latinos that it is their fate or destiny to have HIV/AIDS.

Machismo: An exaggerated sense of masculinity among men, characterized by sexual prowess, dominance, and aggression.

Marianismo: The notion that “a good wife” is submissive to her husband and does not question his decisions.

Personalismo: The desire for close, intimate relationships, including with healthcare providers.

Promotores de salud: Health promoters indigenous to the population they serve, often acting as a “bridge” or system navigator to assist clients with accessing services and referrals.

Respecto: Having and showing respect for others, particularly elders and authority figures.

Simpatía: The desire to maintain harmony, politeness, and respect in relationships.

with other Latino-serving organizations in the surrounding area to help recruit and engage Latinos diagnosed with HIV, effectively demonstrating that there is “no wrong door” into the health care system.⁹

Some clinics have expanded their service base beyond medical care, such as offering access to volunteer attorneys to provide free legal advice and financial and health information seminars. Patients also can receive training on how to apply for a variety of assistance related to free or reduced-cost health care providers, such as the AIDS Drug Assistance Program.

EVALUATING THE RESULTS

Each site that participated in the study has implemented informal and formal evaluation strategies geared to improving the quality of services for clients and collecting data for requisite reports. Program evaluation varies considerably across each site because it is based on internal capacity. Several sites have established quality improvement teams, which are composed of hired vendors or existing staff who have the interest and skill set necessary to measure quality within the organization

Each site engages in some form of client-level demographic and clinical data collection to help inform its approach to monitoring and improving their practices. These approaches have taken several different forms across sites, including client surveys, which offer immediate feedback about patients' needs and the effectiveness of service delivery. Several participating providers convene community or client advisory boards to elicit feedback from HIV positive clients as well as to offer a venue for client advocacy. All the sites work diligently to ensure that HIV-positive Latinos have representation on regional and State HIV prevention and care planning councils. Providers, in turn, are often active participants on Ryan White HIV/AIDS Program Planning Councils, planning councils funded by the U.S. Centers for Disease Control and Prevention, and other State and local HIV bodies to advocate for Latino services. HIV-positive staff members often occupy community member slots on these councils.

Providers present papers and engage in capacity building during regional and national conferences. Those serving large populations of migrant workers have established working relationships with agencies in other States and in parts of Mexico to better track the care of patients who regularly cross State and national borders. These partnerships help providers

find ways to effectively share patient records, lab results, prescriptions, and other documentation.

CONCLUSION

The HRSA study report details a wide range of strategies to recruit and retain HIV-positive Latinos from a wide range of backgrounds into care. Participating providers have demonstrated that strategies do not have to be overly complex or expensive in design and implementation. Rather, they need to be sensitive to the socioeconomic and psychological determinants and realities faced by Latinos in the United States today, particularly with regard to fears of arrest and deportation; poverty; and stigma around HIV, mental health, substance use, and other sensitive health issues.

Overcoming these issues often requires creating medical homes that offer patients not only primary and specialty services under one roof but also a welcoming, safe space free from HIV stigma and homophobia that is overseen by a caring medical staff who speak Spanish and understand Latino cultural norms. Patients who feel respected and understood are more likely to stay in care, have better health outcomes, and enjoy longer lives.

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