SALUD MÓVIL

Provider and Community Perspectives on a Bilingual Mobile + Telehealth HIV Care Model for Latino MSM in Atlanta

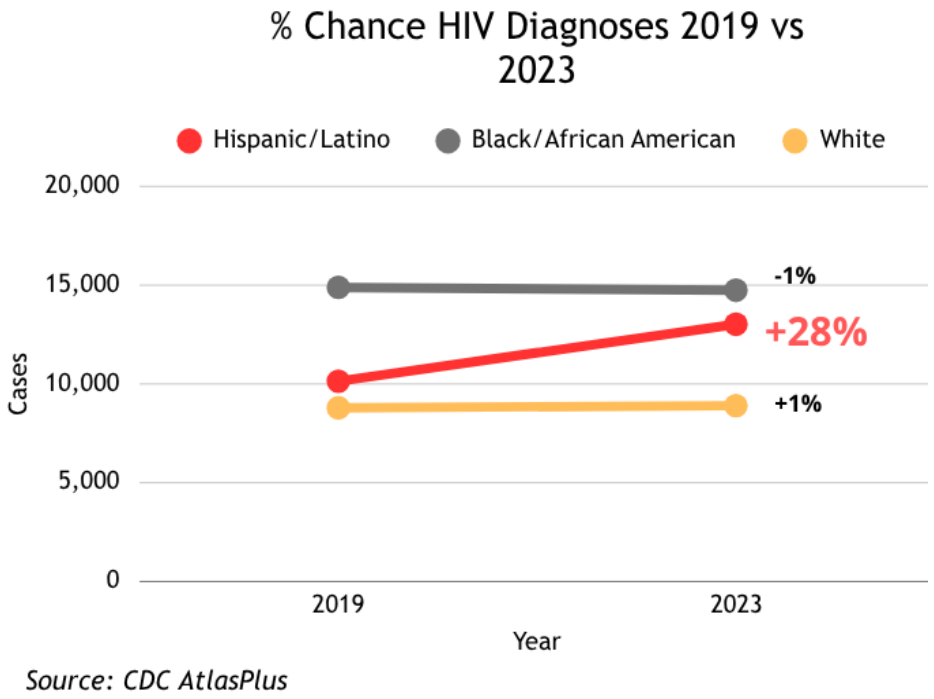
JULIÁN SANTIAGO RAMON[1], JUAN DAVID PATINO-MATEUS[1],

NICOLAS QUIROGA-GUTIÉRREZ[1], DON OPERARIO[2], ALEXANDRA MORSHED[2],

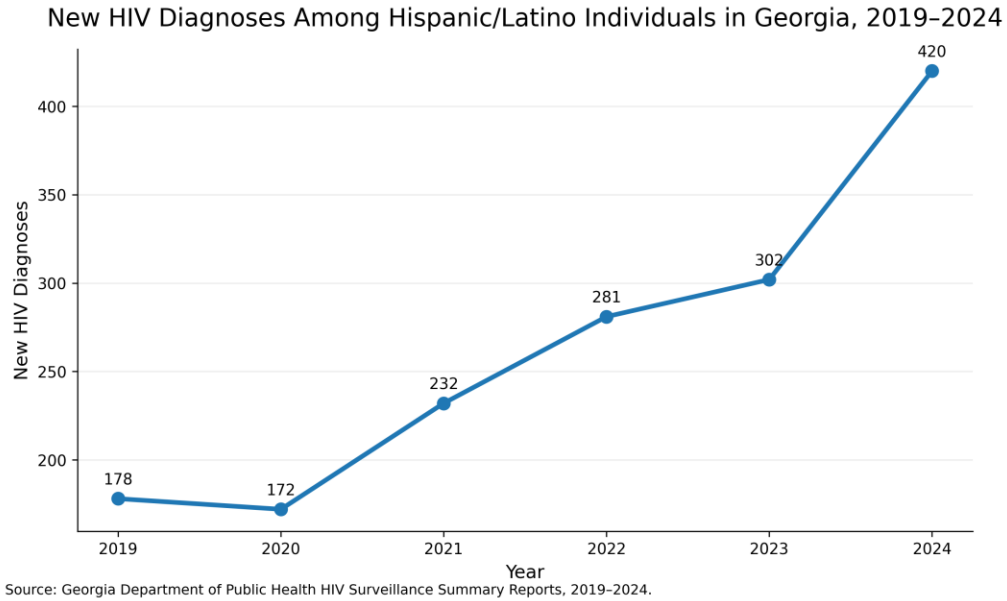
VICTORIA PHILLIPS[2], LEANDRO MENA[1] ,CARLOS S. SALDANA[1]

[1]EMORY UNIVERSITY SCHOOL OF MEDICINE [2]EMORY UNIVERSITY ROLLINS SCHOOL OF PUBLIC HEALTH

BACKGROUND



Source: CDC AtlasPlus



Traditional clinic-based HIV care leaves Latino MSM behind through language mismatch, transportation and work-schedule conflicts, insurance complexity, and structural fear tied to immigration enforcement. SALUD MÓVIL is a bundled, community-informed model that pairs bilingual telemedicine with mobile HIV/STI testing and mobile phlebotomy to move care to where people are, safely, discreetly, and in Spanish.

STUDY OBJECTIVES

What we set out to learn

PRIMARY OBJECTIVE

Explore provider and community perspectives on implementing SALUD MÓVIL — a bundled bilingual telemedicine + mobile HIV/STI testing + mobile phlebotomy model — for Latino MSM in Metropolitan Atlanta.

Identify barriers

to HIV prevention and care among Latino populations

Identify facilitators

of telehealth and mobile service uptake

Develop strategies

community-informed approaches to improve access and engagement

METHODS

Multi-methods, community-informed design

DESIGN & PARTICIPANTS

Multi-methods study
Semi-structured in-depth interviews with:

15 providers with experience serving Latino / LGBTQ+ / HIV populations
15 community members (Latino MSM, Metro Atlanta)

Interviews explored: barriers to care, trust and stigma, cultural and linguistic needs, acceptability of mobile and digital tools, and operational considerations for implementation.

ANALYSIS

Thematic analysis
guided by the Consolidated Framework for Implementation Research
(CFIR 2.0)

CFIR domains:
1. Outer Setting
2. Inner Setting
3. Characteristics of Individuals
4. Intervention Characteristics
5. Process

Findings inform protocol adaptations for the Phase 2 pilot implementation.

PARTICIPANTS

Who we talked to

PROVIDERS · n = 15

Diverse clinical and community roles

- Infectious Disease physicians and HIV clinicians
- Psychiatrists, psychologists, and mental health providers
- Public health leaders (county, state, federal)
- Community health workers and outreach staff
- Nurses, phlebotomists, and lab staff
- Leaders of Latino-serving community-based organizations

COMMUNITY · n = 15

Hispanic/Latino MSM in Metro Atlanta

- Living with HIV and receiving care
- Engaged in or eligible for PrEP
- Mix of insured and uninsured
- Countries of origin across Central and South America
- Varied English proficiency (most preferred Spanish)
- Mix of recent arrivals and long-term residents

Metro Atlanta EHE priority jurisdictions: Fulton · DeKalb · Gwinnett · Cobb counties

Interviews conducted in participant's preferred language (English or Spanish) · June – November 2025

Six salient themes cut across CFIR domains

THEME 1

Language concordance

Outer · Inner · Individuals

THEME 2

Privacy, stigma, discretion

Outer · Individuals

THEME 3

Structural fear & immigration context

Outer Setting

THEME 4

Flexibility: where, when, how

Intervention · Outer

THEME 5

Trust, outreach & word-of-mouth

Process

THEME 6

Workflow, training & team roles

Inner Setting

Each theme maps to one or more CFIR 2.0 domains and drives a specific Phase 2 protocol adaptation.

Language concordance isn't a preference; IT IS the standard of care

KEY FINDING

Language is repeatedly described as the single most important barrier. Participants already declined telemedicine when bilingual support was unclear. Providers confirm bilingual staffing is inconsistent and often means the interpreter line, which erodes trust on sensitive topics.

> *"The language has always been the main barrier I've had... when it's important things like medical, I prefer it explained in Spanish."*
>
> — Community member

> *"Everybody needs to be bilingual, or at least bilingual receptionist, bilingual MA, bilingual phlebotomist... otherwise it slows everything down."*
>
> — Provider

IMPLICATION FOR DESIGN

Bilingual capacity must be built into every touchpoint, scheduling, intake, telemedicine visit, phlebotomy, navigation, and follow-up, not added as interpretation after the fact. Language concordance is infrastructure, not accommodation.

Discretion determines whether people show up — especially at home

KEY FINDING

HIV stigma and fear of being seen accessing services shape every decision about location and visibility. Participants worry about branded vans, neighbors, and family members who don't know their status. Discretion is not a nice-to-have; it determines uptake.

> *"Some people are afraid someone will see them getting tested."*
>
> — Community member

> *"We still have to advertise we're a mobile phlebotomy unit. We don't have to advertise why we're going to their house."*
>
> — Provider

IMPLICATION FOR DESIGN

Use neutral, non-HIV-specific branding. Let participants choose the visit location (home, community site, or clinic) rather than defaulting to home. Separate the purpose of the visit from the visible presence of the team.

The immigration climate is reshaping whether people leave their homes

KEY FINDING

Providers and community members both describe a chilling effect on clinic attendance during heightened ICE activity. For many, driving to a clinic now feels riskier than the condition they are trying to manage. Mobile care is cited as a mitigation, not a convenience.

> *"Because of ICE raids and everything that's going on, it's easier for people to get access this way [Salud Movil]."*
>
> — Provider

> *"I don't want to risk driving without a license... one wrong step and what can I tell you?"*
>
> — Community member

IMPLICATION FOR DESIGN

Do not collect or condition services on immigration status. Emphasize the Certificate of Confidentiality in consent. Offer visit locations that minimize driving and public exposure. Train outreach staff to lead with 'what this is NOT' before describing what it is.

"Easier" means flexible location, flexible hours, and fewer steps

KEY FINDING

Participants described work schedules, transportation, and care fragmentation as the reasons they miss or delay appointments. A mobile + telehealth model is seen as advantageous precisely when it reduces the number of trips, fits around evening/weekend work, and bundles services in a single encounter.

> *"It would be easier if they come to you..."*
>
> *"I have diabetes that run in my family, but I wouldn't think of checking for that at that time... Just knowing that you can do this here as well... I think that'll be amazing"*
>
> — Community member (s)

> *"Any weekday after six would be a perfect time for me... if it fit my commute home, that would be very helpful."*
>
> — Community member

IMPLICATION FOR DESIGN

Build evening/weekend telemedicine slots, multiple location options (home, community partner site, clinic), and bundle HIV + Primary Care + STI + baseline labs in one mobile visit to minimize the number of touchpoints required.

Services only work if the community knows about them, and trusts them

KEY FINDING

Participants and providers converge on the same point: trust in the Latino community is built through relationships and repetition, not flyers. Community-based organizations, peer networks, and visible Spanish-speaking staff are named as the drivers of uptake.

> *"If nobody knows, nobody's going to show."*
>
> — Provider

> *"Having people from the community within the staff, that speaks the language and can go back and forth — that's a big part of creating trust."*
>
> — Community member

IMPLICATION FOR DESIGN

Partner with trusted Latino-serving CBOs and consulates for referral and normalization. Invest in consistent, long-term outreach rather than one-off events. Hire and retain bilingual community health workers as the face of the program.

Mobile care needs defined roles, training, and measurable fidelity

KEY FINDING

Providers stressed that a mobile + telehealth model requires more coordination than clinic care, not less. Designated roles, structured training, safety protocols for field staff, and a reliable chain from specimen collection to lab are non-negotiable.

> *"Having designated people for designated jobs makes the flow a bit easier."*
>
> — Provider

> *"You're going to need a driver who can double as security... at least two people, because people work better in pairs."*
>
> — Provider

IMPLICATION FOR DESIGN

Define a core mobile team (clinician via telehealth, bilingual navigator, phlebotomist, driver/security). Deliver structured pre-launch training. Use fidelity checklists from day one so implementation quality is measurable, not assumed.

FROM INSIGHT TO ADAPTATION

How Phase 1 findings are reshaping the Phase 2 pilot

SYNTHESIS

Six recommendations for mobile + telehealth HIV care

LANGUAGE

Bilingual at every touchpoint

Spanish-speaking scheduler, clinician, phlebotomist, navigator, not interpretation as afterthought.

PRIVACY

Neutral branding + participant choice

Avoid HIV-specific labeling. Let participants pick location and receive visit reminders of confidentiality.

FLEXIBILITY

Evenings, weekends, choice of setting

Telehealth + home visits + community sites. Bundle HIV, primary care, STI, and baseline labs in as few visits as possible.

TRUST

CBO partnerships + word-of-mouth

Latino-serving CBOs, and peer networks drive awareness and normalize engagement.

NAVIGATION

Step-by-step support before and after

Phone / WhatsApp scheduling, walk-through of what to expect, and post-visit follow-up in Spanish.

OPERATIONS

Defined roles + training + fidelity

Core mobile team, pre-launch training, standardized fidelity checklists, and field safety protocol.

NEXT STEPS

Phase 2 pilot implementation at a glance

~60	12	2	1
Recruit participants	Months of implementation	Frameworks — Proctor + RE-AIM	Scalable implementation toolkit

WHAT WE WILL MEASURE

- **Implementation** — Reach · Acceptability · Feasibility · Fidelity · Timeliness
- **Clinical** — Linkage · Retention at 6 and 12 months · PrEP initiation and adherence · HIV viral suppression · STI diagnoses
- **Economic** — Cost per participant · Cost per encounter · Cost per successful linkage
- **Experience** — Participant and provider satisfaction surveys and qualitative exit interviews at 6 and 12 months

THANK YOU

To the 30 community members and providers who shared their time, stories, and expertise.

ACKNOWLEDGMENTS

Carlos S. Saldana, MD
Nicolás Quiroga-Gutiérrez, MD
Don Operario, PhD
Alexandra Morshed, PhD
Victoria Phillips, PhD
Leandro Mena, PhD
CDC funding and MARI program staff
Ponce de Leon Center

CONTACT

Santiago Ramon, MPH (C)
jramon@emory.edu
Emory University School of Medicine,
Emory University Rollins School of Public Health

Juan David Patino-Mateus, MD
jdpatin@emory.edu
Emory University School of Medicine