Care Coordination for Pregnant Women Living With HIV in an Urban, Safety-Net Hospital

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Introduction

Boston Medical Center's multidisciplinary HIV Obstetric Positive Education (HOPE) clinic provides comprehensive obstetric care to pregnant women living with HIV under the Ryan White Program. It serves approximately 20 high risk, predominantly minority, urban women living with HIV each year.

Numerous structural barriers exist for women living with HIV to access health systems. We have implemented a number of client-facing social services such as adherence counseling, transportation and supportive housing referrals. These are an essential part in engaging clients in care, and helping them achieve viral load suppression to decrease risk of HIV transmission to their infants.

Demographics

Table 1: Demographics of unique HOPE Clinic Patients, receiving prenatal care from 2016-2019

	Hope Clinic Patients
Total RW Eligible Clients	**78**
Income	
<FPL	59%
1-2x FPL	27%
3-5x FPL	17%
Race	
Black/African American	76%
White	19%
Other/Declined	10%
Hispanic	19%
Primary Health Insurance Status	
Medicaid	77%
Medicaid & Medicare	10%
Private	10%
ConnectorCare	8%
Trimester Entering Care (82 pregnancies)	
1st	60%
2nd	29%
3rd	11%
Housing Status	
Permanent	74%
Unstable	13%
Shelter/Res. Treatment Facility	12%

Methods and Activities

Clinic with all staff held weekly in OB/GYN to reduce number of appointments.

Our multidisciplinary team includes: ID and OB/GYN providers, high risk OB RN, PharmD adherence specialist, Pediatric ID RN educator, MCM, and peer navigator.

Data for this poster was obtained through existing BMC Ryan White Program records and chart review. Determination of Not Human Subjects Research (NHSR) made by the Boston Medical Center IRB (IRB#H-39948) on 3/30/30.

ART ACCESS

- Linkage to BMC specialty pharmacy including medication mail and blister packing services
- PharmD adherence counseling, therapeutic drug monitoring
- Link clients to health insurance, maintain HDAP
- Clinical research trials offered to clients

WRAPAROUND SERVICES

- Peer Navigation for social support, accompaniment to laboratory, Patient Financial Services, and ID appointments after postpartum care
- MCM referrals to on site WIC office and food pantry, to partner organizations for rental assistance, emergency shelter, English and GED classes, immigration services,. Supportive home and community based visits as needed
- Extensive education to prepare clients and families for baby-related follow up

LINKAGE TO ONGOING ID CARE

- Since 2017, clients identified by MCM and ID provider as at high risk falling out of care postpartum were connected with outreach case manager in ID clinic. In 2017 and 2018, 3 of the 5 women connected with the high risk case manager retained in care over 24 months.
- Peer Navigator able to accompany clients to their ID clinic appts
- Peer and MCM check in with clients via phone calls and text messages up to 9 months postpartum to increase retention in care.

Results

- Last BMC case of maternal-child HIV transmission in April 2014
- 13 women received referrals to Aids Action Committee for rental assistance or housing search programs
- 3 women received referrals to emergency family shelters, 3 women received placements at residential treatment facilities
- Approximately 64 women received transportation services (parking vouchers, bus/subway pass, taxi)
- 51 of 78 women stay at BMC's ID clinic after HOPE care, including 7 women who were not in care before their pregnancy. 27 clients returned to their pre-pregnancy care site

Table 2: Retention in Care Metrics for the Clients Receiving Care at BMC's ID Clinic after Last HOPE Clinic Appointment

Retention in Care Outcomes After Last HOPE Clinic Appointment (2016-2019) For Women Receiving Care at BMC ID Clinic (N=51)	One Year Later	Two Years Later
Retained	67%	41%
Return to HOPE Clinic	4%	10%
Not Retained	14%	10%
To Be Determined	16%	39%

Lessons Learned

Treatment plans are approached on an individualized basis to ensure proper ART prescription, treatment of comorbidities, and to address social determinants of health.

Substantial efforts are expended in working with high risk pregnant women to prevent the transmission of HIV to their exposed infant. Barriers to care such as stigma of HIV, lack of affordable housing, transportation, and food security must be addressed as part of the care plan.

Ongoing Challenges

- **Stigma of HIV impacts:**
  - **Ability to accept HIV diagnosis**
  - **Clients' willingness to start care and treatment**
  - **Disclosure to partner**
- **Need for more affordable housing in Greater Boston area**
- **Focus on: rapid start of ART, or change to regimen appropriate for pregnancy**