NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Models on Engaging Immigrant Women of Color in HIV Care

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AIDS Care Group

Disclosures

Presenter(s) has no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe the epidemiology of HIV in immigrants in the US
2. Describe effective models of reaching the immigrant population
3. Discuss challenges and strategies in engagement and retention in HIV care among immigrant women of color

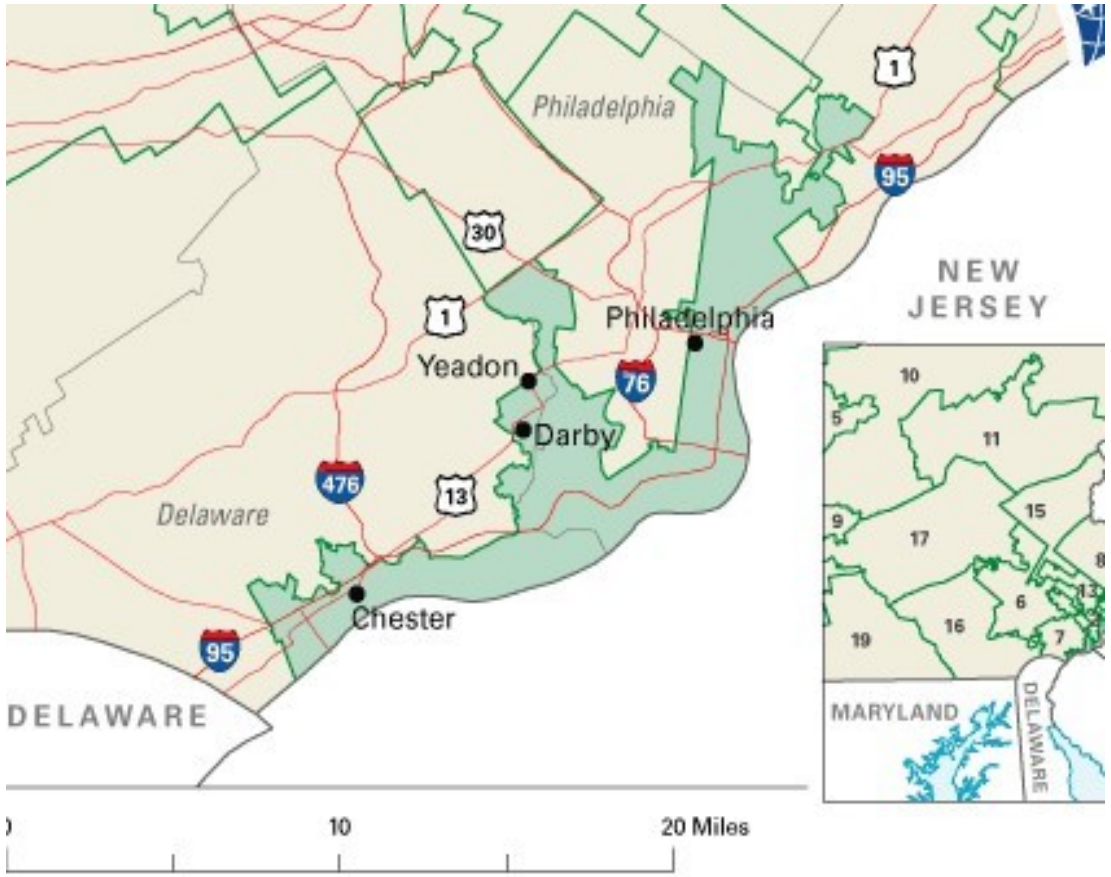
Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

AIDS Care Group

- Incorporated in 1998 to serve a medically underserved area in Chester PA and surrounding communities
- First received Ryan White funding in 1999 – now funded through Parts A, B, C, D and SPNS
- Continuum of care includes primary HIV medical care, dental care, screening and treatment for STIs, Prep, psychological services, nutritional care, medication assisted treatment for opioid use disorders.
- Other services include specialty care for HCV, in-house pharmacy (with free home delivery!) and medication adherence, outreach, transportation, food distribution, case management and housing counseling.



Demographics of Target Population

- 939 patients reported in 2018
- 80-90 new patients seen annually
- 67% of patients served are minorities
- 40% of patients seen are women
- Large immigrant population – primarily African immigrants
  - Referrals mainly from health departments, ER from nearby hospitals, transfers from FQHC city health centers, African primary care docs, online search
- 60% of patients have Medicaid or no insurance
- Sharon Hill office in close proximity to ‘Little Africa’
  - Refugee resettlement agency spurred influx of West Africans
  - ACANA

HIV among African Immigrants in the US

- Number of African-born US residents increased from 200,000 to more than 1.5 million between 1980 and 2009.
- Most African born residents in the US concentrate in large urban epicenters also characterized by high HIV infection rates.
- The stark difference in HIV burden is between US born and African born women.
  - More likely to be diagnosed late
  - Main mode of transmission is heterosexual
  - Engage in care in the later stages of infection

PEER LINKAGE AND RE-ENGAGEMENT

For Women of Color

- Intended for organizations, agencies, and clinics considering a short-term intensive peer-focused model to increase linkage of newly diagnosed and re-engagement of known HIV-positive women of color.

- 4-month intervention to achieve the following outcomes:
attendance to two medical care visits with a prescribing provider;
completion of one lab visit; and
completion of one visit with a case manager.

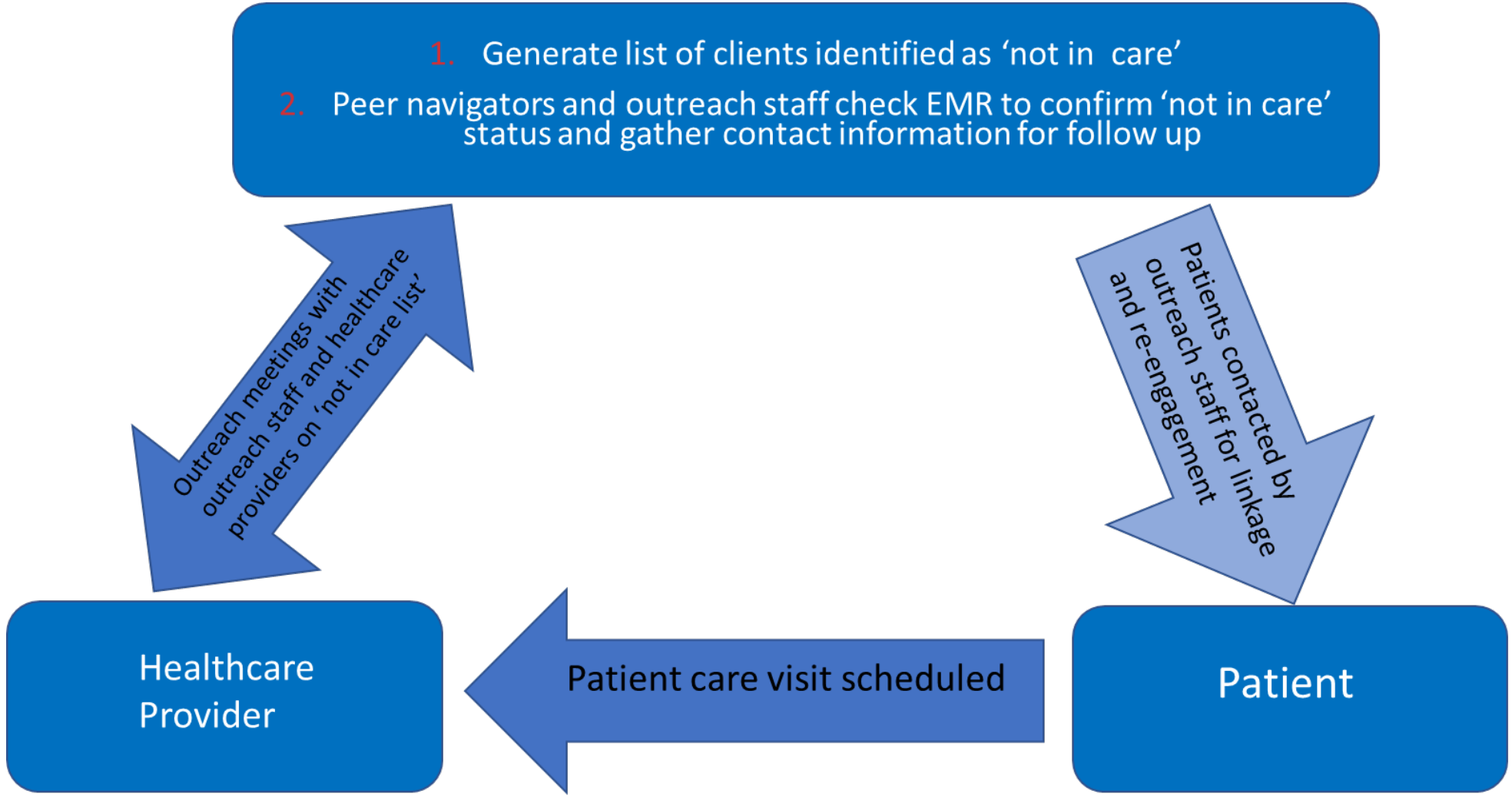
- ACG was one of 3 recipients of SPNS grant to conduct this Intervention.

Peer Navigators

- Peer Navigators are defined as HIV-positive, medication adherent role models living with a shared experience and a shared community membership as the populations they work with.

- Roles includes case finding and outreach; routine appointment reminder phone calls, accompaniment to appointments; transportation assistance; referrals and associated follow-up, and adherence education and all-around support.

Data to Care and Peer Navigation and Provider Model



Results

- 75 WOC enrolled in the Peer Linkage Program.
- 12 were newly diagnosed
- Out of care range: 6 months to 5 years
- Average age: 45
- 3 American born WoC were also co-infected with Hepatitis C and have now been cured.
- 3 African born WoC presented with active Tuberculosis.
- The program has been successful in enhancing the care continuum; 98% of the enrollees have had a second visit, and 77% have achieved viral suppression within 3- 6 months.

Comparison of US born vs African born outcomes

At Baseline	U.S Born WoC (n=52)	African Born WoC (n=23)
Mean Age	47	42
Mean CD4	584	452
Mean VL (copies/mL)	60894	133372
Main barriers to care	Housing and food insecurity, Substance abuse and mental health, and stigma	Navigating a new healthcare system (including lack of insurance and proper identification), employment in the US, and stigma

Case Studies & Lessons learned

Challenges: HIV Stigma

Newly arrived immigrants tend to come to clinic with their traditional garb, over time we observe that the longer they integrate into the society, they tend to wear less of African garb in everyday life, partly to guard their identity.

‘I don’t go to the Sharon Hill Clinic because too many Liberians go there and they talk too much’.

Case Study

- Client from Burkina Faso, came to clinic late last year.
- At the time of enrollment into the program, she had been in the US for about 4 months. Spoke only her tribal language, her brother who had been in the US was her translator. She was the 3rd wife, her husband and one of the wives had passed away. She was notified of her HIV infection after their deaths in her home country but never put on meds.
- At baseline her CD4 was 438 and a VL of 44190.
- Challenge: language barrier, malaria, no insurance, 7 children back in home country.
- Success: case management (SPBP), undetectable VL, not missed any appts, now employed & learning English.

Strategy: Peer Linkage Model

Trust and patience

Holistic model of care

- Comprehensive HIV primary care, dental, mental health services, behavioral health support,

-Case management

Empowering the women

-Peers sharing their own stories of challenges and overcoming

-Self advocacy

Role modeling medication adherence

-Partnership between client and peer for accountability

-Increased adherence over 4 month period

Coordination of care: linkage to other social services

-referrals to immigration services

- Scheduling flexibility (Saturday clinic, second location option)

Case Study 2

- Client from Liberia
- At baseline, CD4 was 4 and VL 84,668. Also presented with neuro-cognitive issues associated with HIV infection.
- Was staying at a nursing home at the time, then shelter but is now stably housed and seeking employment.
- She is still facing challenges with her cognitive health and medication adherence.
- Her CD4 is now over 100 and VL 60 copies.
- A care team is in place to help her in every way.

Cultural Humility

- Understanding their cultural norms in relation to healthcare seeking patterns
- Patience with their own disclosure
- Competing priorities
  - Immigration and integration
  - Employment
- Language vs accent barriers

Case study 3

- Client from Liberia, was enrolled in December 2016. She was uninsured, presented with a myriad of health challenges including a stroke a few years ago which led her being unable to work. She had been in the US for over 30 years, children in Africa, but her green card had expired which limited her access to public assistance. The peer team along with case management linked her to a local service organization that caters to immigration and resettlement social services for African immigrants.
- She also faced various challenges at home since moving in with her family members: manipulation, lack of basic needs.
- Therapy has been beneficial for her.
- Intersection of culture and mental health.

Strategy: Peer Linkage Model

Trust and patience

-overcoming stigma is a slow process

Holistic model of care

- Comprehensive HIV primary care, dental, mental health services, behavioral health support, outreach

-Case management

Empowering the women

-Self advocacy

Role modeling medication adherence

-Partnership between client and peer for accountability

-Increased adherence over 4 month period

- DOT

-In-house pharmacy: option to pick up meds from clinic or drop off services

Coordination of care: linkage to other social services

-Transportation assistance for medical and therapy sessions (uberhealth)

- Grocery store gift cards

- Immigration services

Peer Advocacy and Trust Building

"When I was diagnosed with HIV, I had nobody to help me and keep me in care. This program is the most beautiful thing, especially for women of color, because so many of us don't put ourselves first. I enjoy every minute of the work I do and I know that it makes a difference."

Conclusion

- Important to collect data on country of origin.
- African cohort present different layers of challenges to care that require different responses.
- Cultural humility is a continuous learning process for healthcare providers.
- Peer program has been effective in re-engaging women in care.
  - Peers serve as the bridge between the providers and clients.
  - Including peer and outreach team strengthens the care continuum.
- The power of a (peer's) story can help break stigma and help other women self advocate for their own health needs.

Acknowledgements

- ACG clinical and outreach staff
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