



Peer Outreach Workers Engagement and Retention

FACES Network

SUNY Downstate Medical Center

Brooklyn NY



SERVING FAMILIES FOR OVER 20 YEARS

Background

- POWER has been a 5 year demonstration project funded by the Health Resources and Services Administration (HRSA) Special Projects of National Significance (SPNS) under the Ryan White Care Act to address health disparities affecting HIV+ women of color.
- Added HIV+ women peers to an already existing functioning network of HIV care providers and case managers
- Relies on the peer-case manager dyad and strength of the network to best effect outcomes

Background

- “POWER” Peers are HIV+ women who are hired as part of the clinical team
- Peers reach out to women who are:
 - > Newly diagnosed with HIV
 - > Contact clients who have dropped out of care
 - > Work with clients who are at-risk for dropping out (unstable housing or other unstable social factors such as family and partner issues)
 - > Connect with clients who are transitioning from adolescent to adult care
- Network case managers and peers met weekly for group supervision sessions and were part of weekly case conferences at their own sites

How did the POWER intervention address the barriers women of color encounter in accessing or remaining in care?

POWs are HIV+ women who receive services at one of the participating clinics, they are paid, are on staff and are part of clinical team.

-As one of the POWs said about her work: “I am the bridge to all the services at our clinic.” *Migdalia P., Peer Outreach Worker, Brooklyn Hospital*

Our idea was simple although the follow through was more complicated.

POWs would meet clients in their homes or the field, escort clients to visit, remind clients of visits, The POWs are role models. As one POW said:

-“A Peer Outreach Worker gives support. Our clients see that we are going through some of the same things they are and they are inspired.” *Mina B., Peer Outreach Worker, Life Force, Inc/Housing Works. (MB was later promoted to a Case Manager position)*



Project challenges

- ◉ Turnover of administrators and clinicians
- ◉ Importance of individual POW to clients
- ◉ Disclosure of POWs (unclear how affects project, but a surprise)

Organization level challenges

- Funding Shifts at sites
 - > Life Force subsumed under Housing Works
- Leadership instability at hospital level across Brooklyn is reflected in admin turnover
- Part A Care Coordination funded at same time to POWER with a similar model
 - > overlap at 3 sites leads to competition for clients
- Loss of Part D funding midway through project

Future: How loss of Part D affected POWER

- ◉ Fewer Case Managers/ higher case loads
- ◉ Case management supervision
- ◉ Weekly meetings / continuity of care across sites

Methods

- Prospective intervention study on a convenience sample of women who were “reachable”
- Enrolled HIV+ women of color between November 2010-July 2013 who met study criteria for risk of not receiving HIV care from the following criteria:
 - 1) Newly diagnosed with HIV, never been in care
 - 2) Previously diagnosed, never been in care
 - 3) Previously in care but changed care provider
 - 4) Sporadic care – last visit within 12 months
 - 5) Lost to care (out of care > 12 months)
 - 6) Assessed as “at risk” for dropping out of care (missed appts., adherence problems, substance abuse, etc.)

Methods

- Face-to-face interviews were conducted at baseline and 4 follow-up times: 3; 6; 12; and 18 months.
- Demographic and extensive health history was collected at baseline.
- Barriers to care (30 items- *personal; provider, and structural*), self-assessed health (CDC HRQOL) and aspects of the clinical care team were collected at each follow-up visit.
- Follow-up data was being collected through the end of January 2014.

Data Collection – Baseline and 12 months

1. HIV care status
2. Sociodemographic
3. Self-assessed health using CDC HRQOL
4. Barriers to care – 30 items developed for this study across sites coded as present “yes/no” and recoded into three domains: *personal; provider, and structural*

Demographics

- 196 women enrolled in care between November 2010 - July 2013.
- 75% of enrollees were African American or of Afro Caribbean descent.
- As of October 2013, 112 of enrollees had returned for 12-month follow-up and their baseline barriers and self-assessed health were re-measured.

Enrollment Status from a Cohort at Baseline at 12 months (N=112)

	N	(%)
1) Newly diagnosed with HIV	9	(8.0)
2) Never been in care	15	(13.4)
3) Changed care provider	20	(17.9)
4) Sporadic care (<12 mos)	5	(4.5)
5) Lost to care (> 12 months)	1	(0.9)
6) At risk for dropping out	62	(55.4)

CDC HR-QOL – Global Health Item

Years since HIV diagnosis Mean=11.6 years (SD=8.1), Range 0-29

Percent of women diagnosed within 1 year =11.4%

In general your health is...	Baseline		Year 1 follow-up*	
	N	(%)	N	(%)
Excellent	13	(12)	14	(13)
Very good	13	(12)	24	(21)
Good	36	(32)	46	(41)
Fair	39	(35)	23	(21)
Poor	11	(10)	5	(4)

* $X^2=37.4$, $df=16$, $p=.002$

Age Groups

Age Groups	N	(%)
17-24	27	(24.1)
25-39	20	(17.9)
40-49	43	(38.4)
50-65	22	(19.6)

Mean Years HIV+ 11.6 (SD=8.1), Range 0-29

Most Prevalent Barriers at Baseline, compared to 12 month follow-up*

Months	Baseline		12	
	N	(%)	N	(%)
Need more information	93	(83)	58	(52)
Felt like you should learn to live with it*	87	(78)	66	(59)
Wanted to get back on track on own	85	(76)	71	(63)
Thought you might be judged	75	(67)	57	(51)
Felt embarrassed	68	(61)	62	(55)

* 10 of 30 barriers were reported by 50% or more of the sample at baseline.

Greatest Reduction in Reported Barriers

12 Month – Baseline Change

	N	(%)
Needed more information	- 35	(31)
Felt information would not kept private	- 30	(27)
Uncertainty about housing or finances	- 29	(26)
Care would bring unwanted changes	- 23	(21)
Need to just live with it	- 21	(19)

Conclusions

- ◉ Women report a significant number of barriers upon enrollment, especially related to fears about providers
- ◉ Women report significant improvement in self-assessed health over a 12 month period of care
- ◉ Women report significant reduction in barriers over 12 months, mostly related to concerns about providers
- ◉ Multivariate models will be developed to examine engagement over time



HIV in the US

- ◉ A lot of progress but more needs to be done
- ◉ Major challenges:
 - > 1 in 5 PLWHA are unaware of their status = greater risk for spreading the virus
 - > ¼ of Americans living with HIV are women, and the disease disproportionately impacts women of color
 - > HIV diagnosis for Black women is more than 19 times the rate of White women

Challenges continued...

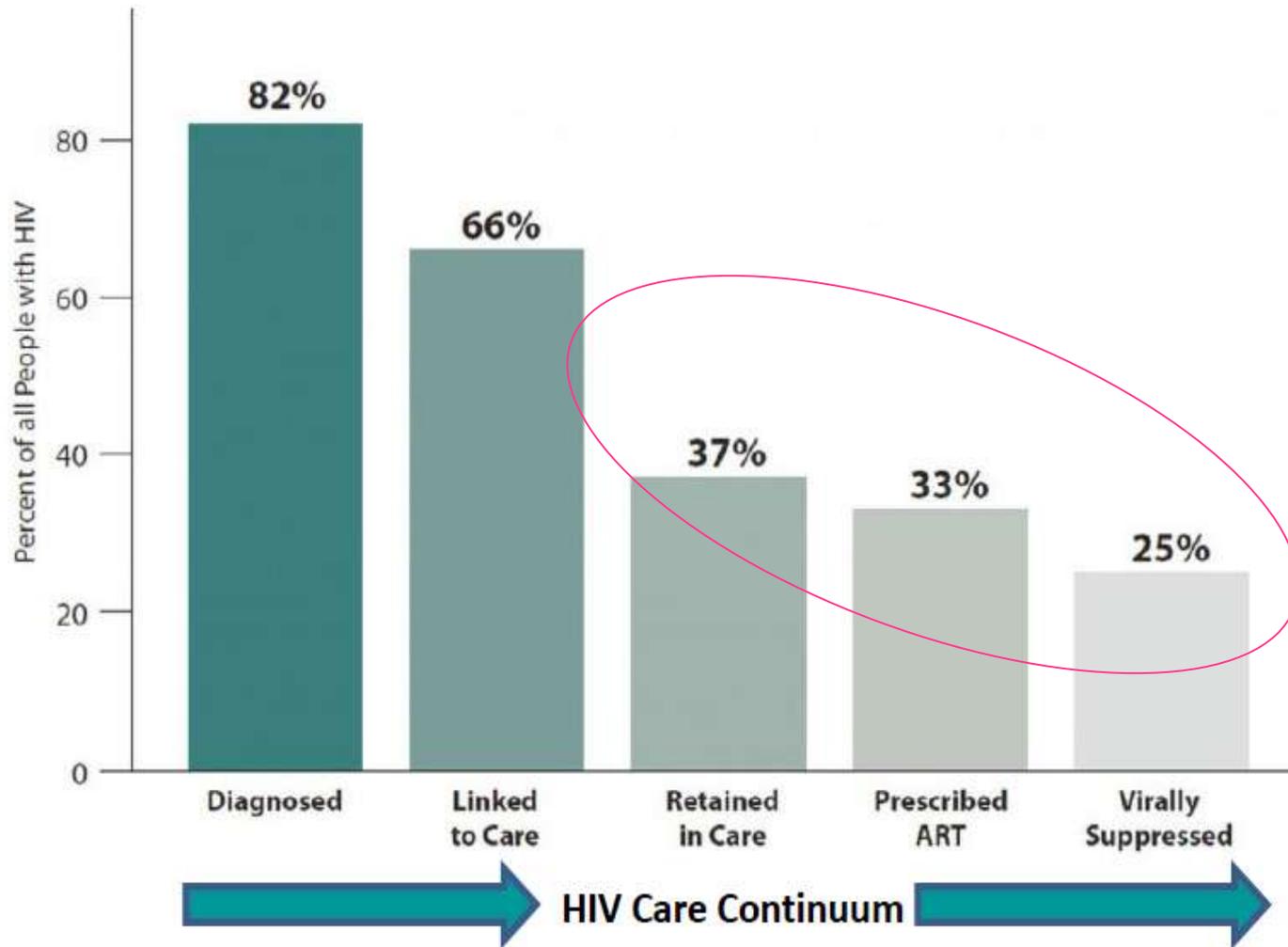
- Racial and ethnic minorities are disproportionately represented in the HIV epidemic and die sooner than Whites.
- 1/4 of new HIV infections occur among adolescents and young adults ages 13-29
- 24% of PLWHA are 50 or older, and 15% of new HIV/AIDS cases occur among this age group.

National Policy

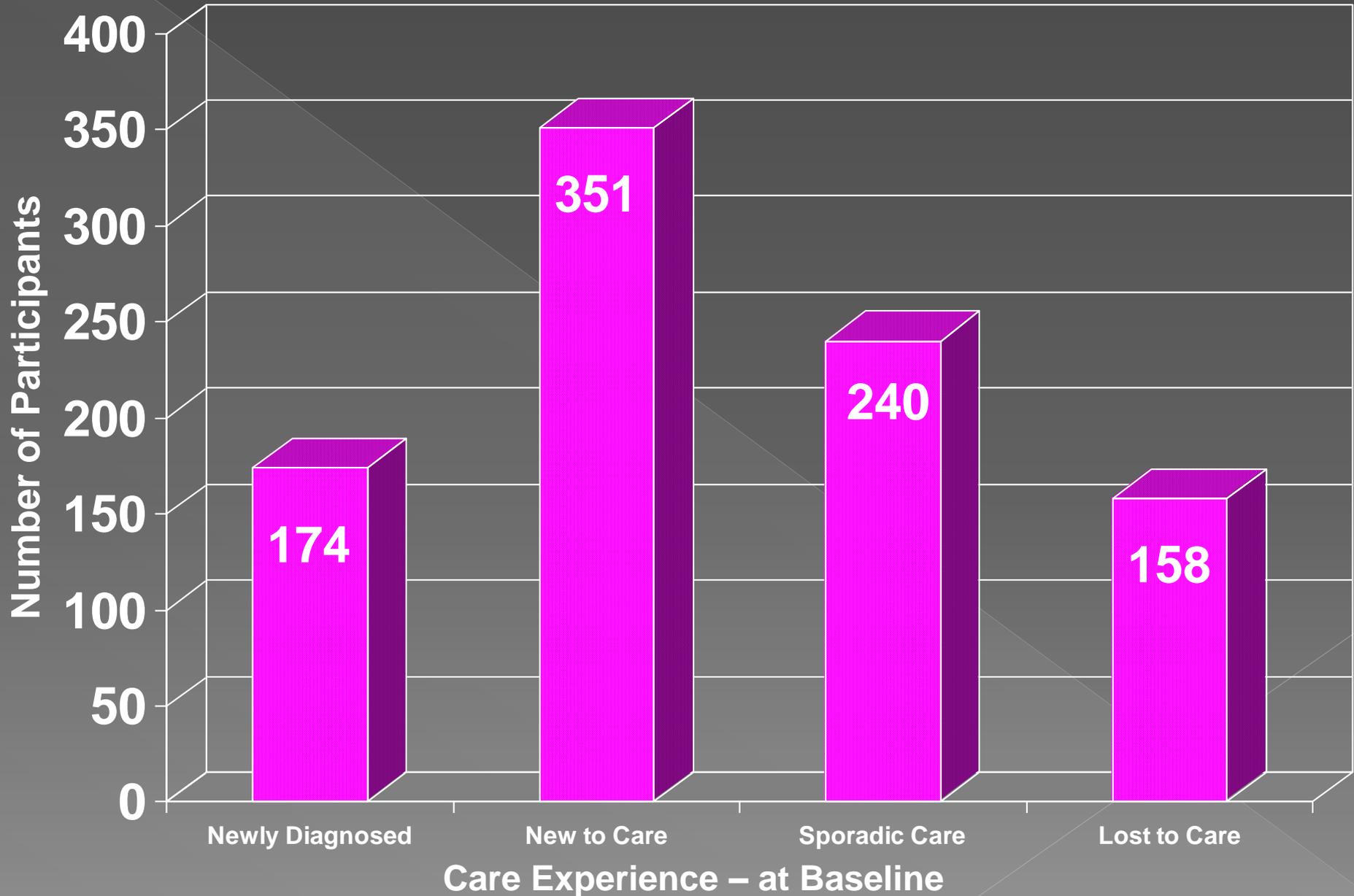
- The National HIV/AIDS Strategy – July 13th, 2010
- 3 Primary Goals:
 - > 1. Reducing the number of people who become infected with HIV
 - > 2. Increasing access to care and improving health outcomes for people living with HIV
 - > 3. Reducing HIV-related health disparities
- Executive Order – The HIV Care Continuum Initiative – July 13th, 2013
 - > Calls for coordinated action in response to data released since the HIV/AIDS Strategy 3 years prior, which shows only a quarter of PLWH in the US achieved viral suppression.

The HIV Care Continuum

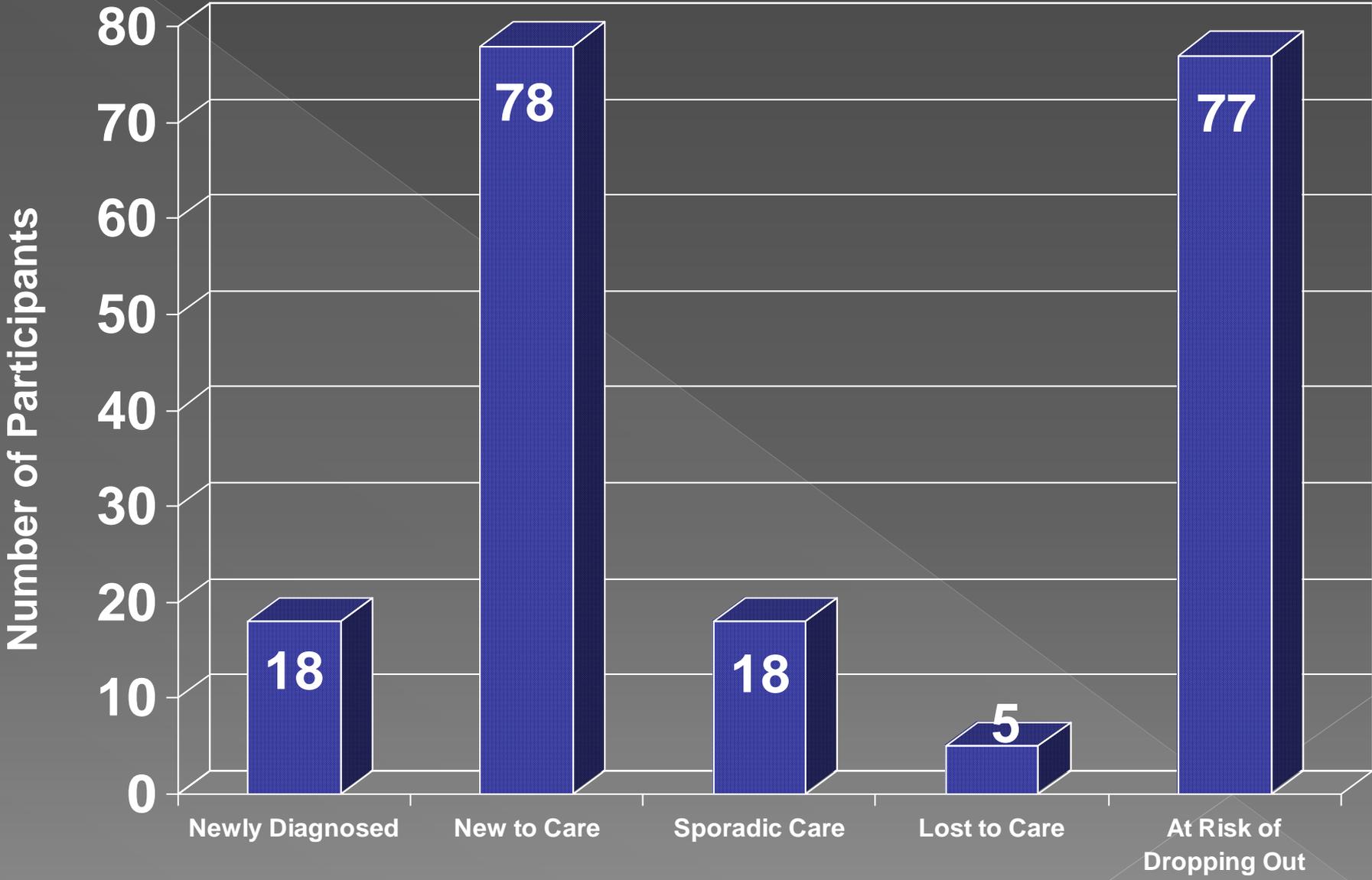
FALL-OFF ALONG THE HIV CARE CONTINUUM IN THE UNITED STATES



National Women of Color Data by Care Experience (n=923)



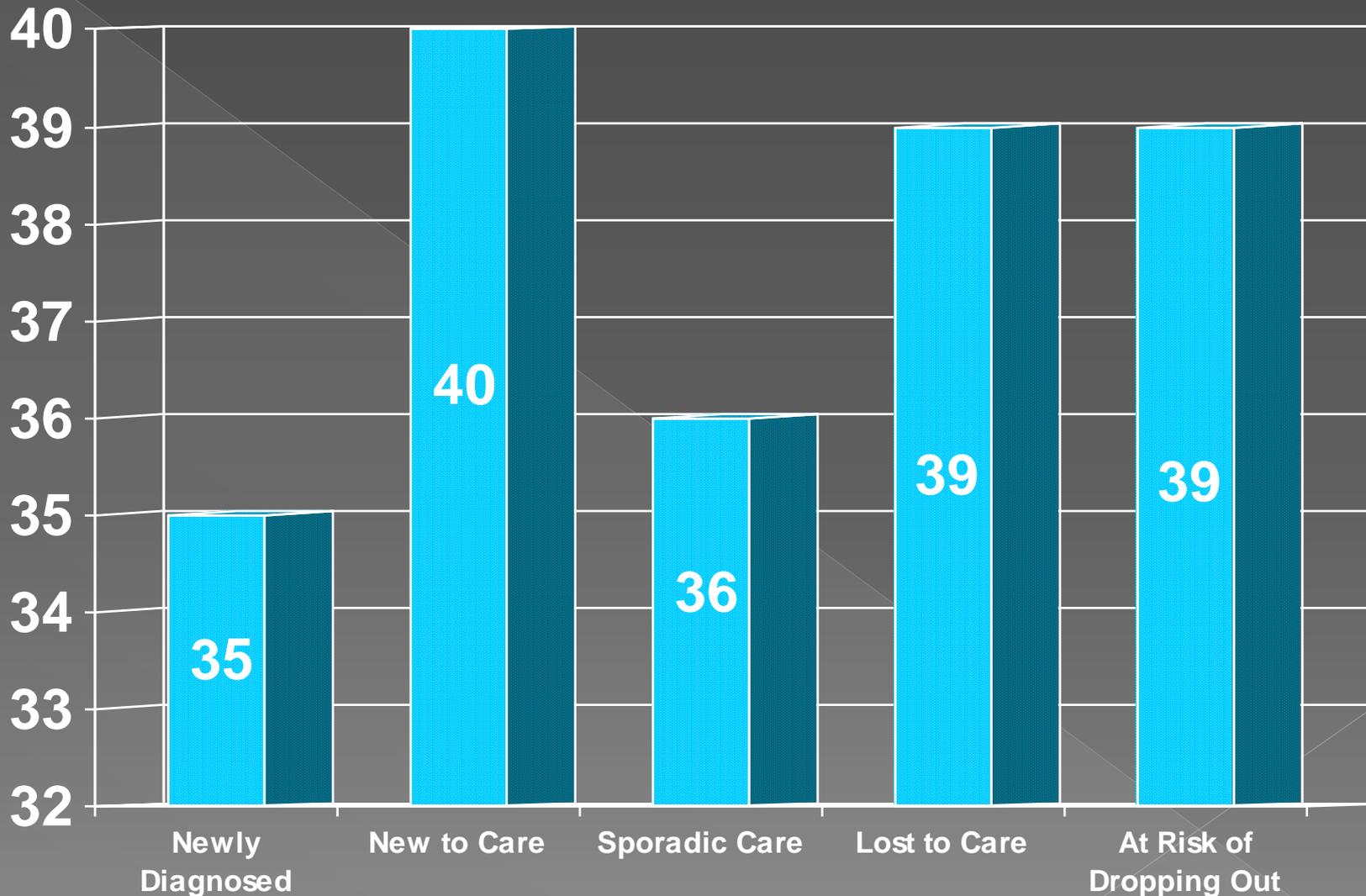
Brooklyn Women Enrolled in POWER by Care Status at Baseline (n=196)



POWER Program, SUNY Downstate Medical Center

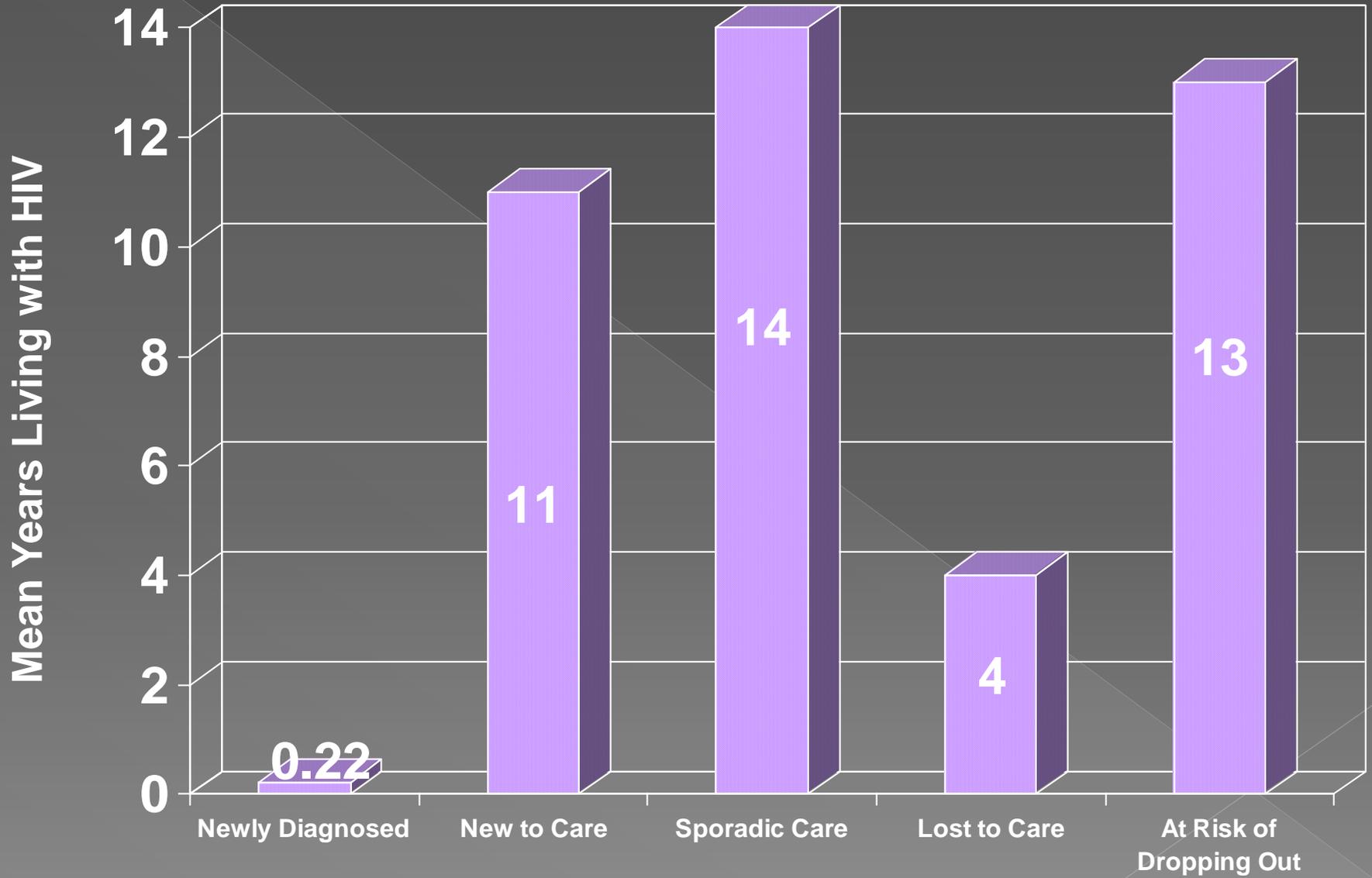
Average Age at Study Entry with HIV by Care Experience

Mean Calculated Age (date of baseline interview DOB)



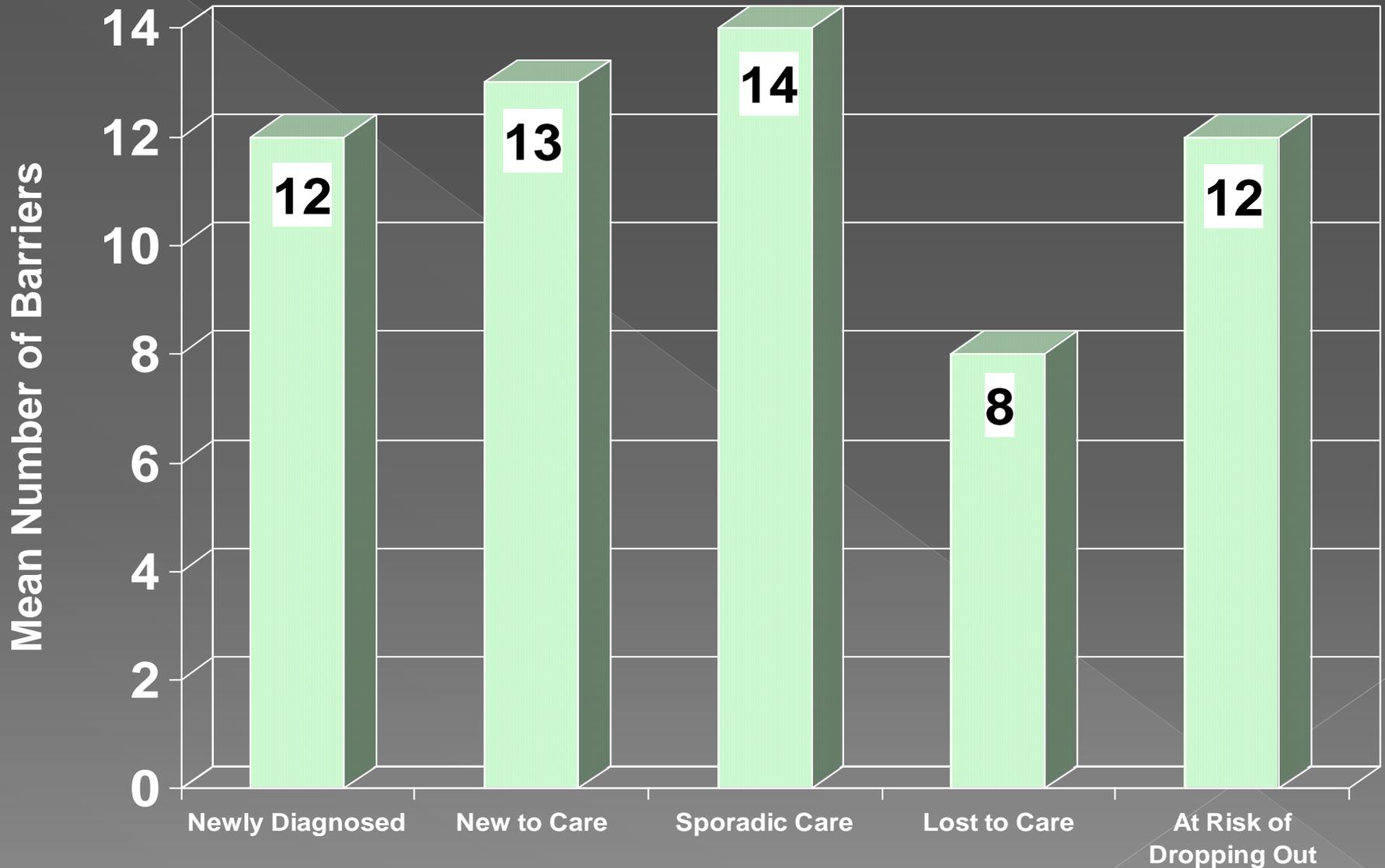
POWER Program, SUNY Downstate Medical Center

Average Number of Years Living with HIV by Care Experience



POWER Program, SUNY Downstate Medical Center

Average Number of Barriers at Entry with HIV by Care Experience



POWER Program, SUNY Downstate Medical Center

Policy & Practice Implications

● Practice:

- POWER – peer outreach workers and CM dyad
- Efficient, comprehensive systems of care
- Wrap-around services (supportive services)
- Interdisciplinary medical teams
- New initiatives – PrEP = prevention?

● Health Policy:

- Health reform, ACA's impact on:
 - Medicaid expansion?
 - Ryan White funding?
- Future funding and resources

Systemic Challenges to Health Care System Impacting POWER's Sustainability

- Defunding of Brooklyn Part D FACES Network in fall 2012; loss of many network case managers and weekly cross-site supervisory meetings; threatened loss of Part C to several hospital sites in Brooklyn
- Instability of hospital system in Brooklyn, particular hospitals that were previously funded under our Part D program (Interfaith Medical Center, SUNY Downstate, Long Island College Hospital, Brookdale Medical Center)
- Changes in the Ryan White CARE Act, in particular the current plan by HRSA to fold Part D mandates into Part C

Systemic Challenges to Health Care System Impacting POWER's Sustainability

- Sustainability of SPNS program will require any combination of complete overhaul of hospital billing practices for HIV services, implementation of EMRs, restoration of lost Part D funding, newly acquired Part A funding
- Perception that ACA has solved society's problems of health disparities through access to health insurance without addressing the issues of HIV diagnosis and linkage to and retention in care; this leading to less funding available for initiatives addressing linkage, engagement and retention similar to the goals of the overall WOC SPNS project

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