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Eye on Farmworker Health

Current Developments in Research and Policy

The Affordable Care Act and Low-Income People Living With HIV: Looking Forward in 2014 and Beyond

Authors: *W. Abara & H. Heiman*
Source: *Journal of the Association of Nurses in AIDS Care (2014) 25(6): 476-482*

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law with the intent of ensuring nationwide access to quality, affordable health care. Less than three months later, the Obama Administration released the first comprehensive National HIV/AIDS Strategy (NHAS) for the United States. The vision contained within this document is to establish the United States as "a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socioeconomic circumstance will have unfettered access to high-quality, life-extending care, free from stigma and discrimination."

Implementation of both the Affordable Care Act and the National HIV/AIDS Strategy has been wrought with challenges. Nevertheless, both continue to garner strong support and present great opportunity for enhancing HIV/AIDS health care within the United States. Abara and Heiman provide a review of HIV health care policy and programs for low-income people living with HIV (PLWH) and assess prospective changes in the context of the NHAS goals and full implementation of the ACA.

Approximately one million people are living with HIV in the United States. The CDC estimates 50,000 new infections occur annually, with incidence greatest among African American and Latino communities. Current research demonstrates that disparities in access to treatment and retention in care persist. Among PLWH, two thirds (66%) are linked to care, approximately two fifths (37%) are retained in care, one third (33%) are prescribed antiretroviral therapy (ART), and only one quarter (25%) have achieved viral suppression thus reducing their risk of transmitting HIV.

The principal means by which low-income PLWH continue to access essential health care services is through Medicaid and the Ryan White Program. Prior to 2014, PLWH had to meet strict income and categorical requirements to be eligible for Medicaid. This often precluded low-income parents and childless adults with HIV from accessing comprehensive HIV care. The Ryan White Program has served as a crucial source of funding since its beginning in 1990. Through this program low-income, uninsured and underinsured PLWH may qualify for

ARTICLES REVIEWED IN THIS ISSUE

financial assistance which covers insurance premiums, deductibles and co-payments so that they may access and remain linked to care. Services covered by this program range from prescription medications to wrap-around services, which are essential non-clinical aspects of care such as transportation to medical appointments, mental and substance abuse counseling, and legal and housing services.

PLWH gain significantly from implementation of the Affordable Care Act. Health insurance companies may no longer use HIV infection as grounds for denying an individual coverage. Annual and lifetime dollar limits on health care coverage are now prohibited which allows for PLWH to retain their coverage. Additionally, in states that have opted to expand Medicaid, individuals with incomes up to 138 percent of the Federal Poverty Level may now access insurance without having to meet categorical requirements. Consequently, many previously ineligible low-income parents and childless adults may now qualify and gain access to critical HIV care. Furthermore, under the ACA the coverage gap in Medicare Part D Prescription Drug Plans has been closed. This will help to ensure continual access to and coverage of antiretroviral medication for PLWH.

Implementation of the ACA presents many opportunities for improving HIV health care programs in the U.S. and realizing the goals of the National HIV/AIDS Strategy; however, challenges remain. First, the ability of states to opt out of expanding Medicaid has detrimental consequences. People living with HIV in these states, in particular low-income individuals, remain ineligible for coverage thus preventing access to necessary comprehensive care. This only serves to further disparities among populations affected by HIV/AIDS. Second, HIV-patients are likely to cycle between Medicaid and health insurance marketplace plans as their incomes change and they qualify or do not qualify for subsidies. Coordination between the two systems is critical to ensure that during times of change patients retain access to treatment and care services. Finally, policymakers are now calling into question the need to continue funding the Ryan White Program as previously uninsured and underinsured PLWH stand to gain the coverage they need through the ACA. It is imperative that funding for the Ryan White Program continue. Under the ACA, insurance plans are not required to cover wrap-around services funded by the Ryan White Program that are a vital component of comprehensive HIV care. Furthermore, in states which have not expanded Medicaid, Ryan White funding will continue to benefit low-income PLWH who remain ineligible for health insurance.

Cell Phone Utilization Among Foreign-Born Latinos: A Promising Tool for Dissemination of Health and HIV Information

Authors: *L. Leite, M. Buresh, N. Rios, A. Conley, T. Flys, and K. Page.*
Source: *Journal of Immigrant Minority Health (2014) 16: 661-669*

Latinos are the largest ethnic minority in the United States and comprise nearly one fifth of the total population. As the Latino population continues to grow, the unmet demand for culturally competent and linguistically appropriate health care becomes ever more pressing. Researchers are increasingly looking to technology-based interventions, such as email or text messaging, as a means for improving access to health education. This paper examines whether information communication technology-based (ICT) interventions may serve as an effective

WHO ARE WE?

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It is a publication by Farmworker Justice, supported by grant number U30CS22741 from the Health Resources and Services Administration's Bureau of Primary Health Care. Each issue includes summaries of recent articles and reports, as well as recommendations for using the information to help health professionals, outreach workers, *promotores de salud*, and advocates strengthen their efforts on behalf of farmworkers and their families.

This issue of Eye on Farmworker Health is a joint publication with Aliados. Aliados is an electronic newsletter covering important recent developments in research on HIV/AIDS and the Latino community. It is a publication by Farmworker Justice and is supported by the Act Against AIDS Leadership Initiative (AAALI). Each issue includes summaries of recent articles and reports, as well as recommendations for using the information in your own communities.

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method for linking Latino migrants to HIV prevention education, testing and treatment services.

In the United States, the Latino population remains disproportionately affected by HIV/AIDS. In Baltimore, Maryland for example, rates of AIDS cases among Latinos doubled between 1997 and 2006 yet decreased among non-Hispanic Blacks by 40 percent and among non-Hispanic Whites by 23 percent. Immigration status, language barriers, cultural differences, and stigma are recognized factors which influence access to HIV testing and in part contribute to the higher estimated lifetime risk of infection for Latinos. In an effort to reduce disparities in quality and access to HIV services, the Baltimore City Health Department (BCHD) established the Latino Outreach Program in 2008. The program offers culturally sensitive, Spanish-language HIV education, testing and linkage to care services for Latino migrants residing in Baltimore. The majority of clients served by the program are foreign born (95%), and by 2010 testing rates among clients increased from 37 to 62 percent. The authors of this research sought to identify whether communication technology interventions may be used to complement ongoing outreach efforts and further improve HIV testing rates among Latinos.

A cross-sectional survey of 209 Baltimore Latinos was conducted at community-based venues between June 2011 and January 2012. The list of venues was generated through preliminary interviews with ten key informants who included outreach workers from the BCHD Latino program, social workers familiar with the Baltimore Latino community, bar owners and clients, and staff from community based organizations. A random number generator was used to select venues and times in order to reach a representative sample of Latinos in the city. During each sampling period interviewers screened every third unit (family, single person, couple) for eligibility and survey recruitment. Eligible participants were required to self-identify as Latino, be 18 years of age or older, provide oral consent, and communicate in Spanish or English. The maximum number of participants per venue was twenty people.

Participants were administered a 21-item survey in interview format. The survey assessed demographics (age, gender, education, race, sex, primary language, country of origin, years in the US); frequency of technology use (cellular phone, text messaging, email and Internet); and interest in receiving health information, HIV education and HIV test results by cell phone, text message, Internet or email. REDCap electronic data capture tools housed at Johns Hopkins University School of Medicine was used to collect and manage study data. Pearson's Chi square test was used for categorical variables and the Wilcoxon-Mann-Whitney test was used for continuous variables when examining characteristics and technology use among participants who had previously been tested for HIV versus those who had not. Multivariable logistic regression was employed to identify factors associated with previous HIV testing, communication technology use and interest in receiving heath information via text messaging. All statistical analysis was performed using Stata version 10.0 for windows.

Over the course of the study, the authors asked 674 eligible individuals to participate and 209 completed the interview. The surveys were completed on the street (54.1%), at health fairs (27.8%) and at community-based organizations (18.2%) frequented by Latinos. Survey participants were predominantly foreign-born (95.7%) and spoke Spanish as their primary language (98.6%). More men

STAY IN TOUCH

For more information on Eye on Farmworker Health, please contact Juan Guevara at jguevara@farmworkerjustice.org.

Please contact Caitlin Ruppel at cruppel@farmworkerjustice.org with any questions related to Aliados. We welcome your feedback at any time!

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(51.7%) were interviewed than women. Two thirds of the survey participants had been in the United States for fewer than 10 years. The majority (70.1%) of participants had previously been tested for HIV, though women were twice as likely as men to have been tested.

In regards to use of technology communication, older age and lower education were associated with lower rates of Internet, email and text message usage. Female participants were more likely to report frequent cell phone usage than male participants. Acceptability for receiving text messaging was high among survey participants. Health education text messages were most acceptable (73.1%), followed by HIV education text messages (70.2%), and receiving HIV test results via text message (68.8%). The authors found that interest in receiving HIV education and test results via text message was associated with higher education and exclusive cell phone ownership.

This study serves as a new contribution to the growing literature on the use of information communication technology-based health interventions and the first to evaluate use of ICT to disseminate HIV information among a primarily foreign-born Latino population. The authors recommend that future studies of text-based health messaging measure literacy levels, which was not included in this research. Furthermore, they recommend that if ICT interventions are utilized to enhance traditional health outreach efforts it is critical that the technology remain accessible to the target population.

HIV and Mexican Migrant Workers in the United States: A Review Applying the Vulnerable Populations Conceptual Model

Authors: *C. Albarrán & A. Nyamathi.*
Source: *Journal of the Association of Nurses in AIDS Care (2011) 22(3): 173-185.*

Migrant workers residing in the United States are subject to social and economic marginalization and consequently experience poor health outcomes. Recognizing the risk factors that underlie migrant workers' health status, and the means by which they are facilitated or mitigated, is critical to the development of effective public health policy and practices which seek to reduce disparities. This is particularly true when addressing the issue of HIV and migrant workers. The intent of this article is twofold: first, to add to the literature by applying the Vulnerable Populations Conceptual Model to existing research on HIV and the U.S. Mexican migrant laborer population, and second, to discuss implications for nursing research, practice and policy.

The authors used PubMed and the Cumulative Index to Nursing and Allied Health Literature to identify research studies for review. Key words used to search for studies included: *Hispanic/Latino/Mexican migrant workers, HIV, AIDS, farm workers, day laborers,* and *United States*. Only studies published between 1996 and 2009 were taken into consideration. Thirty two studies were included in the final review. The authors chose to apply the Vulnerable Populations Conceptual Model to selected research in order to analyze HIV risk among migrant workers primarily through a structural, rather than personal, lens.

The Vulnerable Populations Conceptual Model (VPCM) (Flaskerud & Winslow, 1998) examines the interrelationship between resource availability and relative risk as it pertains to the health status of a vulnerable population. A vulnerable population is defined as a group which lacks sufficient resources and is at increased risk for morbidity and mortality. In this model, resource availability refers to the accessibility of socioeconomic and environmental resources which may influence the ability of a group or individual to avoid risk. Relative risk measures the exposure of an individual or group to risk factors which affect health outcomes. Health status is evaluated in terms of morbidity and mortality.

The authors analyzed resource availability by considering factors occurring at both the macro and micro levels. Specifically, resource availability was assessed in terms of socioeconomic resources [social status, integration, and human capital] and environmental resources [health care]. Social status and integration were operationalized as power differentials, marginalization, and lack of family support. Human capital was measured in terms of income, employment, education and housing. Health care was evaluated in terms of access to care and quality of care received.

Research demonstrates that Mexican migrant workers in the United States lack the socioeconomic and environmental resources necessary to reduce their relative risk for poor health outcomes. Immigration status, social discrimination, lack of health insurance, and inadequate regulations monitoring agricultural workers' income, housing, and employment standards disenfranchise migrant workers at a structural [regulatory and community] level. Cultural norms, gender inequalities, limited English proficiency, and social isolation inhibit migrant workers from improving their access to socioeconomic and environmental resources at a micro [personal or familiar] level.

Reduced access to resources is associated with increased exposure to risk factors and consequently poor health outcomes. In their analysis the authors operationalized risk factors as lifestyle behaviors and choices, health-promoting behaviors, and exposure to stress. The studies reviewed by the authors identify infrequent and inconsistent use of condoms, infidelity, engaging with commercial sex workers, alcohol and drug abuse, depression, and anxiety as behaviors significantly associated with increased risk for HIV infection among Mexican migrant workers. Among the studies reviewed, reported rates of HIV and STI prevalence among migrant workers varied significantly precluding the authors from analyzing health status.

The authors recommend their analysis serve as a basis for further investigation of the structural forces limiting resource availability and contributing to the greater relative risk of HIV infection migrant workers experience. Developing and implementing effective HIV/AIDS prevention, treatment, and care interventions for the migrant worker community is contingent upon comprehensive knowledge of the root causes of their risk status. The authors advocate for increased coordination among health providers serving migrant worker communities as a means to improve accessibility to culturally and linguistically appropriate care. Furthermore, the authors propose binational collaboration between clinicians in the United States and Mexico to ensure continuity of HIV care.

HIV Testing Histories and Risk Factors Among Migrants and Recent Immigrants Who Received Rapid HIV Testing from Three Community-Based Organizations

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Source: *Journal of Immigrant Minority Health (2014) 16: 798-810.*

Although migrant and recent immigrant communities are particularly vulnerable to HIV and other sexually transmitted diseases (STDs), there is limited surveillance-based information available regarding HIV/STD prevalence and risk among these groups. Research has identified mobility, poverty, geographic isolation, immigration status, inability to obtain health insurance, inadequate access to HIV/STD prevention and care services, and sexual risk behaviors as factors that contribute to migrants' susceptibility. Additional studies have shown that migrants are less likely to engage in frequent HIV testing and are more likely to present late to care. Given these findings it is critical that steps be taken to ensure they have access to culturally and linguistically appropriate HIV prevention. This article discusses a demonstration project that sought to identify factors that facilitate or impede migrants' access to and use of HIV/STD testing.

In 2003 the Centers for Disease Control and Prevention (CDC) announced the Advancing HIV Prevention (AHP) initiative that sought to increase the participation of migrant communities and other hard-to-reach populations in HIV-related services. Through this initiative three community-based organizations (CBOs) were funded to conduct rapid HIV testing and administer surveys to migrants in non-clinical settings. The CBOs that carried out the demonstration projects were AIDGwinnett (AGI), based in Lawrenceville, Georgia; the Hispanic Health Council (HHC), based in Hartford, Connecticut; and the United Migrant Opportunity Services (UMOS), based in Milwaukee, Wisconsin. Prior to implementing the AHP project, all three organizations had successfully worked with Latino and other immigrant communities providing HIV prevention and supportive services.

Outreach and testing occurred between March 2005 and February 2007. Each CBO employed a variety of methods to recruit participants. AGI focused their efforts primarily at migrants' workplaces, primary care centers and clinics, and community events. HHC partnered with a University of Connecticut School of Medicine mobile clinical unit to provide testing at agricultural work sites in addition to community gathering spaces. UMOS employed *promotores de salud* (health outreach workers) trained in HIV counseling and testing to reach migrants at their worksites. Community members enrolled in job training and English classes at UMOS were also recruited. Eligible participants were 13 years of age or older, had no previous diagnosis of HIV infection, and provided informed consent. Interested community members who reported a prior HIV diagnosis were not eligible for testing; however, the CBO staff offered assistance with making referrals and linkages to HIV care services.

The CBOs offered rapid HIV testing on an opt-in basis to eligible participants. All individuals received risk-reduction counseling from trained Spanish-English

bilingual CBO staff prior to being tested. The CBOs tested individuals with rapid HIV test kits (OraQuick© Advance™ Rapid HIV-1/2 Antibody Tests) using oral fluid or finger stick whole blood specimens. Any participant who presented with a reactive rapid test result was asked to provide an oral specimen for confirmatory testing by Western blot (OraSure® Oral Specimen Collection Device). A total of 5,247 participants were tested by the three CBOs. Six of these individuals tested positive, five men and one woman. All participants who tested positive returned for their confirmatory results and received risk-reduction counseling, referrals to partner services, and assistance with linkage to care services.

All project participants who received an HIV test were invited to complete a survey on sociodemographic characteristics, immigration histories, HIV/STD risk factors, and HIV testing behaviors. Surveys were administered by CBO staff and conducted as face-to-face interviews. A total of 3,135 surveys were completed. Data was compiled using a QDS™ (Questionnaire Development System) database and analyzed using SAS version 9.1. Multivariate logistic regression was used to identify variables independently associated with prior HIV testing.

Among participants who completed the survey, 2,778 reported they were born outside of the United States. The majority of these immigrants identified as Latino (93%), followed by black (5%) and white (1%). Slightly less than half of participants reported having been in the U.S. for less than five years. There were significantly more male (60%) than female participants. Most respondents reported limited English (78%) and no health insurance (77%). The majority of participants (59%) had not been previously tested for HIV. Limited English proficiency, younger age, and having been born in a Latin American country were associated with decreased likelihood of prior testing for both men and women. Reported HIV/STD risk factors for male and female participants included: having two or more sexual partners in the previous year (45%), engaging in sex while high on drugs or drunk (30%), exchanging goods or money for sex (29%), unprotected receptive anal intercourse (10%), and having an STD diagnosis (6%). Male respondents were significantly more likely than female respondents to have engaged in sex with multiple partners, used drugs or alcohol while having sex, to have given money or goods for sex, and to have inconsistently used condoms while engaging in exchange sex.

The findings of the AHP project reveal discrepancies between the high rates of reported risk behaviors and low rates of HIV infection occurring in migrant communities. The authors recommend further investigation of the factors underlying the inconsistency in order to ensure future efforts to provide HIV testing and care services to migrants are responsive to their realities. They advocate for increased prevention and education interventions to retain low levels of infection among migrants and prevent further transmission.

POLICY UPDATE: FUTURE OF THE RYAN WHITE PROGRAM

The Ryan White Program is a federal program established in 1990 to assist individuals living with HIV.[1] The Health Resources and Services Administration (HRSA) administers the Program, which serves more than half a million people each year. The Program does many things to provide health care to individuals living with HIV/AIDS, including increased access to primary care, prescription drugs (called the AIDS Drug Assistance Program or "ADAP"), oral health services, and other medical services. The Program also provides grants to study the development of innovative models that respond to emerging needs and evaluate how HIV/AIDS affects ethnic/racial minorities and other special populations. All states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and the five Pacific jurisdictions receive grants to provide HIV treatment for the underserved, and some of those grants help migrant health centers provide services for farmworkers living with HIV. Most of the individuals participating in the Ryan White HIV/AIDS Program have an income at or below the federal poverty level and are either uninsured or underinsured and need assistance getting coverage for expensive medications, medical care, or support services.

In his 2016 budget, President Obama proposes to fund the Ryan White Program in the amount of $2.3 billion, which includes $900 million for the ADAP.[2] The President also proposes to invest in other HIV/AIDS prevention and support programs, including $799 million for the Centers for Disease Control and Prevention to continue support for the implementation of the National HIV/AIDS Strategy, $332 million for housing for those with HIV/AIDS, and $3.1 billion for HIV/AIDS research at the National Institutes of Health.

Congress will consider the President's proposed budget when preparing its own 2016 budget resolution, and negotiations between the White House and Congress are likely before a final budget is approved. Farmworker Justice will monitor the negotiations and provide any relevant information to health centers. For more information, contact Mul Kim at mul.kim@farmworkerjustice.org.

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[1]Pub. L. 101-381 (1990); see also, HIV/AIDS Programs, Human Resources and Services Administration, Legislation (accessed on Feb. 5, 2015), available at http://hab.hrsa.gov/abouthab/legislation.html; Kaiser Family Foundation, The Ryan White Program (Mar. 5, 2013) available at http://kff.org/hivaids/fact-sheet/the-ryan-white-program/

[2]White House, Middle Class Economics: Enhancing the Lives of Americans Living with HIV/AIDS and Fighting the HIV/AIDS Epidemic (accessed on Feb. 5, 2015), available at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/fact_sheets/enhancing-the-lives-of-americans-living-with-hiv-aids-and-fighting-the-hiv-aids-epidemic.pdf

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