Lower retention rates in care ultimately translate to lowered survival rates.\(^1\) The Women's HEART Project represents one of 11 HRSA-funded demonstration projects intended to develop innovative strategies for the timely access and entry into HIV care of minority women. The HEART intervention represents a multi-component intervention consisting of intense outreach, medical coordination, patient navigation and peer advocacy/education. Patient navigation included accompanying women to doctor’s appointments, reminding them of appointments and reducing barriers, such as transportation issues, to keep those appointments. Intensive outreach efforts involved street outreach work including repeated attempts to meet with a woman and offer immediate on the spot assistance until the woman was ready to come into care, as well as concentrated efforts to locate women who missed HIV medical appointments to retain them in care. Medical coordination involved expediting labs and preliminary paperwork in preparation for primary care visits. Peer advocacy included one-on-one as well as group level education, the latter in the form of the Healthier Relationships curriculum. Education focused on basic HIV information, self-care, nutrition, medication adherence, developing skills and building self-efficacy about new behaviors, and other supplemental sessions based on the needs of the women. A comparison of preliminary baseline and 3-month data findings for the 109 women enrolled to date in the multi-component intervention are presented here.

**METHODS**

The three community partners in this study are The University of Texas Health Science Center at San Antonio-Community Partnerships, University Health System - Family Focused AIDS Clinical Treatment Services Clinic (FFACTS) and the Alamo Area Resource Center (AARC). One hundred and nine HIV-positive women of color from San Antonio, Bexar County and three surrounding counties have been enrolled to date in this ongoing study. See Figures 1-4 for baseline demographics. Women are eligible if they are: 1) newly diagnosed with HIV (N=28, 25.7%); 2) new to HIV medical care (N=31; 28.4%); 3) sporadic users of care (N=15, 13.8%); 4) have been previously lost to care (N=34; 31.2%), or 5) at risk of being lost to care (N=1, 0.9%).

We are using a longitudinal study design to examine baseline characteristics and changes in outcomes over an 18-month period of time as a result of the intensive outreach, patient navigation, medical coordination, and peer education services that Women’s HEART provides. Data collection methods include face-to-face structured interviews.

**GOAL**

The goal of this preliminary analysis is to examine changes in barriers to care, unmet service needs, and health and wellness indicators over a three-month period (see Table 1 for assessments used).

**PRELIMINARY FINDINGS**

- **Socio-demographic barriers:** 50.5% of HEART participants did not have any form of health insurance, compared to 22.4% of Bexar County’s overall female population under 65 years of age who are uninsured.\(^2\), Of our Hispanic women, 45.5% had low levels of acculturation in regards to ethnic social relations (t=2.89, p<.01). 50.5% of HEART participants did not have any form of health insurance, compared to 22.4% of the US Census Bureau (2009).

- **Health and Wellness:** There was a significant decrease in the average number of days that their activity was limited due to poor health significantly decreased within the first three months of being in the HEART program. Given these preliminary findings, it can be seen that the HEART intervention has helped to counter some of these health disparities and increased overall health.

- **DISCUSSION**

Visibly HEART women experience numerous barriers that are commonly associated with HIV health disparities including delayed entry into care and unequal health outcomes. For instance, antiretroviral medication adherence is associated with educational attainment and employment\(^4\), yet the majority of HEART women are unemployed and undereducated. Research reveals that health insurance is associated with increased HRQOL and decreased mortality\(^5\), however, the majority of women in HEART did not have any form of health insurance at baseline. Patient Navigators and Medical Coordinators in HEART have helped these women gain access to health insurance or foods to pay for medical services. HEART women also experience similar system barriers to accessing HIV care (e.g., transportation issues and long distance to medical facilities) as do many other HIV-positive women\(^6\). The total number of these unmet service needs reported by HEART women has been significantly reduced while in the program. Psychosocial barriers (e.g. poor mental health and poor social support) put these women at greater risk of poor medication adherence and decreased immune functioning\(^7\). Data shows a decrease in these barriers. It can also be seen that women who were originally lost to care reported a higher number of unmet needs at baseline; however, they were most positively affected by the program with a significant decrease in their reported barriers to care and total number of unmet needs as opposed to the other medical or social service.

Overall, HEART women’s health and wellness has increased, with less women reporting poor health and frequent mental distress at follow-up. Also, the average number of days their activity was limited due to poor health significantly decreased within the first three months of being in the HEART program. Given these preliminary findings, it can be seen that the HEART intervention has helped to counter some of these health disparities and increased overall health.