Personnel Identified Barriers and Facilitators to Implementing Culturally Responsive Trauma-Informed HIV Care for Youth in the Southern US

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Background

- Memphis, TN area has the 2nd highest HIV incidence rate in the US[1]
  - Youth account for 1 in 3 diagnoses
- Youth with HIV have high comorbidity of psychological trauma
- Ending the HIV Epidemic plan (EndHIV901) has called on trauma informed HIV care (TIHC) to help reduce this trauma syndemic[2]

Trauma Informed Care, Principle 6:

- Cultural, Historical, & Gender Issues[3]
  - Recognize that people experience trauma differently based on their identities
  - Acknowledge that some traumas disproportionately affect certain identities more than others

Organizations that Practice Culturally Responsive Trauma-Informed Care:

- Move past cultural stereotypes & biases
- Offer culturally responsive services
- Leverage the healing value of traditional cultural connections
- Recognize & address historical trauma
- Advocate to minimize barriers to TIC

Study Objectives

- Part of larger project (K01; PI: Brown) with goal to implement TIHC in pediatric clinic
- Gather personnel perspective on barriers and facilitators of culturally responsive trauma informed care
- Inform future personnel and patient interventions

Method

- One-on-one personnel interviews; audio recorded
- Results analyzed by team of 3, unaffiliated with clinic/interviews
- Deductive code applied for “cultural, historical, and gender issues”
- Consolidated Framework for Implementation Research (CFIR 1.0) applied; thematic analyses conducted using MAXQDA software
  - Matrices created based on saliency and frequency, including job role

Results

- N = 20 Personnel
  - 90% (19) cisgender female; 1 cisgender male
  - 40% (8) Black, 40% (8) White, 10% (2) Asian, 0.5% (1) Native American/Hawaiian, 0.5% (1) Unknown
  - Mean Time Employed = 11.97 years (*SD* = 11.82)
  - Mean Age = 46.58 years (*SD* = 11.40)

Results

- Four major areas assessed to inform the clinic's capacity to fulfill TIC principle 6:
  1. the current state,
  2. ongoing efforts to enhance,
  3. efforts needed,
  4. barriers and facilitators
- Within each section, findings were mapped to key implementation constructs from the CFIR

Current State

- Staff considered themselves highly aware of stigma and bias experienced by patients
    - Yet several used stigmatizing language
- Staff expressed belief in positive culture of inner setting/clinic

“I don’t think there are formal practices, but it is a part of our clinic culture.” –Transcript H

Current State, Cont'd

- Organizational-Level Stigma
  - Exclusion of clinic from hospital, differing resources
- Community Stigma
  - Fear of disclosure; view of clinic in community

"Someone from outside the clinic may ask 'well you are working with this patient population, and just why don't they take their medication'…"
–Transcript L

"Historically, I have not felt embraced by the hospital, for our clinic and our patients, we have to fight for everything for them."
–Transcript D

Ongoing Efforts to Increase Cultural Responsivity

- Clinic-level efforts:
  - Hiring practices
  - Advocacy for patients
  - De-stigmatization of HIV
- Organizational-level efforts:
  - Promotion of DEI; employee resource groups
  - Trainings offered

Ongoing Efforts to Increase Cultural Responsivity

"I think we do a decent job with the staff we hired to also help people feel physically safe, that they are disarming and nonjudgmental." –Transcript S

"Through the DEI council, all these committees were formed and initiatives that kind of trickled down to each clinic." –Transcript D

"I think that we try to normalize. I mean, especially in the beginning of days, just touching a patient, hugging them…" –Transcript P

Additional Efforts Needed

- Updated training format: in-person, human-focused
- Mandated trainings
- Improved environment: more emotionally supportive and patient-friendly
- Patients offered peer support opportunities

Additional Efforts Needed

"…what I have learned from is attending actual meetings where people talk about cultural competence […] from a realistic standpoint"
–Transcript T

'there has not been a concerted effort […] on making our space adolescent clinic-friendly. We have known for a while that that needs to happen."
-Transcript S

"I certainly think that can be a huge impact to hear from somebody who knows what you're going through and to be able to support, especially in the initial phases…" –Transcript V

Barriers to TIC Principle 6

- Informational & Engagement Barriers:
  - Lack of systematic documentation/communication of trauma experience
  - More patient input needed (e.g., CAB)
- Resource Availability/Relative Priority:
  - Limited time for providers; trainings not prioritized
  - Burnout and increasing staff turnover
- Clinic & Organizational Setting Opinion:
  - Staff resistance to change
  - Low organizational leadership engagement
  - Police engagement/perceived threat

Facilitators to TIC Principle 6

- Staff retention/tenure
- Collaboration between staff
- New medical record documentation opportunities (e.g., social determinants of health section of EMR)
- External resources (e.g., AIDS Education and Training Center, expert talks)

Barriers/Facilitators to Culturally Responsive TIC

"Certain patients might have certain preferences (blood draws) and I don't think that is documented anywhere." -Transcript S

"…dealing with security people at the gate when they became upset because the patient didn't match their ID, particularly for transgender patients." -Transcript B

"…but that there are all these other issues going on that impact their behavior. And so it happens informally that way when our team members can speak up (in rounds)." –Transcript D

Conclusions/Future Directions

- It is feasible to interview staff in pre-implementation of TIHC
- Staff belief in positive clinic setting, culture and staff communication/collaboration
  - Personnel trauma impact evident
- Needs:
  - More organizational support
  - Prioritization by leadership/mandated trainings
  - Patient engagement
- Plan to combine with data from patient qualitative interviews to develop personnel and patient interventions

Acknowledgements

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- CFAR Supplement (Brown, PI; Meharry Medical College)

References

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