

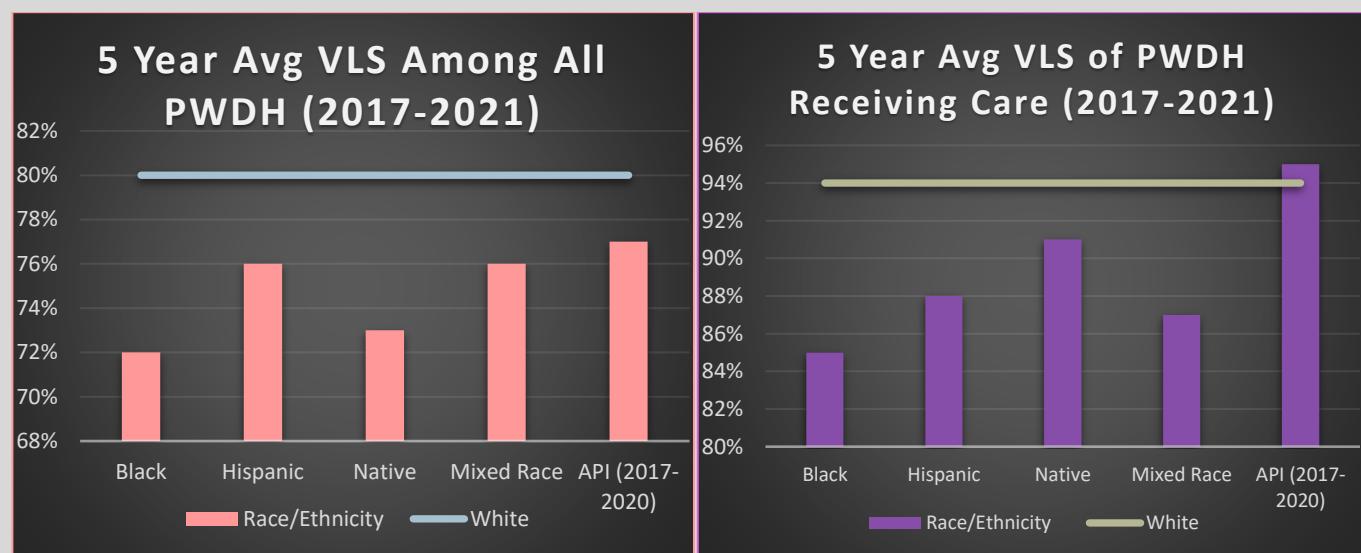
A Racial Justice and Health Equity Approach to Addressing Disparities and Inequities in HIV Viral Load Suppression

New York State Department of Health AIDS Institute, April 2023

Background Viral load suppression (VLS) is an important indicator of successful HIV treatment and increased likelihood of overall positive health outcomes for people living with HIV¹. New York's ETE (Ending the Epidemic) Dashboard tracks several metrics related to viral load suppression. One metric examines VLS rates for all people with diagnosed HIV (PWDH), without regard to level of engagement in HIV care. Another ETE metric specifically examines rates of VLS among people living with HIV who are in care, defined as having a viral load test within the past calendar year resulting in an undetectable status or having less than 200 copies/ml. It is expected that VLS rate would be higher for those who are in care and that having access to care would be a mitigating factor, meaning disparities would be less prominent when comparing VLS rates among Black, Hispanic, Native American, Mixed Race, Asian Pacific Islander (API), Hawaiian and Asian individuals to White individuals in care. Updated ETE data introduces Native Hawaiian/Pacific Islander (NH/PI) and Asian categories for the first time in 2021. API data reflects information collected until 2020.

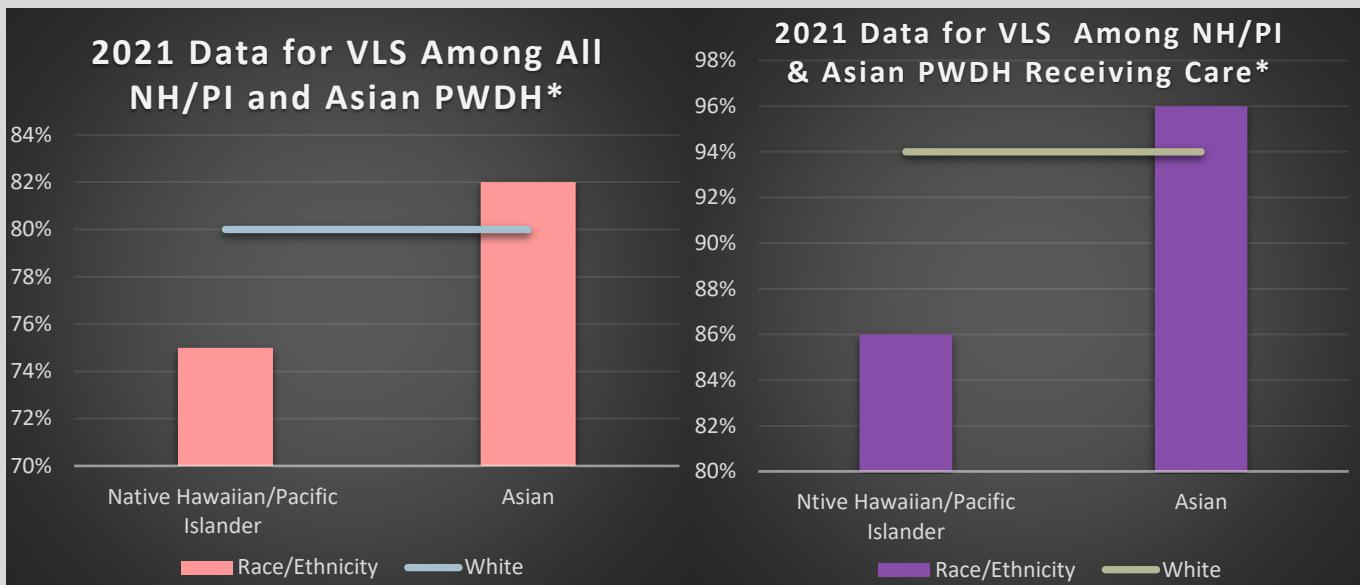


Disparity Observed The graphs below display five-year averages for VLS suppression by race and Hispanic ethnicity for the two metrics noted above. The graph on the left examines VLS by race for all people diagnosed with HIV regardless of care status. This graph shows that Black, non-Hispanic individuals have an 8-point lower percentage of VLS, and Hispanic individuals have a 4-point lower percentage of VLS than White individuals. Mixed Race and NH/PI PWDH experience a 4-point and 7-point lower percentage of VLS, respectively. Further, examining the graph on the right demonstrates that the disparity is greater when compared by race or ethnicity for PWDH who are in care, with a 9-percentage point difference for Black PWDH, and 6-percentage point difference for Hispanic PWDH, when compared to White PWDH. For Mixed Race individuals, the disparity for those in care is 7 percentage points. Data from 2021 regarding NH/PI shows a similar trend in disparities. This is particularly concerning if the expectation is that accessing care would have a mitigating effect on disparities.



The disparity between White PWDH and Black, Hispanic, Mixed Race and NH/PI PWDH is higher when comparing cumulative data for individuals who are in care versus all PWDH regardless of care status. This is disturbing as care should be mitigating the disparity, but instead it is increased.

¹ Drain PK, Dorward J, Bender A, et al. Point-of-Care HIV Viral Load Testing, an Essential Tool for a Sustainable Global HIV/AIDS Response. *Clin Microbiol Rev*. 2019;32(3)e00097-18. Published 2019 May 15. doi:10.1128/CMR.0097-18



*NH/PI and Asian data reflected depicts trends in 2021, independent of past data recorded.

Applying a Health Equity / Racial Justice Analysis

The clinical approach to understanding health disparities and inequities focuses primarily on differences in individual client attitudes, knowledge, and behaviors that impact health outcomes, without consideration for larger societal circumstances within which the person lives. The racial justice analysis takes into consideration these larger social realities, including available social determinants of health ([SDOH](#)) and the specific experiences that Black, Hispanic, mixed race and NH/PI have interacting with the health care system, the impact of systemic racism and implicit bias, and how these together affect health and health-seeking behaviors.

To apply a health equity/ racial justice analysis, consider the three questions below:

What are the conditions that result in lower VLS rates for PWDH from Black, Hispanic, Mixed Race and NH/PI people compared to White?

Why is there an on-going disparity between White and Black, Hispanic and NH/PI when comparing rates for individuals living with HIV who are in care?

Is the disparity, in fact, an inequity that is avoidable, unfair, and unjust? What can be done to eliminate this disparity and the inequities?

Actions For Health Facilities and Community Based Organizations (CBOs) to Consider:

- Routinely screen for and address inequitable access to SDOH.
- Develop partnerships in your community to facilitate client access to SDOH needs.
- Provide staff training on racism, implicit bias, stigma, anti-discrimination, and health equity:
 - Train staff on implicit bias and work to mitigate the impact of bias on quality of care;
 - Educate PWDH about rights and resources available; and,
 - Celebrate diversity with a wide variety of activities led by staff and consumers.

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- Examine data at your agency-level to monitor disparities including conducting chart reviews to identify differences in care provided and health outcomes by race
- Maximize opportunities for reimbursement related to addressing SDOH needs and promoting health equity, including:
 - Educate providers about appropriate use of billing codes (ICD and CPT);
 - Work with insurers to expand implementation of Value Based Payment models; and,
 - Apply for available local, state, or federal grant funding.
- Acknowledge historical and current day negative experiences that communities of color have interacting with the health care system generally, and with the HIV care system, specifically.
- Take steps to end any [Race Based Medicine](#) practices.
- Make efforts to better understand the intersectionality and cumulative impact of these factors on health and health-seeking behaviors at the community and individual level.
- Engage the agency's Consumer Advisory Board to explore how to improve the experience of patients from communities of color at the agency.
- Convene ongoing workgroups consisting of leadership, staff, and consumers to address racial inequity through education, discussion and the development of quality improvement efforts aimed at measuring and reducing racial/ethnic inequity.
- Establish policies and procedures to formalize and ensure continuity of all changes made at the clinic/agency level to address inequitable healthcare.