A Health Equity Approach to Addressing Disparities in HIV Viral Load Suppression
New York State Department of Health AIDS Institute, 2025

The purpose of this document is to identify disparities in viral load suppression by race/ethnicity and provide strategies to promote health equity.

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 HIV[1]. New York's Ending the Epidemic (ETE) Dashboard tracks several metrics related to viral load suppression. The two metrics examined in this document track viral load suppression rates among people diagnosed with HIV. The first metric examines VLS rates for all people with diagnosed HIV (PWDH), without regard to level of engagement in HIV care. The second metric examines rates of VLS among people living with HIV who are in care. Viral load suppression is defined as having a viral load test within the past calendar year resulting in an undetectable status or having less than 200 copies/ml. In 2021, New York State (NYS) legislation addressing discrimination separated the single combined Asian and Pacific Islander category into two distinct categories: Asian, and Native Hawaiian/Pacific Islander (NH/PI). Hence, updated Ending the Epidemic data introduced separate Asian and NH/PI categories for the first time in 2021. The graphs provided below show 3-year averages (2021-2023) for Asian, Black, Hispanic, Multi-Race, Native American, Native Hawaiian/Pacific Islander (Native Hawaiian/PI) and White individuals diagnosed with HIV.

Disparity Observed

Figure 1: 3-Year Average Percentage of Viral Load Suppression Among All People with Diagnosed HIV (2021-2023)

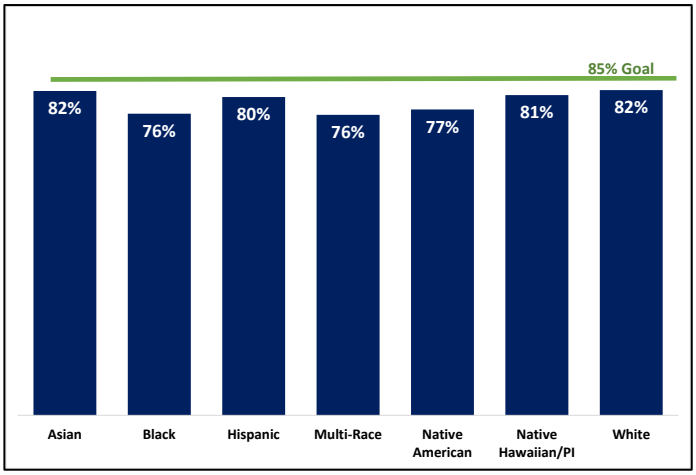

Figure 2: 3-Year Average Percentage of Viral Load Suppression Among People with Diagnosed HIV Receiving Care (2021-2023)

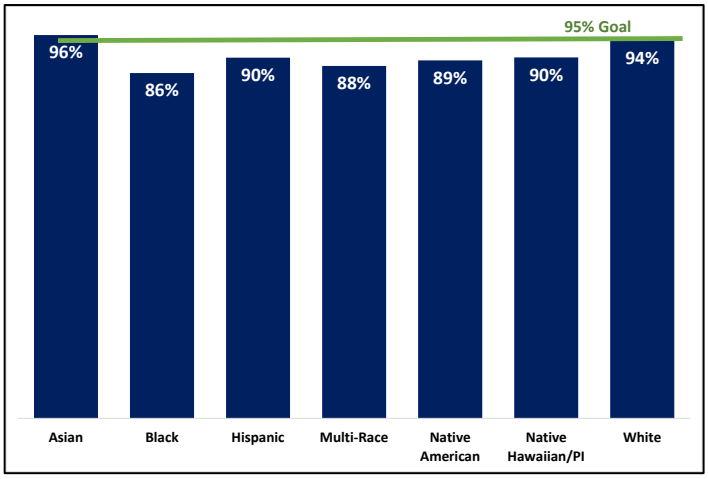

Figure 1 demonstrates the disparity in 3-year average viral load suppression rates between demographic race/ethnicity groups among all people with diagnosed HIV regardless of care status for the period of 2021-2023. The line (green when in color) indicates that the goal for this metric is 85%. The racial and ethnic groups with the largest difference to the goal viral load suppression are Multi-Race, Black, and Native American individuals at 9.3, 9.0 and 8.0-percentage points lower than the established goal. Viral load suppression for Hispanic individuals shows a 4.8-percentage point difference compared to the goal. The difference for Native Hawaiian/Pacific Islander, Asian, and White individuals was lower by 4.4, 3.3 and 3.1-percentage points, respectively.

Figure 2 demonstrates the disparity in 3-year average viral load suppression rates between demographic racial and ethnic groups for people with diagnosed HIV who are receiving care. The top line (green when in color) indicates that the goal for this metric is 95%. The viral load suppression rate for Black, Multi-Race, and Native American individuals diagnosed with HIV is lower than the goal by more than 5-percentage points. The difference for individuals who are Hispanic or Native Hawaiian/Pacific Islanders was 4.8-percentage points below goal. In contrast the difference for Asian and White people with diagnosed HIV who are in care was 0.8 and 0.6-point, respectively.

[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

Although care is a mitigating factor, we still observe a wide difference to the goal for Black, Hispanic, Multi-Race, Native American and Native Hawaiian/Pacific Islander individuals.

Identifying Differences with Regard to the Impact of Care in 3-Year Average Viral Load Suppression Rates (2021-2023)

	Asian	Black Non-Hispanic	Hispanic	Multi-Race	Native American	Native Hawaiian/Pacific Islander	White
Difference in 3-year average viral load suppression in all people with diagnosed HIV Compared to Goal	-3.3 (81.7%)	-9.0 (76.0%)	-4.8 (80.2%)	-9.3 (75.7%)	-8.0 (77.0%)	-4.4 (80.6%)	-3.1 (81.9%)
Difference in 3-year average viral load suppression in people with diagnosed HIV receiving care Compared to Goal	+0.8 (95.8%)	-8.7 (86.3%)	-4.8 (90.2%)	-6.9 (88.1%)	-5.5 (89.5%)	-4.8 (90.2%)	-0.6 (94.4%)
Difference in 3-year average viral load suppression in people with diagnosed HIV receiving care compared to all people with diagnosed HIV	**+4.1**	**+0.3**	**0.0**	**+2.4**	**+2.4**	**-0.4**	**+2.5**

Applying a Health Equity 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. In this analysis, we compared viral load suppression percents to the goal set for all race groups.* The health equity analysis should account for larger social realities, including available social determinants of health (SDOH) and the specific experiences that Black, Hispanic, Multi-Race, Native American, and Native Hawaiian/Pacific Islander people have interacting with the health care system, the impact of discrimination, implicit bias, and how these together affect health and health-seeking behaviors.

*Arrington LA, Kramer B, Ogunwole SM, et al. Interrupting false narratives: applying a health equity lens to healthcare quality data. BMJ Qual Saf. 2024;**33**:340–344.

To apply a health equity analysis, we recommend that clinical providers consider the three questions below:

What are the conditions that result in lower viral load suppression rates for Black, Hispanic, Multi-Race, Native American, and Native Hawaiian/Pacific Islander individuals who are living with HIV?	Why is there an on-going disparity for Black, Hispanic, Multi-Race, Native American, and Native Hawaiian/Pacific Islander people 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 CARE FACILITIES AND COMMUNITY BASED ORGANIZATIONS (CBOs) TO CONSIDER:

Acknowledging and Understanding Historical Context

- Acknowledge historical and current negative experiences within communities of color in healthcare.
- Understand the intersectionality and cumulative impact of these factors on health and health-seeking behaviors.

Data Monitoring and Elimination of Race-Based Medicine

- Examine agency-level data to monitor disparities, conducting chart or record reviews or by race.
- Take steps to end any Race-Based Medicine practices.

Social Determinants of Health (SDOH) Integration

- Routinely screen for and address inequitable access to social determinants of health. Refer to Health Equity Competencies for Health Care Providers
- Develop community partnerships to facilitate client access to social needs.

Staff Training and Community Education

- Provide continuous staff training on implicit bias, stigma, anti-discrimination, and health equity and work to mitigate its impact on quality of care.
  - Monitor the impact of these trainings on the quality of services provided.
- Educate Persons with diagnosed HIV (PWDH) about their rights and available resources.
- Celebrate diversity with a variety of activities led by staff and consumers.

Reimbursement and Value-Based Payments

- Maximize opportunities for managed care reimbursement related to addressing social determinants of health needs and promoting health equity.
- Educate providers about appropriate use of billing codes (ICD and CPT).
- Work with insurers to expand the implementation of Value-Based Payment models.
- Apply for available local, state, or federal grant funding.

Consumer Involvement and Quality Improvement
• Convene ongoing workgroups (leadership, staff, consumers) to address health equity through education, discussion, and quality improvement efforts. • Engage the agency's Consumer Advisory Board, if available, to improve the experience of patients from communities of color.
Institutionalization of Changes
• Establish policies and procedures to formalize and ensure sustainability of all changes made at the clinic/agency level to address inequitable healthcare.

Find training for health and human services providers on health equity on **hivtrainingny.org**

Contact the AIDS Institute's Office of Health Equity and Policy Initiatives:

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