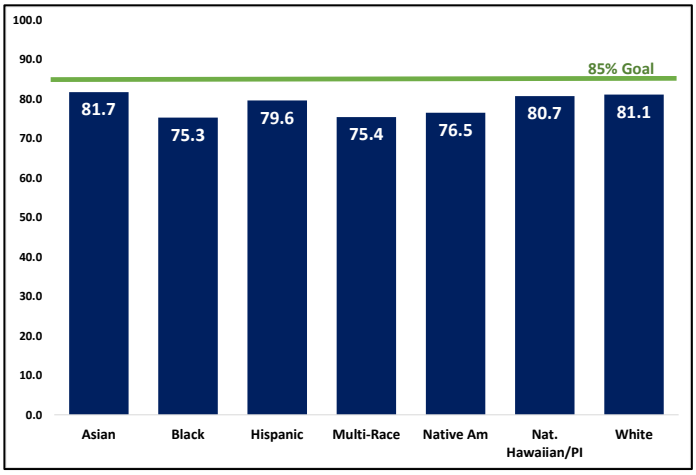
A Racial Justice and Health Equity Approach to Addressing Disparities and Inequities in HIV Viral Load Suppression New York State Department of Health AIDS Institute, 2024

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

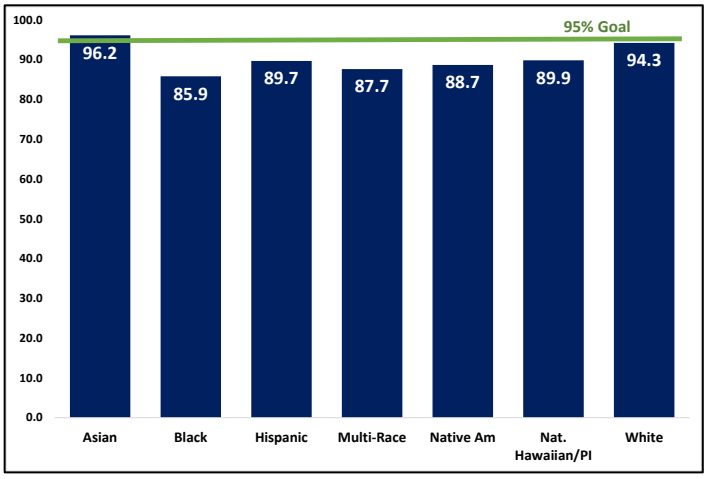
Background Viral load suppression (VLS) is an important indicator of successful HIV treatment and increased likelihood of overall positive health outcomes for people living with HIV[1]. New York's Ending the Epidemic (ETE) Dashboard tracks several metrics related to viral load suppression. The two metrics examined in this document track viral load suppression rates among people diagnosed with HIV. The first one examines VLS rates for all people with diagnosed HIV (PWDH), without regard to level of engagement in HIV care. The second Ending the Epidemic (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. In 2021, New York State (NYS) legislation addressing discrimination and racial justice 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 set of graphs provided below demonstrate 2-year averages (2021-2022) for Asian, Black, Hispanic, Multi-Race, Native American, Native Hawaiian/Pacific Islander and White individuals diagnosed with HIV.

Disparity Observed

2-Year Average Percentage of VLS Among All PWDH (2021-2022)



2-Year Average Percentage of VLS Among PWDH Receiving Care (2021-2022)



The above graph on the left demonstrates the disparity in 2-year average viral load suppression (VLS) rates between demographic race groups among all PWDH regardless of care status for the period of 2021-2022. The top line (depicted in 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 Black, Multi-Race and Native American individuals at 9.8, 9.6 and 8.5-percentage points lower than the established goal. The viral load suppression rate for Hispanic individuals demonstrates a 5.4-percentage point difference to the goal. The difference to the goal viral load suppression for Native Hawaiian/Pacific Islander, White and Asian individuals is lower by 4.3, 3.9 and 3.3-percentage points respectively.

The above graph on the right demonstrates the disparity in 2-year average VLS rates between demographic racial and ethnic groups for people with diagnosed HIV (PWDH) who are receiving care. The top line (in green when colored) indicates that the goal for this metric is 95%. The graph demonstrates that the viral load suppression rate for Black, Multi-Race, Native American, Hispanic and Native Hawaiian/Pacific Islanders diagnosed with HIV remains lower than the goal by more than 5-percentage points. The rate for White and Asian PWDH who are in care is close to the goal with a viral load suppression rate higher than 95% for Asian individuals by 1.2-percentage points.

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

[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

Identifying Differences with Regard to the Impact of Care in 2-Year Average VLS Rates (2021-2022)

	Asian	Black Non-Hispanic	Hispanic	Multi-Race	Native American	Native Hawaiian/Pacific Islander	White
Difference in 2-year average VLS All PWDH Compared to Goal (85% viral load suppression)	-3.3 (81.7%)	-9.8 (75.3%)	-5.4 (79.6%)	-9.6 (75.4%)	-8.5 (76.5%)	-4.3 (80.7%)	-3.9 (81.1%)
Difference in 2-year average VLS PWDH Receiving Care Compared to Goal (95% viral load suppression)	+1.2 (96.2%)	-9.2 (85.9%)	-5.3 (89.7%)	-7.3 (87.7%)	-6.3 (88.7%)	-5.1 (89.9%)	-0.7 (94.3%)
Difference in 2-year average VLS in PWDH receiving care compared to All PWDH	**-4.5**	**-0.6**	**-0.1**	**-2.3**	**-2.2**	**+0.8**	**-3.2**

Applying a Racial Justice and 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 rates to the goal set for all race groups.* The racial justice analysis takes into consideration larger social realities, including available social determinants of health (SDOH) and the specific experiences that Black, Hispanic, Multi-Race and Native American people 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.

*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 racial justice and health equity analysis, we recommend that clinical providers consider the three questions below:

What are the conditions that result in lower VLS rates for PWDH from Black, Hispanic, Multi-Race, Native American and Native Hawaiian/Pacific Islander individuals?	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 racism, 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 racial 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 racial justice and health equity on **hivtrainingny.org**

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

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