

Reducing HIV-Related Health Disparities in the Health Resources and Services Administration's Ryan White HIV/AIDS Program

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) supports direct health care treatment and support services to more than 50% of all people living with diagnosed HIV in the United States. A critical goal of the RWHAP is to reduce HIV-related health disparities to help end the HIV epidemic.

From 2010 through 2016, the RWHAP made significant progress reducing viral suppression disparities among client populations, particularly among women, transgender persons, youths, Blacks or African Americans, and unstably housed clients.

To assist with the reduction of the remaining disparities in HIV-related health outcomes among clients, the RWHAP continues to support planning and resource allocation for RWHAP Parts A through D and AIDS Drug Assistance Program, as well as through implementing policy and program initiatives, Special Projects of National Significance, evaluation studies, and collaborations to disseminate effective interventions. (*Am J Public Health*. 2018;108:S246–S250. doi:10.2105/AJPH.2018.304689)

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The Ryan White HIV/AIDS Program (RWHAP), administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau, supports direct health care and support services for more than half a million people living with HIV (PLWH)—more than 50% of all people living with diagnosed HIV in the United States.^{1,2} The RWHAP has successfully created effective patient-centered services to support strong provider-patient relationships. The RWHAP funds grants to cities or counties, states, and local community-based organizations to coordinate and deliver efficient and effective HIV care, treatment, medication, and support services for low-income PLWH. Since it was established, the RWHAP has developed a comprehensive system of safety-net providers to deliver these services. The RWHAP is critical to ensuring that PLWH are linked to and retained in care, are able to adhere to medication regimens, and remain virally suppressed. These goals are crucial not only to ensuring optimal HIV health outcomes among PLWH but also to preventing further transmission of the virus and, ultimately, ending the HIV epidemic.³

HRSA has focused on four goals to inform programmatic efforts and funding to end the HIV epidemic: (1) reduce the number of people who become infected with HIV, (2) increase

access to care and improve health outcomes for PLWH, (3) achieve a more coordinated national response to the HIV epidemic, and (4) reduce HIV-related health disparities.^{3,4}

Essential to reducing HIV-related health disparities is the ability to monitor client-level health outcomes of PLWH served by the RWHAP. The RWHAP recipients and sub-recipients submit de-identified client-level data to HRSA through the RWHAP Services Report, including data to monitor progress toward achieving select indicators of HIV-related health outcomes,⁴ such as retention in HIV medical care and viral suppression. Since 2010, client-level RWHAP Services Report data have been used to assess the demographics of clients receiving services, progress in HIV-related outcomes, and disparities in HIV-related outcomes.

This commentary outlines trends in addressing disparities in viral suppression rates among PLWH served by the RWHAP and its initiatives to enhance efforts to reduce disparities in HIV-related health outcomes among key populations.

RWHAP DATA

We used data from the RWHAP Services Report, HRSA's primary source of annual, client-level data reported by more than 2000 funded grant recipients and subrecipients. These data have been reported since 2010, and HRSA has used these data to assess the demographics of clients receiving services through the RWHAP and their HIV-related outcomes. We used data from the 2010 and 2016 calendar-year RWHAP Services Report data sets. HRSA calculates viral suppression rates for PLWH who had had at least one outpatient ambulatory health service visit and had at least one viral load test reported during the calendar year; HRSA defines clients as virally suppressed if their most recent viral load test result within the calendar year was fewer than 200 copies per milliliter.

SELECT RWHAP CLIENT DEMOGRAPHICS

In 2016, the RWHAP served slightly more than 551 500 clients. Nearly two thirds (62.8%) of

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RWHAP clients were living at or below 100% of the federal poverty limit in 2016, according to the US Department of Health and Human Services.

In 2016, nearly three quarters (73.3%) of RWHAP clients were from racial/ethnic minority populations; almost half of clients were Black or African American (47.1%; Table 1). In addition, approximately one quarter were women (27.3%) and 1.3% were transgender. Approximately one fifth of clients were aged 34 years or younger (22.5%) and 14.0% had temporary or unstable housing.⁵ Since 2010, the distribution of

RWHAP client sociodemographic characteristics has been relatively stable (Table 1). Clients with these demographics have notable disparities in HIV-related health outcomes relative to the rest of the RWHAP population.

TRENDS IN VIRAL SUPPRESSION DISPARITIES

The proportion of RWHAP clients with a suppressed viral load has increased substantially since 2010: we observed a 15.4 percentage point increase from

2010 (69.5%) through 2016 (84.9%; Table 1). In addition, the number of patients receiving an outpatient ambulatory health service increased by nearly 90 000 from 2010 to 2016, an increase of 35%; RWHAP providers are simultaneously caring for more clients and working with clients toward achieving improved outcomes.

Gaps have decreased among key populations with historically disparate viral suppression rates. Table 2 presents the percentage point differences between these key population and associated comparison groups in 2010 compared with 2016.

Between 2010 and 2016, the gap between male and female clients decreased from 5 percentage points to 1 percentage point. In addition, the gap between male and transgender clients decreased from 9 percentage points to 6 percentage points (Table 2). Similarly, the disparity between Black or African American clients and White clients was 13.0 percentage points in 2010 but decreased to 8.1 percentage points in 2016.

Although there are still significant disparities in viral suppression among younger RWHAP clients, we observed

TABLE 1—Ryan White HIV/AIDS Program Clients (Non-AIDS Drug Assistance Program) Select Characteristics and Viral Suppression: United States, 2010 and 2016

	2010		2016		Percentage Point Change Virally Suppressed, 2010–2016
	Total Clients, No. (%)	Total OAHS Clients, No. (% Virally Suppressed ^a)	Total Clients, No. (%)	Total OAHS Clients, No. (% Virally Suppressed ^a)	
Gender					
Male	380 893 (68.5)	178 220 (70.9)	392 845 (71.4)	243 838 (85.4)	14.5
Female	170 543 (30.7)	75 024 (66.3)	150 451 (27.3)	95 648 (84.0)	17.7
Transgender	4 326 (0.8)	1 886 (61.5)	7 166 (1.3)	4 244 (79.4)	17.9
Race/ethnicity					
American Indian/Alaska Native	2 922 (0.5)	1 246 (70.4)	2 768 (0.5)	1 516 (83.0)	12.6
Asian	5 238 (1.0)	2 641 (78.8)	7 366 (1.4)	4 709 (92.3)	13.5
Black/African American	256 136 (47.2)	118 257 (63.3)	257 617 (47.1)	165 330 (81.3)	18.0
Hispanic/Latino	119 840 (22.1)	56 038 (73.6)	126 257 (23.1)	81 501 (87.2)	13.6
Native Hawaiian/Pacific Islander	1 105 (0.2)	488 (70.5)	962 (0.2)	493 (84.8)	14.3
White	152 115 (28.0)	70 583 (76.3)	145 812 (26.7)	86 350 (89.4)	13.1
Multiple race	5 719 (1.1)	2 774 (70.4)	6 142 (1.1)	2 938 (82.9)	12.5
Age, y					
< 13	11 495 (2.1)	1 260 (71.8)	4 800 (0.9)	1 017 (84.7)	12.9
13–24	36 889 (6.6)	15 194 (46.6)	25 076 (4.6)	16 057 (71.1)	24.5
25–34	83 168 (15.0)	41 383 (58.6)	93 426 (17.0)	61 324 (77.6)	19.0
35–44	143 215 (25.8)	70 139 (69.2)	107 704 (19.6)	70 054 (82.9)	13.7
45–54	188 582 (33.9)	87 169 (74.1)	167 331 (30.4)	104 527 (87.1)	13.0
55–64	76 256 (13.7)	33 424 (79.1)	119 413 (21.7)	71 802 (90.6)	11.5
≥ 65	16 350 (2.9)	6 532 (83.6)	33 231 (6.0)	19 380 (93.9)	10.3
Housing status					
Stable	378 842 (82.0)	191 214 (71.2)	449 267 (86.1)	295 956 (86.1)	14.9
Temporary	65 833 (14.2)	30 287 (63.7)	45 767 (8.8)	28 519 (78.9)	15.2
Unstable	17 617 (3.8)	5 994 (54.8)	26 907 (5.2)	14 408 (72.0)	17.2
Total	556 175	255 172 (69.5)	551 567	344 161 (84.9)	15.4

Note. OAHS = outpatient ambulatory health services.

^aVirally suppression rates for people living with HIV who had at least one OAHS visit and had at least one viral load test reported during the calendar year; clients were defined as virally suppressed if their most recent viral load test result within the calendar year was fewer than 200 copies per milliliter.

TABLE 2—Ryan White HIV/AIDS Program Client Disparities in Viral Suppression: United States, 2010 and 2016

	Percentage Point Difference in Viral Suppression, 2010	Percentage Point Difference in Viral Suppression, 2016	Percentage Point Change in Difference, 2010–2016
Gender (Ref = male)			
Female	4.6	1.4	–3.2
Transgender	9.4	6.0	–3.4
Race/ethnicity (Ref = White)			
American Indian/ Alaska Native	5.9	6.4	0.5
Asian	–2.5	–2.9	–0.4
Black/African American	13.0	8.1	–4.9
Hispanic/Latino	2.7	2.2	–0.5
Multiple races	5.9	6.5	0.6
Native Hawaiian/ Pacific Islander	5.8	4.6	–1.2
Age, y (Ref = 55–64)			
<13	7.3	5.9	–1.4
13–24	32.5	19.5	–13.0
25–34	20.5	13.0	–7.5
35–44	9.9	7.7	–2.2
45–54	5.0	3.2	–1.8
≥65	–4.5	–3.3	1.2
Housing status (Ref = stable housing)			
Temporary	7.5	7.2	–0.3
Unstable	16.4	14.1	–2.3

significant disparity reductions. Older clients have the highest viral suppression rates in the RWHAP. Between 2010 and 2016, the gap between clients aged 13 to 24 years and clients aged 55 to 64 years decreased from 33 percentage points to 20 percentage points, and between clients aged 25 to 34 years and clients aged 55 to 64 years it decreased from 21 percentage points to 13 percentage points.

Lastly, we saw smaller gains among clients with unstable or temporary housing. The gap between clients with unstable housing and stable housing decreased from 16 percentage points in 2010 to 14 percentage points in 2016. There were smaller gains among

clients with temporary housing. The gap between clients with temporary and stable housing decreased from 7.5 to 7.2 percentage points between 2010 and 2016.

Although the RWHAP has made notable progress in terms of viral suppression outcomes across specific client subpopulations, we continue to see disparities by age, race, gender, and housing status.

RWHAP RESPONSE TO HIV-RELATED DISPARITIES

Using data to drive program and decision-making, HRSA

continues to support planning and resource allocation for RWHAP Parts A through D and AIDS Drug Assistance Program, as well as multiple policy and program initiatives to address observed differences in HIV-related outcomes. These include RWHAP Part F Special Projects of National Significance (SPNS), evaluation studies, and collaborations to increase uptake of effective interventions to reduce disparities in access to care and HIV-related outcomes.

Using the RWHAP data, HRSA collects and disseminates information highlighting disparities in HIV-related outcomes among key RWHAP populations. Since 2015, HRSA has released its RWHAP Annual Client-Level Data Report, which allows recipients and subrecipients to monitor and support efforts to improve care and treatment of PLWH. The Data Report includes demographics and health outcomes across the RWHAP, including by states and metropolitan areas.

HRSA additionally requires that RWHAP Parts A through D recipients detail in their applications how they plan to address disparities, and RWHAP site visits have focused on initiatives to address disparities. In addition, HRSA released policy guidance to focus on addressing disparities in 2015: HRSA detailed the expectations for clinical quality management (CQM) programs in the Clinical Quality Management Policy Clarification Notice 15–02.⁶ HRSA encouraged recipients to collect and analyze performance measure data that align with the National Goals to End the HIV Epidemic.⁷ These standardized measures, data, and analyses pave the way for identifying and addressing outcome disparities across different populations within their jurisdictions

and promotes transparency in care provision and client outcomes.

SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

The SPNS program supports the development of innovative models of HIV care and treatment to respond to emerging needs of clients served by the RWHAP. Since 2010, HRSA has supported multiple projects to identify effective interventions to improve care among RWHAP clients, including transgender women of color and youths.

First, the SPNS Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color initiative was a multisite demonstration project funded during fiscal years 2012 through 2017.⁸ The nine demonstration sites designed, implemented, and evaluated innovative interventions to improve timely entry, engagement, and retention in quality HIV care for transgender women of color living with HIV.

Second, the SPNS Use of Social Media to Improve Engagement, Retention, and Health Outcomes Along the HIV Care Continuum initiative implements and evaluates innovative social media methods to identify, link, and retain underserved, uninsured, hard-to-reach youths and young adults (aged 13–34 years) in HIV primary care and supportive services.⁹ These are system approaches using a variety of social media, Internet, and mobile-based technologies to improve engagement and retention in care and viral suppression. HRSA is funding this

initiative for fiscal years 2015 through 2019.

Third, the SPNS Dissemination of Evidence Informed Interventions initiative disseminates four adapted linkage and retention interventions from previous HRSA initiatives to improve health outcomes along the HIV care continuum.¹⁰ The goal is to produce four evidence-informed care and treatment interventions that are replicable, cost-effective, capable of producing optimal HIV care continuum outcomes, and easily adaptable to the changing health care environment. This project, funded for fiscal years 2015 through 2020, will advance the replication of evidence-informed interventions from four past SPNS initiatives: (1) Enhancing Linkages for Those Newly Released From Jails,^{11–13} (2) Innovative Methods for Integrating Buprenorphine Opioid Abuse Treatment in HIV Primary Care,^{14–17} (3) Targeted Outreach and Intervention Model Development for Underserved HIV-Positive Populations Not in Care,^{18–21} and (4) The Secretary's Minority AIDS Initiative Fund Retention and Re-engagement Project.²²

Also promoting dissemination of evidence-informed interventions, the Using Evidence-Informed Interventions to Improve Health Outcomes Among People Living With HIV initiative, funded for fiscal years 2017 through 2021, facilitates implementation of evidence-informed interventions to reduce health disparities related to HIV and improve HIV-related outcomes. Twenty-six RWHAP recipients and subrecipients are funded to support interventions in four focus areas: improving HIV health outcomes for transgender women, improving HIV health outcomes for Black

men who have sex with men, integrating behavioral health with primary medical care for people living with HIV, and identifying and addressing trauma among people living with HIV.

EVALUATION STUDIES AND COLLABORATIONS

HRSA funds multiple evaluation studies and collaborations to identify and disseminate strategies for reducing disparities among youths, Black men who have sex with men, clients with unstable housing, and other key populations served by the RWHAP. The focus has been on developing interventions to drive improvement for populations with disparities for whom limited or no evidence-based or randomized controlled interventions are available.

Currently, the Building Futures: Supporting Youth Living With HIV evaluation study helps to develop and provide technical assistance for youth-serving RWHAP providers to overcome barriers to care, address gaps in care, and optimize health outcomes for this special population. The completed study will contain information gathered from 24 sites to document best practices for improving HIV care and treatment outcomes for youths living with HIV. The aggregated knowledge will inform technical assistance webinars geared toward youth-serving RWHAP providers.

The Center for Engaging Black MSM Across the Care Continuum is an online resource providing effective tools, models of care, resources, and trainings to advance HIV health care for young and adult Black men who have sex with men.²³ This tool

aims to increase health literacy for both health care providers and Black men who have sex with men, in addition to providing a directory of culturally competent health care providers for Black men.

In addition, The Secretary's Minority AIDS Initiative Fund supports the Improving HIV Health Outcomes Through the Coordination of Supportive Employment and Housing Services initiative. This initiative funds the design, implementation, and evaluation of innovative interventions that coordinate HIV care and treatment, housing, and employment services to improve HIV health outcomes for low-income, uninsured, and underserved PLWH in racial and ethnic minority communities. These coordinated services aim to decrease the impact of social determinants of health that affect long-term HIV health outcomes for PLWH.

Between 2014 and 2016, HRSA collaborated with the Health Resources Inc and the New York State AIDS Institute through the National Quality Center to form the HIV Cross-Part Care Continuum Collaborative to effect measurable improvements along the HIV Care Continuum for five states.²⁴ The HIV Cross-Part Care Continuum Collaborative used the learning collaborative model based on the Institute for Healthcare Improvement Breakthrough Series Collaborative to engage all HIV providers across RWHAP funding streams in each of the five states to increase retention in HIV care and improve viral suppression. To improve retention and viral suppression, the main activities focused on building capacity for CQM.

The activities of the HIV Cross-Part Care Continuum Collaborative included building

CQM infrastructure, aligning CQM goals across all RWHAP Parts within select states to jointly meet the legislative CQM mandates, and implementing state-wide quality improvement activities to coordinate HIV services across RWHAP Parts.

On the basis of the success of the HIV Cross-Part Care Continuum Collaborative and maturation of RWHAP grant recipients' CQM programs, HRSA funded a new cooperative agreement focused solely on quality improvement and improving patient health outcomes. The new cooperative agreement, HRSA's RWHAP Center for Quality Improvement and Innovation, will launch a learning collaborative focused on addressing viral suppression disparities in 2018.

CONCLUSION

The RWHAP data show that HIV-related outcome disparities among PLWH across specific sociodemographic strata are decreasing. HRSA's efforts and initiatives described previously and the ongoing activities of RWHAP recipients and subrecipients have been critical for identifying disparities in care and outcomes among RWHAP clients and identifying strategies for reducing these disparities among the low-income clients receiving RWHAP-funded services. Although great improvements have been made, notable differences remain. Continued focus and effort will be essential for eliminating outcome disparities among HIV-impacted populations served by the RWHAP. **AJPH**

CONTRIBUTORS

P. Mandsager led the writing. A. Marier completed the analyses and contributed to the writing. S. Cohen and M. Fanning

assisted with the article and analyses. H. Hauck and L. W. Cheever reviewed the article and approved the final version. All authors conceptualized the article.

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