Racial Disparities in the Integrated HIV Prevention and Care Plan

Presented to the HIV Planning Group

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Racial Disparities in the Integrated Plan

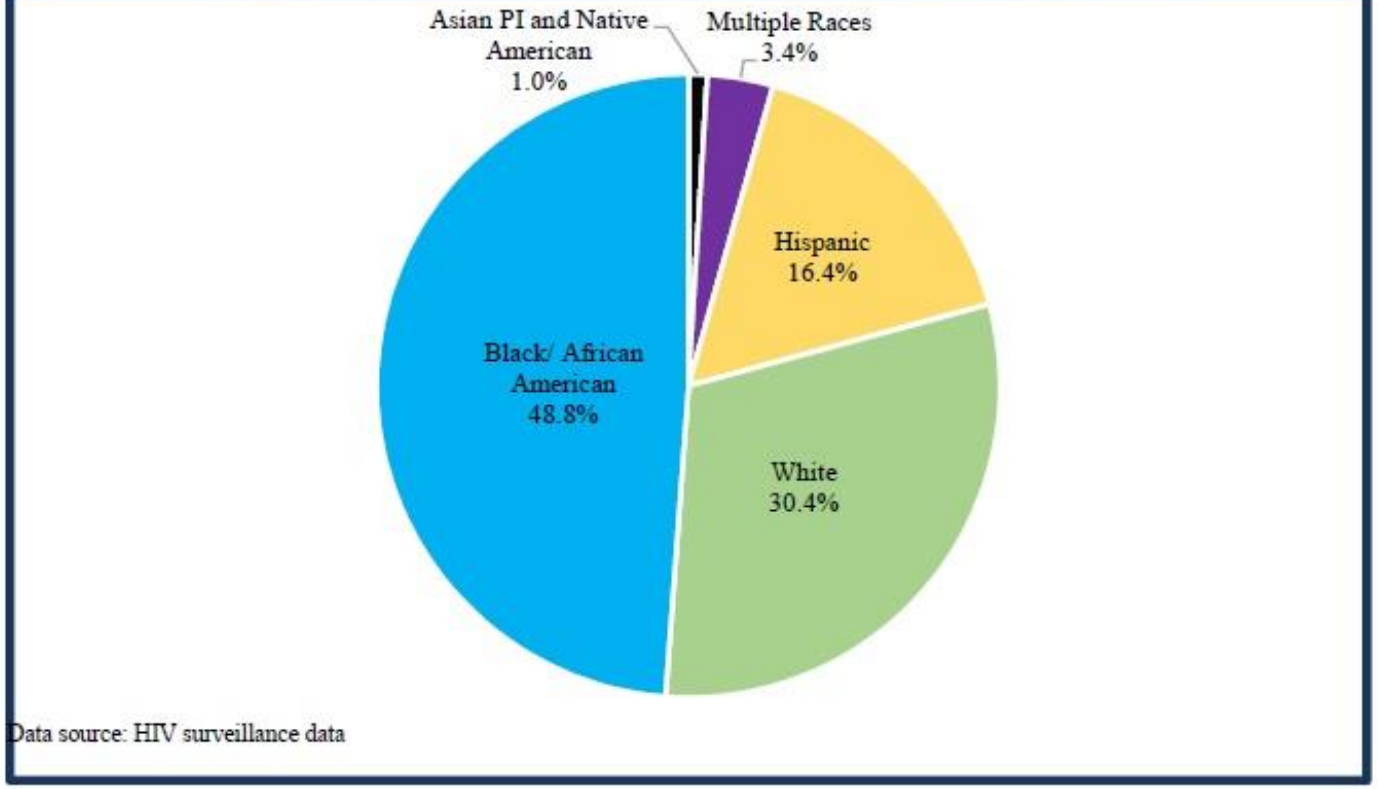
Purpose: Identify existing points the plan

- Section I: Statement of Need
- Section II: The Integrated HIV Prevention and Care Plan
- Section III and Appendixes

Section I: Statement of Need

A. Epidemiology
B. HIV Care Continuum
C. Financial and Human Resource Inventory
D. Assessing Needs, Gaps and Barriers
E. Data: Access, Sources, and Systems

Figure 6: PLWH and Diagnosed by Year-End 2015 by Race/Ethnicity, Pennsylvania



Data source: HIV surveillance data

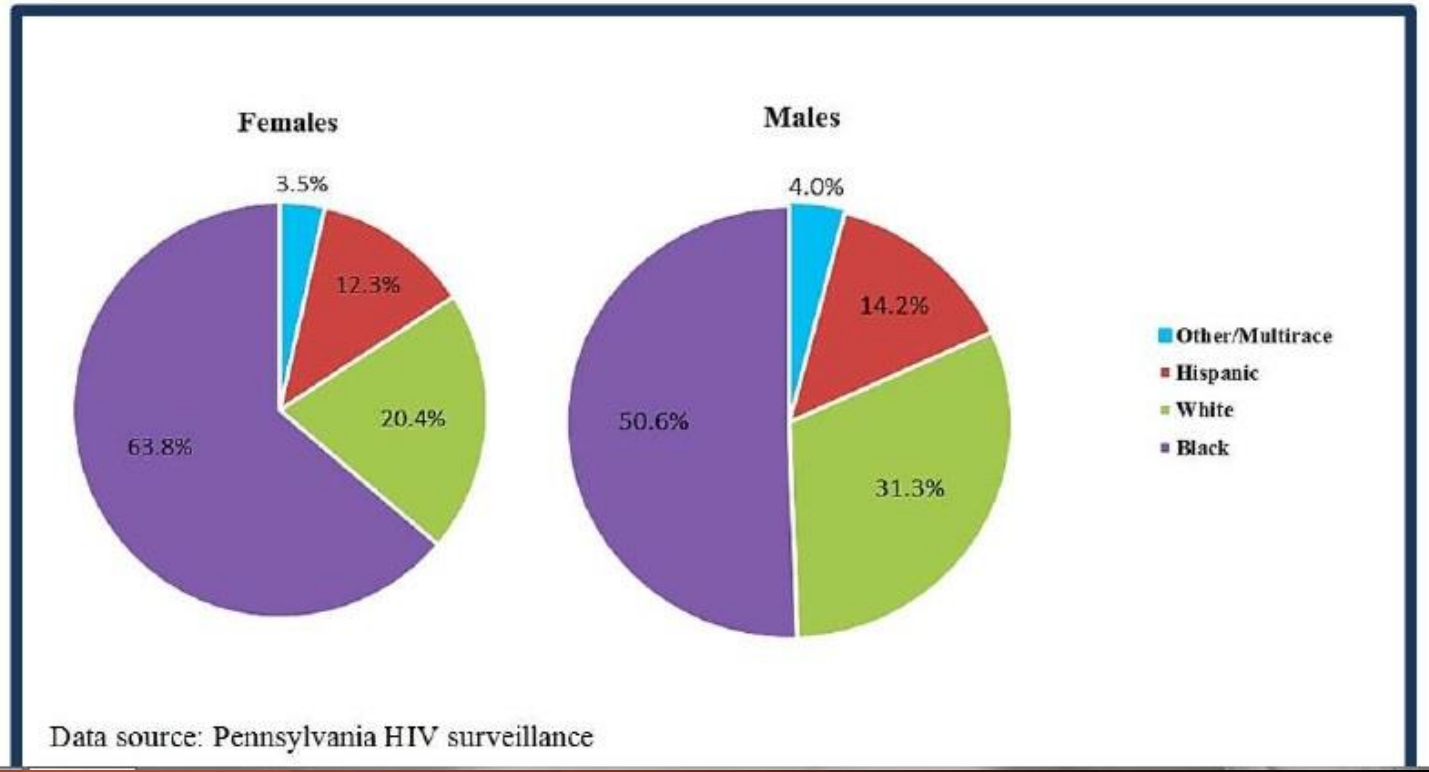
Section I:
A. Epidemiology

Measurable impacts/evidence of racial disparities

New HIV Cases by Sex and Race/Ethnicity

Blacks make up over 50% of the new HIV cases for both gender groups. Among females, 948 (63.8%) were Blacks, 303 (20.4%) were white, 183(12.3%) were Hispanic and 52 (3.5%) were other/multiraces. Among males, 2,577 (50.6%) were Blacks, 1,592(31.3%) were white, 721 (14.2%) were Hispanic and 204 (4.0%) belonged to other races or multiraces. The proportion of diagnosed HIV cases was three times more in Black females than white females (63.8% versus 20.4%) (Figure 2).

Figure 2: New HIV Cases by Sex and Race in Pennsylvania, 2011 to 2015



Data source: Pennsylvania HIV surveillance

The Epi

New HIV Cases by Race

Blacks and Hispanics are disproportionately represented in the number of new cases diagnosed compared to their representation in the estimated general population of Pennsylvania. A total of 3,525 (53.6%) new cases were diagnosed in Blacks compared to 1,895 (28.8%) cases among whites (Table2). A crude risk ratio for Blacks is approximately 4.9 (derived by dividing 54.0% of new cases by 11.0% of the total population). The crude risk ratio for Hispanics is 2.3 (derived by dividing 14.0% of new cases by 6.0% of the total population) (Table 3).

Table 2: New HIV Cases by Race and Year in Pennsylvania

Year of diagnosis	Total	White	Black	Hispanic	Native American	Asian	Multirace
Total	6,580	1,895	3,525	904	14	107	135
2011	1,414	412	752	207	0	15	28
2012	1,458	402	783	217	3	21	32
2013	1,336	376	728	161	5	28	38
2014	1,207	359	633	164	4	23	24
2015	1,165	346	629	155	2	20	13

ata source: HIV surveillance data

Table 3: Distribution of New HIV Cases and General Population by Race, Pennsylvania

Race/Ethnicity	Total Cases	Percent of Total Cases	Percent of Total Population
White	1,895	29%	83%
Black	3,525	54%	11%
Hispanic	904	14%	6%

Data source: HIV surveillance data

The Epi

New HIV Cases by Race and Risk

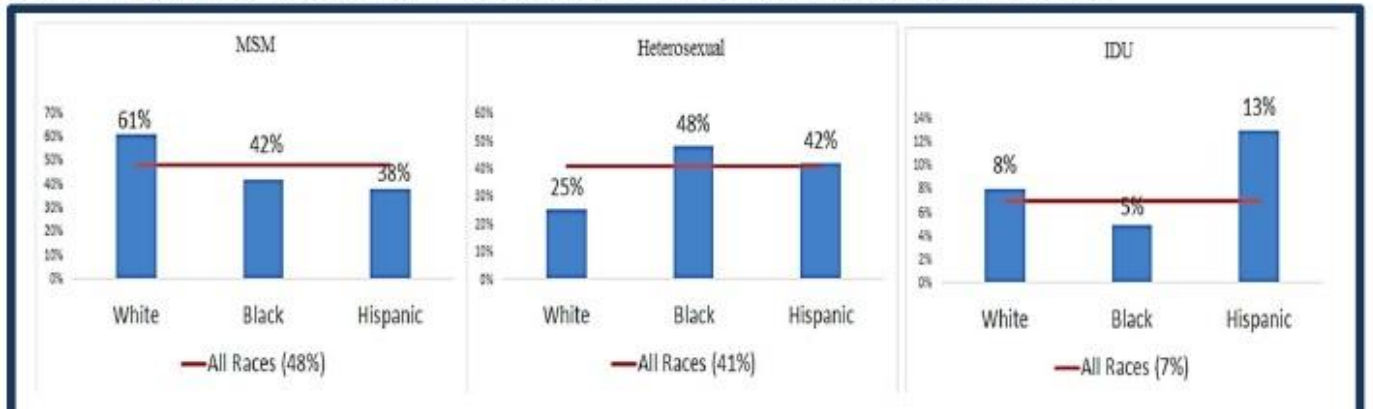
By transmission category, among whites, the majority (60.8%) of the cases identify men who have sex with men (MSM) as the primary risk factor (Table 5). The proportions of MSM-related cases for Blacks and Hispanics were 43.4% and 37.5%, respectively. For Blacks the highest proportion of cases are due to heterosexual transmission (48.3%) compared to 25.1% among whites and 41.9% among Hispanics (Figure 4). Hispanics have the highest proportion of IDU as the primary mode of transmission (13.5%) compared to 8.5% for whites and 4.8% for Blacks.

Table 5: New HIV Cases by Race and Risk, Pennsylvania

Risk	All	White	Black	Hispanic	Native American	Asian	Multirace
All risks	6,580	1,895	3,525	904	14	107	135
MSM	3,134	1,153	1,526	339	4	48	64
Heterosexual	2,670	476	1,704	379	9	50	52
IDU	459	161	170	122	0	2	4
MSM-IDU	142	55	43	36	1	3	4
Pediatric	38	2	27	4	0	1	4
Other/unknown	137	48	55	24	0	3	7

Data source: HIV surveillance data

Figure 4: Proportion of New HIV Cases by Race and Selected Risk in Pennsylvania



The Epi

New HIV Cases by Race and Age at Diagnosis

Blacks are disproportionately represented among those who are age 15-24 at diagnosis. While overall Blacks make up 3,525 (54.0%) of all newly diagnosed cases, they make up 65.6% of the new diagnosed cases in the 15-24 age group. Whites make up 1,895 (29.0%) of all newly diagnosed cases but 35.3% of these cases are in the age group 45-54. The highest proportion of newly diagnosed cases among Hispanics was in the age group 35-44 at 16.5% (Table 4).

Table 4: New HIV Cases by Race and Age at Diagnosis

Age group	All	White	Black	Hispanic	Native American	Asian	Multirace
All ages	6,580	1,895	3,525	904	14	107	135
<13	33	2	23	3	0	1	4
13-14	11	2	9	0	0	0	0
15-24	1,430	257	939	177	5	16	36
25-34	1,720	505	890	255	4	36	30
35-44	1,368	420	665	226	1	30	26
45-54	1,300	460	625	169	3	14	29
55 - 64	574	198	302	59	1	6	8
65+	144	51	72	15	0	4	2

Table 10: PLWH by Race/Ethnicity and Region, Pennsylvania

Race/Ethnicity	Total	AACO	AIDSNET	NE	NC	SC	SW	NW
Asian PI	297	219	13	5	6	21	29	4
Black	17,158	13,439	680	194	258	1,012	1,390	185
Hispanic	5,763	3,179	1,285	160	129	778	146	86
Multiple Races	1,202	636	140	42	28	157	176	23
Native American	43	38	0	2	1	1	0	1
White	10,681	4,828	1,019	527	357	1,733	1,814	403

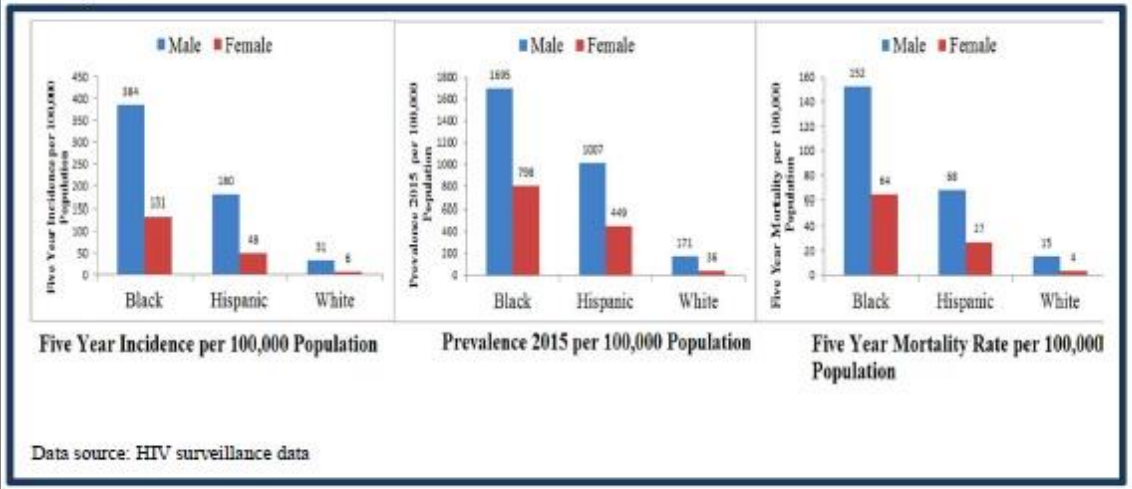
Data source: HIV surveillance data

More Epi

Incidence, Prevalence and Mortality Rates per 100,000 Population by Race and Sex

Disparities exist in incidence, prevalence and mortality rates by race and sex. These rates are highest for Blacks and lowest for whites as shown in Figure 8 below. The incidence rate was highest among Black males (384.2 per 100,000 population) compared to white males (31.2 per 100,000 population) or Hispanic males (179.7 per 100,000 population). HIV prevalence was also highest among Black males (1,695.3 per 100,000 population) compared to white males (171.5 per 100,000 population) or Hispanic males (1,007.1 per 100,000 population). The death rate among PLWH was also highest among Black males (152.4 per 100,000 population) compared to white males (15.0 per 100,000 population) or Hispanic males (68.0 per 100,000 population).

Figure 8: Incidence, Prevalence and Mortality Rates per 100,000 Population by Race and Sex, Pennsylvania



Data source: HIV surveillance data

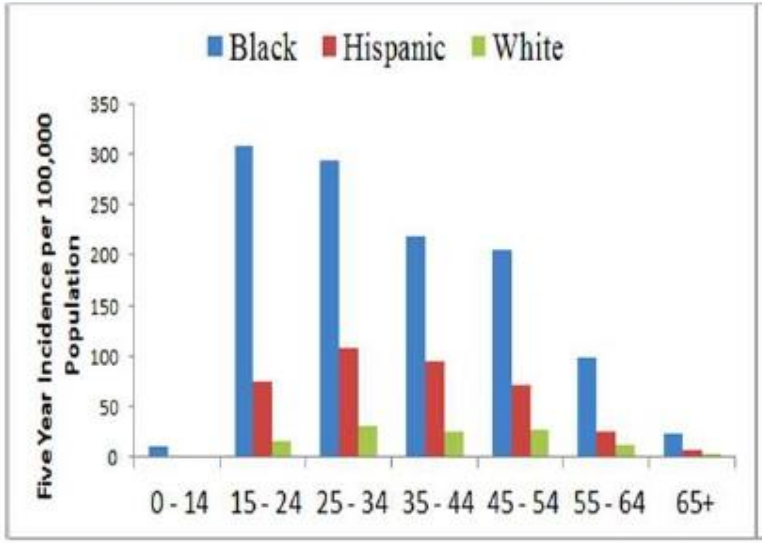
Table 12: Relative Risk for Black and Hispanic Incidence, Prevalence and Mortality by Race and Gender Compared to Whites, Pennsylvania

Sex and Race/Ethnicity	Relative Risk for Incidence	Relative Risk for Prevalence	Relative Risk for Mortality
Black males	12	10	10
Black females	23	22	18
Hispanic males	6	6	5
Hispanic females	8	12	8

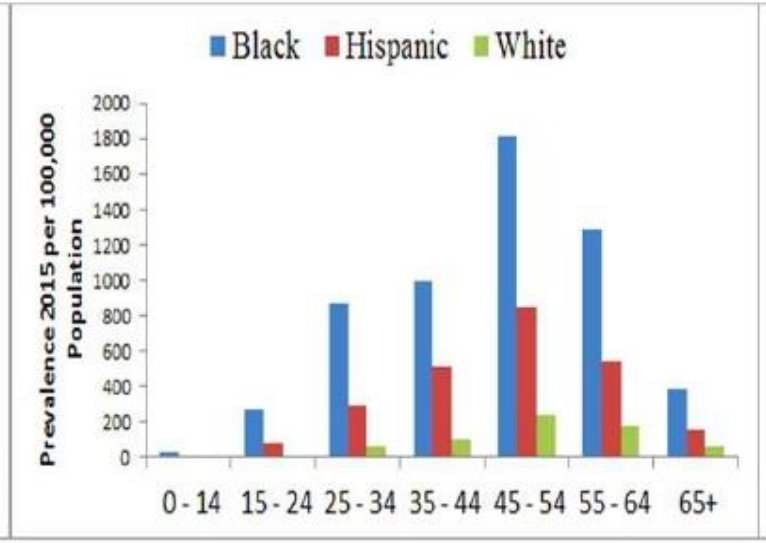
Data source: HIV surveillance data

The Epi

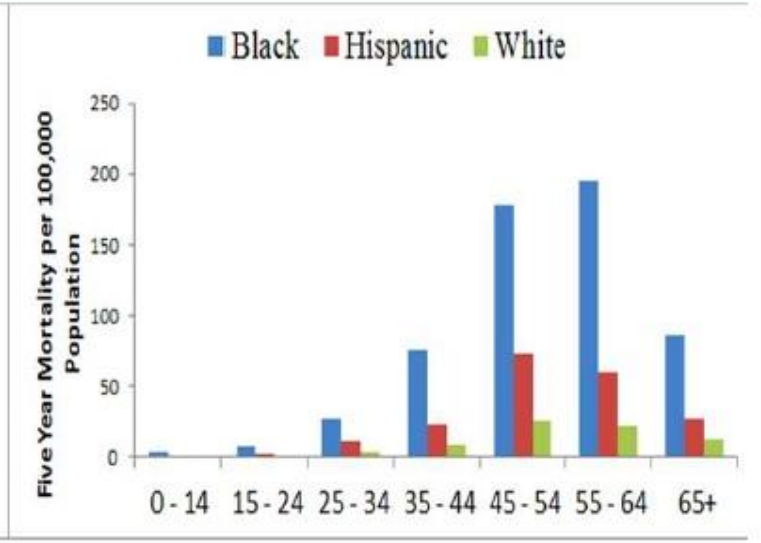
Figure 10: Incidence, Prevalence and Mortality Rates per 100,000 Population by Age* and Race, Pennsylvania, 2011-2015



Five Year Incidence per 100,000 Population



Prevalence 2015 per 100,000 Population



Five Year Mortality Rate per 100,000 Population

*For incidence age is age at diagnosis, for prevalence age is age as of 12/31/2015. For mortality age is age at death.
Data source: HIV surveillance data

Still Epi

Table 18: Percent of Pennsylvania Adults Age 18-64, Ever Tested for HIV, PA, 2014

Socio-demographic characteristics	Percent	CI*
All	41	39-43
Sex		
Male	38	35-41
Female	44	41-47
Age group		
18-29	40	35-45
30-44	55	51-59
45-64	31	29-34
Educational status		
<High school	46	36-56
High school	35	31-38
Some college	43	39-47
College degree	44	40-47
Income		
<$15,000	62	53-69
$15,000-$24,999	54	46-60
$25,000-$49,999	38	34-43
$50,000-$74,999	35	30-40
$75,000+	39	35-42
Race/Ethnicity		
White	34	31-36
Black	75	68-80
Hispanic	69	58-78

*CI: Denotes 95% Confidence Interval (CI)

Data source: Pennsylvania Behavioral Risk Factor Surveillance System, 2014

B: The HIV Care Continuum

2. Engagement Disparities

"…the need has been identified to further engage young Black and Latino men who have sex with men (MSM) in an effort to reduce new infections and identify more PLWH who are not aware of their status. These goals will be pursued by focusing on targeted testing and partner services as well as expanding demonstration projects. The DOH has plans to replicate interventions that have been proven to be successful in other areas within the jurisdiction to affect the HIV Care Continuum relative to this at-risk population." (p 46)

2. Service Needs

The coordinated needs assessments point to several HIV prevention and care service needs among special populations at risk for HIV and PLWH including sexual and gender minority populations, injection drug users, people with disabilities and people living in rural areas of Pennsylvania. Disparities in access to care for certain populations and underserved groups requires increased coordination among HIV prevention, care, and treatment programs, as well as other necessary services including substance abuse and mental health services, housing, and transportation. The service needs assessment findings of the Division of HIV Disease, in concert with the HPG and the HPCP, are outlined below.

Gay, bisexual, and other men who have sex with men of all races and ethnicities and geographical location face challenges along the care continuum, particularly in terms of getting tested, being linked, and being retained in care. In 2015, the Incidence Subcommittee decided that it needed to gather current data indicating up-to-date incidence rates in the state. After some discussion, it became clear that in Pennsylvania those data operate on a time delay. Working with DOH staff, the Subcommittee concluded that existing 2013 incidence data was sufficient enough to clearly show that Black and Latinx (the non-binary gender neutral/gender inclusive spelling of 'Latino/a') gay and bisexual male youth and trans youth age 13- 29 currently account for a significant proportion of new HIV cases entering the Continuum. The subcommittee then requested from the University of Pittsburgh HPCP staff a literature review regarding the usefulness of HIV testing at Emergency Departments for reaching black and Latinx gay and bisexual male youth and trans youth. They also reviewed data about the rates of HIV testing of this population at HIV testing sites in the state. These reviews allowed the HPG and the Division to develop a clearer, evidence-based understanding of where these subpopulations were located within the continuum of care (i.e., estimating those unaware of their status, not linked to care, or not retained in care). The subcommittee found that the literature about routine testing of patients at Emergency Departments does not yet indicate whether such testing is effective. Most of the literature focused on the feasibility of establishing such testing, and reports about its implementation were not yet conclusive. The examination of the state HIV testing and epidemiological data indicates that despite efforts to implement routine and targeted testing and other prevention activities, more work must be done to actively engage this most disproportionately affected population.

To drive these efforts, the Incidence Subcommittee developed resolutions as recommendations to the state. Specifically, the subcommittee requested that the Division "work with young black and Latino men who have sex with men (MSM) in hopes of reducing new infections, by identifying PLWH who are not aware of their status, with the focus on targeted testing and partner services as well as expanding demonstration projects similar to Project Silk." Project Silk is an innovative program in the Pittsburgh Metropolitan Statistical Area that provides a safe and supportive space for young MSM and transgender individuals. This recreation-based public health intervention provides HIV and STD prevention and linkage to HIV care as well as a number of other support services. Project Silk has demonstrated consistently high levels of identifying new HIV cases in addition to successfully linking into care a significant number of young men who had tested positive for HIV but who were not linked to care or had later been lost to care. [Please see **Appendix F1** for a full description of this project.] The Subcommittee concluded that this particular project would be especially relevant to promote increased testing among this high-incidence group and to improve retention. It therefore recommended that the DOH replicate the project in other areas within the jurisdiction to affect the HIV Care Continuum relative to this at-risk population.

D: Assessing Needs, Gaps and Barriers

HPG research of racial disparities and recommendation for Project SILK diffusions (p 58-59)

Section 2: The Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan
B. Collaborations, Partnerships, and Stakeholder Involvement
C. People Living With HIV (PLWH) and Community Engagement

A. The Plan

A. Integrated HIV Prevention and Care Plan

*Activities and language referencing “high risk individuals” or “PLWH” were *not* included in this summary

NHAS Goal I: Reducing New HIV Infections

#	Activity	Target Population	Resp. Party
2	Focus prevention efforts/activities on high-risk and disproportionately impacted populations	PLWH, MSM, High risk heterosexuals, IDU (of all races and ethnicities, including MSM/IDU); Black MSM; Black and latinx women and men, young Black MSM age 15-24, and transgender women	Department of Health and CDC and state funded providers
7	Implement/replicate innovative HIV prevention interventions in targeted geographic areas that, in addition to HIV/STD testing, address a broad range of services such as behavioral health and other supportive services (e.g. housing, education, employment) which contribute to a reduction in HIV/STD incidence.	MSM and transgender women of color ages 15-24	PA Department of Health, HPCP

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NHAS Goal III: Reducing HIV-related Disparities and Health Inequalities

State Objective 2: Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.

Strategy 1: Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities

#	Activity	Target Populations	Resp. Party
37	Coordinate discharge of incarcerated individuals between corrections facilities and medical providers and SPBP to ensure access, linkage to care and adherence to Medications	Newly released PLWH	County corrections, Department of Health

Strategy 2: Reduce stigma and eliminate discrimination associated with HIV status

#	Activity	Target Populations	Resp. Party
39	Utilize social media marketing to reduce stigma and reach Blacks at high risk or those lost to care	BMSM	HPCP
40	Replicate Project Silk in applicable geographic areas	YB-MSM and TG	HPCP

The Plan

NHAS Goal III: Reducing HIV-related Disparities and Health Inequalities

State Objective 2: Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.

Strategy 3: Reduce HIV-related disparities in communities at high risk for HIV infection

#	Activity	Target Populations	Resp. Party
41	Convene roundtable discussions to highlight the relevance of the intersecting issues of HIV and the Black community.	BMSM	HPCP
42	Expand the number of participating providers conducting MAI activities.	Minorities living with HIV	Department of Health

B. Collaborations, Partnerships, and Stakeholder Involvement

1. Stakeholder Involvement in Planning:

- "the Incidence [subcommittee] is studying factors affecting rates of new HIV diagnoses among African American youth… [including] receiving a report on social barriers around violence based on in-depth interviews of transgender (MtF) African American and Native American women in Pittsburgh, PA. …[They also] received a report from the staff and community leaders who developed Project Silk, a successful recreation-based public health intervention for Black MSM, bi, and trans-identified youth in Pittsburgh." (p 88)

- "Areas that the [IHPCP Feedback] survey identified for further outreach and support include… Latinx (5%); African American communities (17%), particularly women of color…" (p 90, also Appendix E)

2. Missing Stakeholders:

"…Members attending HPG meetings are… influencing the planning process and identifying the disparities in our engagement process. Stakeholders who have been identified to improve the HPG's planning process in 2016 include: youth between the ages of 13-29, especially African Americans and Latinx; transgender individuals; current or former injection drug users, people with disabilities; former prisoners who are HIV positive; individuals who identify with RWHAP; ethnic/racial minorities with HIV or at high risk for acquiring HIV, including native peoples." (p 90)

C. People Living with HIV (PLWH) and Community Engagement

2. Engagement Reflectiveness

"Epidemiological information regarding HIV rates in Pennsylvania indicates that minority communities (particularly African Americans) as well as MSM are disproportionately affected by HIV in the Commonwealth. In 2015 35% of voting HPG members self-identify as MSM, 35% as African American, and 4% Latinx." (p 94)

4. Impacted Community Contributions

Reiteration of the Incidence Committee's work from page 88 around the disparities facing African American communities and youth (p 96)

Section 3 & Appendixes

Monitoring and Improvement

Appendixes:

- **Appendix B**
- **Appendix F**

Monitoring and Evaluation: Suggested Improvements

- New HPG Recommendations
  - After careful analysis throughout 2018, the HPG Assessment subcommittee requested—and the HPG approved—the recommendation that the IHPCP be updated to include language recognizing systemic impact of racial discrimination along the HIV Continuum.

Appendixes

- Appendix B: MAAETC reported that providers ranked very highly their need for training on assisting racial/ethnic minorities. It also discusses in-depth the Minority AIDS Initiative, which directly seeks to address disparity in the prevalence and incidence of HIV based on race and ethnicity (p 130-133 & 143).

- Appendix F1: Project SILK (p 151-155)

- Appendix F2: 2014 Needs Assessment Report found that nationally, non-whites, especially Hispanic/Latinx, experienced the greatest delays and non-linkage. It also identified large impacts from negative experiences in testing and post-test counseling including a perception of both racism and HIV stigma. (p 156)

HPG Discussion

Goal: To assess whether the IHPCP can better acknowledge and address the impacts of racial disparities in HIV Planning.

Discussion: What stood out to you in these presentations? OR
How do racial disparities impact your work or experiences?

Planning Questions:

- What gaps in the Plan do you see or have you experienced that are impacted by racial disparities? What other input or data is needed?
- How does (or could) the work of the Office of Health Equity intersect with the IHPCP?