RACIAL AND CULTURAL DISPARITIES IN HIV CARE
Interventions for Improvement

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Learning Objectives

- Improve rates of routine HIV screening among African-American and Latino patients
- Utilize strategies for improving level of cultural competency when providing care to African American and Latino patients with or at risk for HIV
- Initiate ART for all African American and Latino patients diagnosed with HIV as per the DHHS guidelines

The Disproportionate Burden of HIV Faced By African Americans
African Americans Are More Likely to Die of HIV Infection

Age-Adjusted Death Rates for HIV Disease by Sex and Race/Ethnicity, US, 2007

* Figure does not meet standards of reliability or precision


Rates of Stage 3 (AIDS) Classifications Among Adults and Adolescents With Diagnosed HIV Infection, by Race/Ethnicity 2000-2011 – United States

Note: All diagnosed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

* Hispanics/Latinos may be of any race.

* Includes Asian/Pacific Islander Legacy cases.
**Why Are Morbidity/Mortality Rates Higher in Blacks?**

- Never in care/delayed entry into care
- Late initiation of ART/less time on ART
- Missed visits/lower retention in care
- Lower treatment success
- Higher prevalence of comorbidities
- Poverty/competing priorities
- Substance use
- Mistrust of medical establishment

*Courtesy of Kimberly Y. Smith, MD. CROI 2012.*
Patient 1 Video
An Older Male Patient With HIV
Questions For Group Discussion

- Why do you think this patient was never offered an HIV test by his primary care clinician?

- Do you routinely discuss issues of sexual health, including HIV and HIV prevention, with patients over 50? Do you find these conversations difficult? If so, why?

- How do you think his health would be now had he been diagnosed and treated sooner?

NA-ACCORD: Risk of Death Associated With Deferral of ART

- 2 parallel analyses of 17,517 HIV-positive patients stratified by CD4+ count (351-500 cells/mm$^3$ or >500 cells/mm$^3$) at ART initiation

- Compared relative risk of death:
  - “Early” therapy (initiated when the CD4+ count was above each of the 2 thresholds) vs “deferred” therapy (initiated when the CD4+ count fell below the threshold)

- 69% increase in risk of death for deferred vs early therapy in patients with CD4+ count of 350-500 cells/mm$^3$

- 94% increase in risk of death for deferred vs early therapy in patients with CD4+ count >500 cells/mm$^3$

Late Start and/or Early Stop to ART = Reduced Survival

- Late initiation or early ART discontinuation results in life-expectancy loss
- Data indicate minorities present later and have higher rates of premature discontinuation
- Racial/ethnic minorities lose, on average, 1.5 more years of life than whites
- Outreach efforts should focus on these issues in minorities

How Can We Improve This?

**CDC Recommendations for HIV Testing in Health Care Settings**

- Routine voluntary testing for all patients ages 13 to 64 years in all health care settings
  - Not based on patient risk
- Opt-out testing
  - No separate consent for HIV
  - Pretest counseling not required
  - Repeat HIV testing left to discretion of provider, based on risk
  - Results in increased HIV testing rates


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**Changing HIV Testing Laws: Impact on Survival**

- Comparison of diagnosis rates in states with opt-out (24.9%) vs opt-in testing (19.9%)
- In states with opt-out testing, HIV is diagnosed at a higher CD4 cell count → better treatment outcomes
- Computer-based simulation model of HIV disease applied to these data
- If all remaining states switched to opt-out testing, potential national survival gain would be ~600,000 years of life

**Linkage to Care**

- Testing and identifying patients with HIV is not enough
- Primary care and HIV care are necessary
- Primary care and HIV care can be considered a continuum
- Establishing a linkage with an experienced HIV care provider prior to providing routine HIV testing is essential to ensure successful referrals
- Determine who will manage each component of PC issues
- Implementing procedures to ensure successful referrals is critical
- Timely and effective communication are essential

**Strategies for Appropriate Linkage to Care**

- Upon testing positive for HIV, a direct and rapid link from positive test to HIV care regardless of insurance status
- Link with testing centers, STD clinics, health departments
- Systematic follow-up for “no shows”
- Earlier treatment initiation provides opportunity for success (ie, “test and treat”)
Initiating Treatment

When to Start ART: DHHS and IAS-USA Panel

- Recommend ART for all patients with CD4+ count ≤500 cells/mm³, and those with specific conditions or morbidities¹,²

- Consider ART for all patients, regardless of CD4+ count or symptoms¹,² (DHHS: 50% favor starting, 50% view as optional)¹

Rationale for ART

- Effective ART with virologic suppression improves and preserves immune function in most patients, regardless of baseline CD4 count
  - Earlier ART may result in better immunologic responses and clinical outcomes
    - Reduction in AIDS- and non-AIDS-associated morbidity and mortality
      - Reduction in HIV-associated inflammation and complications
    - ART strongly indicated for all patients with low CD4 count or symptoms
- ART can significantly reduce risk of HIV transmission
- Recommended ARV combinations are effective and well tolerated

Initial Treatment: Choosing Regimens

- 3 main categories:
  - 1 NNRTI + 2 NRTIs
  - 1 PI + 2 NRTIs
  - 1 II + 2 NRTIs
- Combination of NNRTI, PI, or II + 2 NRTIs preferred for most patients
- Fusion inhibitor, CCR5 antagonist not recommended in initial ART
- Few clinical end points to guide choices
- Advantages and disadvantages to each type of regimen
- Individualize regimen choice
ART Efficacy and Race: Generally Similar

### ARTEMIS

**DRV/r vs LPV/r, treatment-naive**

N = 383 receiving DRV/r¹

- n = 137 white;
- n = 77 Hispanic;
- n = 80 black;
- n = 44 Asian

Similar among racial groups, from 80% of Caucasians to 100% of Asians

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### Study M05-730

**LPV/r QD or BID, treatment-naive²**

- n = 499 white;
- n = 165 nonwhite (73% black)

77% white, 75% nonwhite; P = .672

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### CASTLE

**ATV/r vs LPV/r³**

- n = 428 white;
- n = 163 black;
- n = 173 Asian;
- n = 108 other

ATV/r: 77% white, 71% black, 83% Asian, 83% other

LPV/r: 73% white, 78% black, 90% Asian, 76% other

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NNRTIs vs PIs: Advantages/Disadvantages

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<tr>
<th>Regimen</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<td>NNRTI-based</td>
<td>Long half-lives</td>
<td>Low genetic barrier to resistance—single mutation</td>
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<tr>
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<td>Best virologic response (EFV)</td>
<td>Potential for cross-resistance</td>
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<td>PI options retained for future use</td>
<td>More rash, CNS side effects than PI-based regimens</td>
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<td>Lower pill burden vs PI-based regimens</td>
<td>Potential for CYP450 drug interactions</td>
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<td>Transmitted resistance more common than with PIs</td>
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<tr>
<td>PI-based</td>
<td>Good virologic and immunologic response</td>
<td>Metabolic complications with some PIs</td>
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<td>Higher genetic barrier to resistance vs NNRTIs and RAL</td>
<td>More GI side effects than NNRTI-based regimens</td>
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<td>Lower risk of PI resistance at failure</td>
<td>Higher potential for clinically significant drug interactions vs NNRTI-based</td>
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<td>NNRTI options retained for future use</td>
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Special Populations

Men Who Have Sex With Men (MSMs)
HIV/AIDS Cases Among Men Who Have Sex With Men
Aged 13-24, by Race/Ethnicity, 2001-2005 (33 States)

Note: Data statistically adjusted for reporting delays and redistribution of cases in persons initially reported without an identified risk.

HIV in Men Who Have Sex with Men (MSM)

- From 2005-2008, diagnoses of HIV infection increased approximately 17% among MSM\(^1\)
- Among all Hispanic/Latino MSM in 2006, the largest number of new infections (43%) occurred in the youngest age group (13-29 years), though a substantial number of new HIV infections (35%) were among those aged 30–39 years\(^2\)
- In 2008, one in five (19%) MSM in 21 major US cities were infected with HIV
  - Nearly half (44%) were unaware of their infection\(^3\)

Patient 2

An African American MSM Recently Diagnosed With HIV
Questions For Group Discussion

- What do you think of the patient’s explanation for why many MSMs don’t use condoms?
- Do you routinely raise issues of sexual health with your patients?
- What role does stigma play in HIV prevention and care in gay men?
- What cultural issues might come into play when speaking with African American male patients about sexual health issues?

Provider Goals in Sexual History Taking

- Develop a genuine rapport
- Make sexual history taking routine
- Use normalizing statements
- Acknowledge discomfort
- Speak clearly about sexual behaviors
- Reinforce confidentiality
HIV Among Women of Color

Numbers of AIDS Diagnoses among Adult and Adolescent Females, by Race/Ethnicity, 1985–2010—United States and 6 U.S. Dependent Areas

Note: All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.

* Includes Asian/Pacific Islander legacy cases.
Race and Gender Disparities in the Use of ART

HIV Research Network (HIVRN)
Factors Associated With Receipt of ART*

*Multivariate analysis odds ratio of receiving ART at 10 primary care sites.
IDU=Injection drug user.
Does Treatment Differ in Female HIV+ Patients?

- In general, no sex differences in virologic efficacy of ART
- Some evidence of sex differences in metabolism and response to some ARVs
- Increased risk of certain ARV adverse effects:
  - NVP-associated hepatotoxicity (especially if initiated at CD4 count >250 cells/µL)
  - Lactic acidosis: avoid d4T + ddI, if possible
  - Metabolic complications (eg, lipoaccumulation, elevated triglycerides, osteopenia/osteoporosis)

Does Treatment Differ in Female HIV+ Patients? (cont’d)

Efavirenz

- Teratogenic in nonhuman primates
- Risk of neural tube defects occurs during the first 5-6 weeks of pregnancy, before many pregnancies are confirmed
- Do pregnancy test before starting EFV (women of childbearing potential)
- Counsel about potential risk to fetus and desirability of avoiding pregnancy while on EFV
- Use alternative ARV agent in women who are trying to conceive or who are not using effective contraception, if feasible
“Cultural competency is the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities and protects and preserves the dignity of each.”

- Seattle King County Dept of Public Health, 1994
Cultural Competency

- Ability for organizations or individuals to work effectively in multicultural interactions
- Recognition of differences and similarities
- Understanding
- Appreciation
- Resides on a continuum
- Limitations

The AWARE Model: Communication Across Cultures

- **A**ccept the other person’s behavior without judging it based on what that behavior means in your culture
- **W**onder what the person’s behavior means in his/her culture, rather than what it means in your culture
- **A**sk what it means to the person, showing a respectful interest

Noel Day, Polaris Research & Development
The AWARE Model: Communication Across Cultures (cont’d)

- **Research and read about the other person’s culture so you are able to place their behavior in the context of their cultural word view.**

- **Explain what the behavior means in your culture. Demonstrate and or describe the behaviors in your culture that would express similar feelings or meanings.**

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Cultural Competency: Online Training/Resources

AETC. BeSafe. A cultural competency model for African Americans.

AETC National Multicultural Center. Online training curricula for cultural competence in HIV-focused health care.
http://www.aetcnmc.org/

http://minorityhealth.hhs.gov
Summary

- African Americans account for a disproportionately high percentage of HIV cases and AIDS-related deaths
- Black HIV-positive patients are more likely to start treatment late and to stop treatment early
- Screening directed to communities of color can increase early detection rates (CDC Expanded HIV Testing Initiative) and thereby facilitate early start to treatment
  - Evidence suggests that testing and treating all comers may reduce community viral load and transmission rates
  - Early treatment prevents transmission

Summary (cont’d)

- Most obstacles to successful treatment are cultural and socioeconomic rather than medical
- With the proper support, African Americans can succeed with ART just as well as other demographic groups
Additional Resources: Local Health Care System-level Steps

- Visit AAHIVM Web site to find an HIV provider near you
  - http://www.AAHIVM.org (Click on FIND A PROVIDER)
- Call local Health Department
  - Inquire about HIV programs in your area
- Obtain pamphlets to disseminate to patients regarding HIV prevention and screening procedures

AAHIVM = American Academy of HIV Medicine.

Additional Resources (cont’d)

Downloadable tools and resources may be found on www.myCME.com/HIV2013