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COMMENTARY

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Pandemic-Era Policies That Can Help End the HIV Epidemic for Latinas/os/xs

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The COVID-19 pandemic disrupted HIV-related prevention and treatment services, especially in the first wave of the pandemic.[1–4] Compared with January through March 2020, during April to June 2020, the number of HIV tests performed declined by 32%; the number of people prescribed pre-exposure prophylaxis (PrEP) decreased by 6%; and new HIV diagnoses declined by 6%.[4]

These numbers rebounded by July to September 2020, which is likely attributed to policies enacted by the federal Public Health Emergency (PHE) and recommended by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB). HAB encouraged states to permit telehealth visits, provide home delivery for antiretroviral therapy, and offer flexibility (e.g., self-attestation) in enrollment and recertification in the AIDS Drug Assistance Program (ADAP).[4]

These policies resulted in implementation of telehealth and home delivery of HIV testing and medications at an unprecedented pace, quickly scaling up innovations to maintain services in line with Ending the HIV Epidemic (EHE) priorities.[4] At the same time, there is evidence that not all populations benefited equally from these innovations—there was a surge in sexually transmitted infections during the COVID-19 pandemic[5] and a failure to rapidly recognize and respond to mpox among populations who were also at risk for HIV.[6]

We now have an opportunity to leverage the pandemic-era momentum to help at-risk populations achieve EHE goals. During the 1st year of the pandemic, more than a quarter of the 30,635 new HIV diagnoses were among Latina/o/x individuals, accounting for the second highest number of diagnoses across racial/ethnic groups in the United States.[7] While the overall trend in HIV diagnosis in the United States has been steadily declining since 2010,[7] rates for Latinas/os/xs have increased.

From 2015 to 2018, Latinas/os/xs were the only racial group with increasing HIV incidence rates, and these rates increased at a rate four times higher relative to White Americans.[8] In 2019, 29% of the 34,800 estimated new HIV infections in the United States were among Latinas/os/xs,[9] but only 14% of PrEP-indicated Latinas/os/xs were prescribed PrEP.[10] In a study from 2000 to 2018, the repeat risk for syphilis was highest among Hispanic men (16%) compared with any other racial/ethnic group.[11]

Compared with White Americans, Latina/o/x persons have disproportionately lower access to quality health care and behavioral health services,[12] pay more for health care services, experience more delays in HIV diagnoses, and experience more barriers accessing PrEP.[13]

We reflect on how the pandemic-era policies affected HIV prevention and care service delivery for Latinas/os/xs and how these policies can be continued or adjusted for EHE. We draw on key informant interviews from representatives of the Mid-Atlantic Centers for AIDS Research Consortium Latinx Working Group (MACC Latinx), a group funded by the National Institutes of Health (NIH). The MACC Latinx is a coalition of academics, health care providers, federally qualified health centers (FQHCs), and public health practitioners dedicated to EHE for Latinas/os/xs in the mid-Atlantic region.

The mid-Atlantic region has a large population of Central American migrants.[14] For example, the District of Columbia (DC) metropolitan (metro) area, including DC, northern Virginia, and parts of Maryland, is home to over 900,000 Latinos, 53% of whom are foreign-born.[15]

Among US metro areas, DC metro has the second highest proportion of Latino immigrants. DC area's share of undocumented immigrants has grown recently, in contrast to a declining national rate, and was estimated at 425,000 in 2016.[16] This number has likely grown because of recent efforts by southern states to bus migrants north[17] and, more broadly, because of rising rates of Central American migrants to the United States.[18]

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Moreover, there is emerging evidence that pandemic-related disruptions affected HIV-related outcomes in the mid-Atlantic region. In DC, there was a 20% decline in HIV testing from 2020 to 2021 and an overall decline of 32% from 2019.[19] The decline in testing compounded already inadequate HIV-related outcomes for Latinas/os/xs. Among Latinos/xs diagnosed with HIV in DC between 2017 and 2021, only 64% were virally suppressed within 6 months of diagnosis,[19] substantially below the target set by the Office of National AIDS Policy that 80% of those diagnosed with HIV should be virally suppressed by 2020.[20]

Key Informant Perspectives on Challenges and Opportunities for Serving the HIV Prevention and Care Needs of Latinas/os/xs During the Pandemic

We interviewed 8 key informants from the MACC Latinx. Informants serve primarily low-income, undocumented, and limited English proficient Latinas/os/xs. Interviews were conducted through Zoom. Informants included physicians, program managers, nurses, academics, and one Executive Board member. All interviews were conducted and transcribed in English and then coded using thematic analysis by two research assistants with Dedoose software. The research received an exemption from the American University Institutional Review Board (IRB-2022-293).

Our findings revealed challenges and opportunities under three domains: addressing the social determinants of health, maintaining access to services, and meeting requirements of new health funding sources and programs.

Addressing the social determinants of health

Challenges. Key informants spoke about how the pandemic increased their Latina/o/x clients' social needs, including food, housing, and job security: ''It was dramatic how [many] people were completely without where to live and what to eat, [because] there is no safety net right?'' (Program Director, FQHC). Another informant elaborated: ''We saw mostly those [same] barriers and challenges getting worse for us. We saw people losing their [housing] because they didn't have money to pay their rent.'' (Program Manager, FQHC).

Several informants expanded services to address food insecurity:

> I think one thing that we did consistently [for] this community was food distribution, though, we never had done [food distribution] before [the pandemic]. Before the pandemic, we had a more HIV-oriented kind of action.

Housing, including lack of privacy and housing resources, posed additional challenges for Latina/o/x clients. One informant discussed how clients living with HIV who lacked privacy struggled with adherence because of fear that cohabitants would learn of their diagnosis. Informants spoke about the rise of domestic abuse and challenges of safely housing their clients: ''Housing and shelter services are very scary in DC. There are even fewer now. Shelters have closed for different reasons, and it's very complicated.'' (Program manager, FQHC).

Opportunities. In response to the pandemic, informants had to ''reinvent how to be open,'' by expanding services beyond their usual domains, and quickly ''shifting gears,'' particularly through virtual means. Informants reinvented their organizations as ''one-stop shops'' and used COVID-19 supplemental funds to provide needed colocated services: ''We put COVID CARES money towards food vouchers, transportation, and everything so that we could retain our clients.'' (Program director, FQHC).

Informants also mentioned mailing resources such as personal protective equipment, sanitizer, contraceptives, and testing kits.

Maintaining access to services

Challenges. Many informants discussed the challenge of shifting services to virtual platforms. Informants reported varied levels of experience with providing virtual services before the pandemic. Prepandemic some organizations already offered telehealth, while others had little prior experience: ''Telehealth has been the largest service we had to adopt; the telehealth option was not existent before the pandemic.'' (Physician, FQHC). Another challenge that was noted in reaching Latina/o/x clients was the ''digital divide'':

> ''Some clients didn't have the bandwidth in their phones or didn't have access to the Internet to be on a Zoom meeting for an hour. People wanted to participate but didn't have access to the technology or enough resources for Internet access.'' (Program Director, FQHC).

Informants lamented the consequences of the lack of in-person services, including sexually transmitted infection (STI) and HIV screenings:

> ''We've seen fairly steady or even sometimes an increase of sexually transmitted infections like syphilis, gonorrhea, chlamydia, particularly among higher-risk individuals or men who have sex with men and transgender individuals.'' (Physician, FQHC).

In addition, there were social consequences of losing in-person services: ''Normally in the in-person group, clients have some food, play some music, talk. It's worth more than just the therapy itself. You don't get this from Zooming in from home.'' [Executive Director, Community-Based Organization (CBO)]. While virtual opportunities were helpful, they also sometimes hid problems: ''[In virtual spaces], you don't know who is really listening, who is invested, what is the problem, right? Sometimes people are there but not really there.''

Informants noted that a critical challenge was the shortage of available Spanish-speaking and culturally competent health care workers, especially nurses and mental health providers. At the same time, there was increased demand for mental health services. Moreover, many informants mentioned burnout among their Spanish-speaking staff, who worked extra hours to keep clients retained in care:

> ''During the early days of the pandemic, we had a few behavioral health clinicians who spoke Spanish, who actually took on the responsibility of providing therapy to individuals for periods of time. And now these clinicians have left the [FQHC] since they were burnt out by the huge population and the lack of people like them to provide this [service]. And so, it is sad.'' (Physician, FQHC).

Opportunities. To counteract the loss of in-person services, informants commended virtual platforms as ''an

incredible opportunity to learn new ways to do the work that we do and also help people who never could have joined us.'' These sessions served as support and health education groups: ''[One staff member] was on Facebook doing live chats to members of the community. He promoted mailing the HIV self-testing kit to clients. And it still happens, it's still going, these live Facebook events.'' (Board of Directors Member, CBO).

Online support groups reduced isolation and were more convenient for some clients. Some informants discussed how they used telehealth for case management and physician consultations, which had added benefits: ''We save time, we save money, because people don't need to come in just to fill out some paperwork.''

To enhance access for Latina/o/x clients, some informants expanded clinic hours. Finally, many informants described their staff's intense commitment to the Latina/o/x community as a strength: ''We were a skeleton crew here. It was like two or three of us staying every day from Monday through Saturday. We just rested on Sundays.''

> ''I think a lot of us go above and beyond…That's just what we do. A lot of us are here today by way of community health centers. Our work is like a love letter back to the community. We don't blink twice. We just roll up our sleeves. But it would really be nice if there were more sleeves to roll up.'' (Nurse, FQHC).

Meeting requirements of new health funding sources and programs

Challenges. Informants described receiving large COVID-19 relief grants to work with their local Latina/o/x communities; however, funding also sometimes came with unique stipulations. For example, one informant explained that funds were difficult to spend because of the shortage of Spanish-speaking health care workers: ''The money came to us requiring us to hire seven nurses. Like which nurses? Where are the nurses?'' (Program Director, FQHC). Further, new funding sources required new monitoring and reporting systems:

> ''The fiscal [logistics] are really hard to manage. For example, if you have a finance system that can handle X amount of money and then you put another half a million [dollars] on top of it, how are you going to manage this [correctly] with good internal control?''

An ongoing challenge was that undocumented clients did not benefit from the increased funding or regular government safety net programs: ''One of the biggest challenges is that the Latino community doesn't have insurance. I would say at least 60% of our Latino clients are uninsured.'' (Program Director, FQHC). Informants lamented that their undocumented clients demonstrated many needs that were not reimbursable by grants or programs:

> ''For the undocumented… aside from the fear of deportation, there is the challenge of access to things such as housing, transportation… when we have individuals who are homeless, it's hard to place them… or when we have people who need substance abuse treatment… we don't have many options.'' (Program Director, FQHC).

Opportunities

Informants said that the massive funding available for COVID-19 prevention and treatment was one of the first times that the government recognized the power of community-based organizations to meet the health needs of Latina/o/x communities. Some informants mentioned that ADAP provided more flexibility during the pandemic; for example, their Latina/o/x clients who were living with HIV could receive their medications through the mail.

Informants also noted that there was a shift by insurance companies in reimbursement for telehealth, as prepandemic insurance did not reimburse for telehealth or required that telehealth occur by video conference.

Pandemic-Era Policies to Support EHE for Latinas/os/xs

As the MACC Latinx, we recommend several pandemic-era policies that should be maintained or expanded to help end the HIV epidemic for Latinas/os/xs, including (1) maintaining reimbursement for telehealth; (2) recognizing the importance of the social determinants of health by funding programs that provide quality food, housing, transportation, and health insurance coverage regardless of immigration status; and (3) addressing the shortage of Spanish-speaking health care workers through incentive programs and training/hiring of Spanish-speaking community health workers (CHWs).

Below we discuss how to move forward with these policy recommendations, with an emphasis on the mid-Atlantic states.

The PHE for COVID-19, which expired on May 11, 2023, expanded telehealth services covered under traditional Medicare and allowed some evaluation and behavioral health services to be provided through audio-only telehealth. Our informants lauded the benefits of telehealth reaching some Latina/o/x clients, while acknowledging the ongoing digital divide that prevents Latinas/os/xs without reliable internet from accessing services.

To ensure that Latina/o/x communities can access telehealth care, there should be more investment in enhancing internet and digital access for low-income Latina/o/x populations. Going forward, practitioners should regularly monitor client preferences for in-person or telehealth care.

It is encouraging that Medicaid's telehealth flexibilities will remain intact, even after the expiration of the PHE. However, there is more that can be done at the state level to expand telehealth coverage. As the primary regulators of private health insurance, states may mandate private insurance coverage of telehealth. Another action that states can take is to accept the Affordable Care Act (ACA) Medicaid expansion; 10 states—6 of them southern—have failed to adopt the Medicaid expansion portion of the ACA, although there has been recent movement for some states to join and North Carolina recently adopted expansion.[21]

States can also enhance access for US-born Latinas/os/xs and permanent residents by retaining the continuous enrollment period for Medicaid that existed under the PHE. States can also continue pandemic-era policies of streamlining paperwork and requirements for Medicaid enrollment and reenrollment to encourage increased and continuous participation/coverage.

Undocumented and temporary-status Latina/o/x immigrants do not qualify for Medicaid and cannot purchase insurance through the ACA health exchanges. Further, they may fear accessing health care because of deportation

threats.[22] Undocumented and temporary-status immigrants are best served by states expanding local health insurance programs to include them; two examples are Medi-Cal[23] and the DC Alliance[24] program.

Moreover, states can retain the pandemic-era changes to ADAP. Following HRSA's lead, Virginia, New Jersey, and Washington, DC, allowed ADAP beneficiaries to have medications sent to their homes, set up secure file transfer systems for online ADAP applications, and allowed the dispensing of 90 days of medication at one time. Maryland loosened their ADAP recertification requirements through a State of Emergency, allowing for continuous enrollment of anyone who was eligible for ADAP by March 2020 and allowing case managers to sign attestations. These changes loosened requirements and increased access.

While the pandemic-era flexibility in ADAP allowed for a more resilient HIV care system, we note that any policy changes may have been challenging to understand for beneficiaries whose primary language is not English. It is unclear how much was done to advertise program changes to Spanish-speaking Latinos at risk for or living with HIV. Further, undocumented individuals are not always eligible for ADAP services, since they are managed by the state, or they may also fear accessing ADAP services because of deportation threats, which is a critical gap in HIV care coverage.

Unfortunately, the end of the PHE will reverse some of the progress made on addressing the social determinants of health. Supplemental Nutrition Assistance Program (SNAP) is one the largest antipoverty programs in the United States, promoting food security and health for millions. During the pandemic, SNAP benefits were increased, but this emergency allotment expired for benefits distributed after February 2023,[25] leaving many SNAP participants—who are disproportionately households with children, individuals with disabilities, or elderly[26]—with benefits too low to support healthy diets.[27]

Similarly, many of the housing protections and assistance that protected renters and homeowners during the pandemic were temporary. States could streamline eligibility requirements and (re)enrollment procedures and increase benefit levels for safety net programs using state funds. As an example, in December 2022, DC permanently increased SNAP benefits, expanded eligibility for emergency rental assistance, and increased a rapid rehousing subsidy program.[28]

However, it is important to note that undocumented immigrants are not eligible for SNAP or housing assistance; even permanent residents face a 5-year waiting period to become eligible for these programs.[29]

Finally, programs are needed to scale-up the Spanish-speaking HIV workforce who played a critical role, and yet who were strained by the intense needs of their Latina/o/x communities, during the pandemic. Changes were made at the beginning of the pandemic that expanded opportunities for CHWs to better serve the Latina/o/x population. For example, in March 2020, the Maryland Department of Health, Office of Population Health, opened a ''grandfathering'' process for experienced limited English proficiency (LEP) CHWs to receive CHW certification.

The traditional certification process required that the CHW pay for and take unpaid leave to enroll in a 2-week accredited training course; currently, these courses are only available in English. Through June 2021, in lieu of the training course, CHW employers were able to complete a letter of validation to attest to the CHW's understanding and knowledge of the nine core competencies required for CHW certification. However, this temporary process ended with the pandemic.

Making the certification more accessible to LEP CHWs would provide more opportunities for this important segment of the public health workforce to assist in HIV prevention/care services for Latinas/os/xs. Reinstating the temporary ''grandfathered'' certification process that was in place from March 2020 through July 2021 as well as offering the accredited training course in Spanish would be an important step toward expanding the Spanish-speaking HIV prevention and treatment workforce.

The federal and state policies that were put in place during the COVID-19 pandemic showed that when necessary, we can address the social determinants of HIV risk and care for Latinas/os/xs. Pandemic-era policies that expanded access to health insurance, telehealth, and social services and harnessed a more robust Spanish-speaking health care workforce should be continued and expanded to end the HIV epidemic for Latinas/os/xs.

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Disclaimer

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