UCLA
UCLA Previously Published Works

Title
Achieving Health Equity and Continuity of Care for Black and Latinx People Living With HIV.

Permalink
https://escholarship.org/uc/item/9725k6mg

Journal
American Journal of Public Health, 113(S2)

ISSN
0090-0036

Authors
Loeb, Tamra Burns
Banks, Devin
Ramm, Kate
et al.

Publication Date
2023-06-01

DOI
10.2105/ajph.2023.307222

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

Achieving Health Equity and Continuity of Care for Black and Latinx People Living With HIV

Tamra Burns Loeb, PhD, Devin Banks, PhD, Kate Ramm, BS, Isabella Viducich, MSW, Quonta Beasley, BA, Juan Barron, BA, Elizabeth Lee Chen, MPH, Enricka Norwood-Scott, Kimberly Fuentes, MSW, Muyu Zhang, MA, MS, Arleen F. Brown, MD, PhD, Gail E. Wyatt, PhD, and Alison B. Hamilton, PhD, MPH

ABOUT THE AUTHORS

Tamra Burns Loeb, Enricka Norwood-Scott, Muyu Zhang, Gail E. Wyatt, and Alison B. Hamilton are with the Department of Psychiatry and Biobehavioral Sciences, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles (UCLA). Gail E. Wyatt and Alison B. Hamilton are also guest editors of this special issue. Devin Banks is with the Department of Psychological Sciences, University of Missouri–St Louis. Kate Ramm is with the Department of Medicine–Endocrinology Division, UCLA Health. Isabella Viducich is with Jennifer Keaney and Associates Inc, Los Angeles. Quonta Beasley is with the Graduate School of Education and Psychology, Pepperdine University, Los Angeles. Juan Barron and Arleen F. Brown are with the Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine, UCLA. Elizabeth Lee Chen is with the Fielding School of Public Health, UCLA. Kimberly Fuentes is with the Luskin School of Public Affairs, UCLA.

The COVID-19 outbreak and public health response have exacerbated racial health inequities, including those related to HIV. Black and Latinx communities are disproportionately impacted by morbidity and mortality associated with the intersecting pandemics of HIV and COVID-19. Structural racism has manifested in race-related social determinants of health (SDOH) that underlie these health inequities.[1]

Black and Latinx people living with HIV (PLWH) are disproportionately exposed to poverty, barriers to health care access, and trauma, all of which increase the risk of substance use and mental health symptoms that interact with SDOH and compromise treatment adherence.[2] In addition, PLWH are more likely to experience medical comorbidities, including cardiovascular disease, the leading cause of mortality in the United States and an independent risk factor for poor COVID-19–related outcomes.[3] As these underlying risk factors increase Black and Latinx PLWH's vulnerability to morbidity related to both HIV and COVID-19, understanding their health strategies during these intersecting health crises could reveal important strength-based approaches for mitigating the impact of SDOH among these populations.

In this editorial, we consider how the care experiences of Black and Latinx PLWH could inform culturally relevant, multilevel strategies for managing public health crises like COVID-19 in the context of structural racism and bolster care for PLWH facing new health threats. We focus on two conditions of the COVID-19 pandemic: (1) disease prevention and management and (2) in-person care disruptions and the rapid uptake of telehealth.

TRANSLATING PUBLIC HEALTH STRATEGIES FOR HIV TO COVID-19

Public health efforts to mitigate COVID-19 risks have relied on behavioral and social change strategies, many stemming from lessons learned from the HIV pandemic.[4] Accordingly, research has called for expansions of investments in HIV infrastructure, policies, and research, as well as the engagement of PLWH communities, to develop effective COVID-19 public health responses.[5] While there are obvious differences between HIV and COVID-19 (e.g., mode of transmission),[5] individual-level mitigation efforts have failed to identify and leverage PLWH's use of patient-centered strategies to minimize COVID-19 risks. This is a missed opportunity.

Identifying attitudes and skills that PLWH may have transferred from their management of HIV to the mitigation of COVID-19 risk could inform prevention efforts aimed at minimizing new public health threats. For example, health care professionals could be empowered to foster self-efficacy among patients living with chronic illness (and, thus, at risk for emerging public health crises) by building on known care strategies and highlighting similarities in risk management approaches across varying health threats. In addition, public health messages for inevitable, emerging health crises could be improved by understanding whether HIV-specific self-management strategies are translatable to manage COVID-19 risks and whether they vary as a function of common health comorbidities and SDOH that affect PLWH.

Like responses to HIV, COVID-19 responses must address race-related inequities in SDOH that confer disease

AJPH Supplement 2, 2023, Vol 113, No. S2

risk and decrease service utilization.[5] While structural-level interventions are necessary to achieve racial health equity, novel patient-centered approaches to navigating inequities should not be overlooked. Among Black and Latinx PLWH specifically, experiences navigating a racialized and chronic health condition like HIV could be translated to other public health crises as they intersect with structural racism. For instance, while living with HIV may have heightened perceptions of COVID-19 risk and engagement in protective health coping strategies for some patients, it may have increased medical mistrust, compromising ongoing HIV self-management and new COVID-19 risk management for others from minoritized racial/ethnic groups.

Approaches like these could be applied not only to health equity interventions for future public health crises but also to those for PLWH. Public health responses could incorporate culturally relevant interventions that empower racialized PLWH to apply their management of previous health and social challenges to new problems. For example, resilience and critical race consciousness have been identified as facilitators of HIV care and predictors of improved immune function among Black PLWH.[6,7]

Interventions incorporating critical consciousness that promote awareness of and adaptive action against structural racism and other forces of oppression may increase self-efficacy and reduce HIV risk behavior and other risks associated with racialized public health crises (e.g., the opioid overdose crisis).[8] Such interventions should be developed in collaboration with Black and Latinx PLWH to ensure their cultural and clinical relevance. These patient-centered strategies are an important component of risk-reduction efforts in the context of enduring race-related SDOH; however, to achieve health equity, the onus remains on institutions and policymakers to dismantle policies that maintain structural inequities perpetuating health disparities.

CONTINUITY OF CARE AND DIGITAL INCLUSION

Continuity of care has been identified by PLWH as an important component of effective treatment.[9] Preventing discontinuity of care is especially important for those living with chronic illness and who experience race-related inequities in access to SDOH as these patients' treatment adherence relies on maintenance of established relationships with trusted providers. COVID-19–related public health mandates forced changes in health service delivery, including clinic closures and scaling back or suspension of non–COVID-19–related health appointments.[2] Restricted in-person contact with providers led to fears of disruptions in patient health care utilization and adherence despite the rapid transition to digital platforms.

Transitioning health services to digital platforms has potential to increase the reach and frequency of care and may reduce concerns about continuity of care for those with chronic health conditions like HIV. However, it may also widen existing health disparities among those who experience digital barriers. Like many with chronic conditions, PLWH made the transition to remote health care during the pandemic. However, inequities in digital inclusion, including health literacy, digital skills, and access to technology, as well as limited English proficiency, greatly restricted the ability of some PLWH to participate in remote monitoring of clinical care and other telehealth services.[2,10] Digital inclusion itself is an SDOH that interacts with others: older, racially/ethnically minoritized, and low-income PLWH are more likely to experience lack of access to technology and low electronic health literacy, which, in turn, threaten continuity of care.[11]

While many Black and Latinx people lack consistent access to digital technology,[10] those that do have computer or smartphone access may not have the needed skills to effectively use their device to access telemedicine or telehealth services; indeed, these populations were less likely to use video platforms than other racial/ethnic groups early in the pandemic.[12] For Latinx PLWH, language barriers may further exacerbate these inequities.[12] Although the challenges and successes of the COVID-19–related growth of telemedicine have been well-documented, understanding the health care experiences of a population that requires consistent multidisciplinary care (i.e., PLWH) during this period could inform ongoing improvements to telemedicine and ensure continuity of care for those who need it most.

This information is particularly important as COVID-19 becomes endemic. Documented inequities in telehealth access as a function of race, socioeconomic status, and language must be addressed at multiple levels to prevent the exacerbation of current inequities in health care access. Provider solutions include offering preappointment sessions that could be scheduled to aid those with difficulties accessing or utilizing technology for telehealth visits and problem-solve barriers.[13]

Patient-related factors associated with the effectiveness of telemedicine must also be identified. For example, some patients report greater satisfaction with telemedicine than in-person appointments, particularly those engaged in behavioral health treatment or facing transportation barriers to treatment.[14] However, without policy solutions to

increase access to and knowledge of digital technology solutions among people who are Black, Latinx, non-English speaking, and living in poverty, members of these groups will continue to be excluded from the benefits of telemedicine and experience discontinuity of care. Given the aforementioned intersectionality of Black and Latinx PLWH, this population is well-positioned to serve as key participants in the development of such solutions.

CONCLUSION

Mitigating public health crises requires multilevel intervention, including policies and programs to address structural inequities and barriers to health care access experienced by vulnerable subpopulations. In addition, patient-centered behavioral strategies can be leveraged to mitigate health risks among those disproportionately impacted by race-related SDOH. By understanding the adaptation of public health strategies for management and continuity of care in HIV, tailored public health messages can be used to lower the risks associated with COVID-19 and other public health crises as they intersect with race-related SDOH.

Because PLWH have an increased risk of future comorbidities and complications associated with COVID-19, the management of their HIV status could be adapted to reduce exposure and risk of COVID-19 and other public health problems. For example, these management strategies have potential translations to harm reduction and drug overdose prevention, which are increasingly and disproportionately affecting Black and Latinx people with and without HIV. In addition, the telemedicine experiences of Black and Latinx PLWH during the COVID-19 pandemic could inform programs and policies that increase digital inclusion and reduce the impact of structural inequities on continuity of care in an increasingly digital health care space.

Given the enduring and pernicious nature of race-related SDOH, the skills and challenges of PLWH in morbidity prevention and care continuity should be better understood with the ultimate goal of improving health equity for Black and Latinx PLWH in the face of current and emergent health threats. AJPH

CORRESPONDENCE

Correspondence should be sent to Tamra Burns Loeb, PhD, UCLA Semel Institute for Neuroscience and Human Behavior, 760 Westwood Plaza, Los Angeles, CA 90024 (e-mail: tloeb@mednet.ucla.edu). Reprints can be ordered at https://ajph.org by clicking the “Reprints” link.

PUBLICATION INFORMATION

Full Citation: Loeb TB, Banks D, Ramm K, et al. Achieving health equity and continuity of care for Black and Latinx people living with HIV. *Am J Public Health*. 2023;113(S2):S107–S109.

Acceptance Date: January 2, 2023.

DOI: https://doi.org/10.2105/AJPH.2023.307222

CONTRIBUTORS

T. B. Loeb, A. F. Brown, A. B. Hamilton, and G. E. Wyatt designed the research. T. B Loeb, D. Banks, K. Ramm, I. Viducich, Q. Beasley, J. Barron, E. L. Chen, E. Norwood-Scott, K. Fuentes, M. Zhang, and A. B. Hamilton collected, analyzed, or interpreted the project data. T. B. Loeb, D. Banks, K. Ramm, A. F. Brown, and A. B. Hamilton wrote or edited the editorial. T. B Loeb and D. Banks provided final revisions.

ACKNOWLEDGMENTS

Funding was provided by the UCLA David Geffen School of Medicine COVID-19 Research Award Program (HE-06); National Heart, Lung, and Blood Institute (U01HL142109, 3U01HL142109-04S3); and American Lung Association COVID-19 and Emerging Viruses Research Award (9230290). A. B. Hamilton is supported by a VA Health Services Research and Development Research Career Scientist Award (RCS 21-135).

CONFLICTS OF INTEREST

The authors are not aware of any conflicts of interest.

REFERENCES

1. Spinner GF. The intersection of HIV, COVID-19 and system racism. *J Health Dispar Res Pract.* 2021;14(2):78–88. Available at: https://digitalscholarship.unlv.edu/jhdrp/vol14/iss2/8. Accessed July 30, 2022
2. Waterfield KC, Shah GH, Etheredge GD, et al. Consequences of COVID-19 crisis for persons with HIV: the impact of social determinants of health. *BMC Public Health.* 2021;21(1):299. https://doi.org/10.1186/s12889-021-10296-9
3. Alonso A, Barnes E, Guest JL, Shah A, Shao IY, Marconi V. HIV infection and incidence of cardiovascular diseases: an analysis of a large healthcare database. *J Am Heart Assoc.* 2019;8(14):e012241. https://doi.org/10.1161/JAHA.119.012241
4. Eaton LA, Kalichman SC. Social and behavioral health responses to COVID-19: lessons learned from four decades of an HIV pandemic. *J Behav Med.* 2020;43(3):341–345. https://doi.org/10.1007/s10865-020-00157-y
5. UNAIDS. HIV and COVID-19: a unique moment in time to learn, leverage and build resilient systems for health. September 9, 2020. Available at: https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/september/20200909_covid_hiv. Accessed July 30, 2022.
6. Geter A, Sutton MY, Hubbard McCree D. Social and structural determinants of HIV treatment and care among Black women living with HIV infection: a systematic review: 2005–2016. *AIDS Care.* 2018;30(4):409–416. https://doi.org/10.1080/09540121.2018.1426827
7. Kelso GA, Cohen MH, Weber KM, Dale SK, Cruise RC, Brody LR. Critical consciousness, racial and gender discrimination, and HIV disease markers in African American women with HIV. *AIDS Behav.* 2014;18(7):1237–1246. https://doi.org/10.1007/s10461-013-0621-y
8. Harper GW, Cherenack EM, Slye N, Jadwin-Cakmak L, Hudgens M. Pilot trial of a critical consciousness-based intervention for Black young gay and bisexual men living with HIV: Mobilizing Our Voices for Empowerment (MOVE). *J Racial Ethn Health Disparities.* 2023;10(1):64–82. https://doi.org/10.1007/s40615-021-01197-z
9. Cooper V, Clatworthy J, Youssef E, et al. Which aspects of health care are most valued by people living with HIV in high-income countries? A systematic review. *BMC Health Serv Res.* 2016;16(1):677. https://doi.org/10.1186/s12913-016-1914-4
10. Loeb TB, Adkins-Jackson P, Brown AF. No internet, no vaccine: How lack of internet access has limited vaccine availability for racial and ethnic minorities. *The Conversation*. February 8, 2021. Available at: https://theconversation.com/no-internet-no-vaccine-how-lack-of-internet-access-has-limited-vaccine-availability-for-racial-and-ethnic-minorities-154063. Accessed August 7, 2022.
11. Rubin R. Internet access as a social determinant of health. *JAMA.* 2021;326(4):298. https://doi.org/10.1001/jama.2021.11733
12. Eberly LA, Kallan MJ, Julien HM, et al. Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. *JAMA Netw Open*. 2020;3(12):e2031640. https://doi.org/10.1001/jamanetworkopen.2020.31640
13. Adepoju OE, Chavez A, Duong K. Telemedicine during the pandemic: leaving the visually impaired and others with disabilities behind? *Health Affairs Forefront*. September 6, 2022. https://doi.org/10.1377/forefront.20220902.944304
14. Ramaswamy A, Yu M, Drangsholt S, et al. Patient satisfaction with telemedicine during the COVID-19 pandemic: retrospective cohort study. *J Med Internet Res.* 2020;22(9):e20786. https://doi.org/10.2196/20786