HIV Integrated Planning Council
Comprehensive Planning Committee
Thursday, May 17, 2018
2-4pm

Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Mark Coleman, Tiffany Dominique, La'Seana Jones, Gerry Keys, Nicole Miller, Joseph Roderick, Gail Thomas, Adam Thompson (*remote*)

Excused: Katelyn Baron, Dave Gana, Pamela Gorman, Peter Houle, Lorrita Wellington

Absent: Dorothy McBride-Wesley

Guests: Jill Beaumont (AACO), Tyrone Smith

Staff: Nicole Johns, Mari Ross-Russell

Call to Order: T. Dominique called the meeting to order at 2:03pm. Those present then introduced themselves.

Approval of Agenda: T. Dominique presented the agenda for approval**.** T. Dominique stated many committee members are not able to be present today and suggested the committee should table to the "Finalize Retention Plan" discussion item. **Motion:** G. Keys moved, G. Thomas seconded to approve the amended agenda. **Motion Passed:** All in favor.

Approval of Minutes: T. Dominique presented the minutes for approval. **Motion:** G. Thomas moved, M. Coleman seconded to approve the minutes. **Motion Passed:** All in favor.

Report of Chair:

- **Committee Meeting Times and Remote Access**

A. Thompson stated the Executive Committee discussed the conference calling and remote participation in their May 2018 meeting. At this time remote participation was left at the discretion of each committee's co-chairs. Also, he wanted to discuss the meeting times of the Comprehensive Planning Committee. He suggested the Comprehensive Planning Committee could meet the same day as the Planning Council. A. Thompson acknowledged the Nominations Committee meets the same day as the Planning Council but he wanted to gauge interest from the committee about moving its meeting day and time. He added it's difficult to attend 3 meetings per month; the Executive, Comprehensive Planning, and the Planning Council. M. Ross-Russell suggested the Executive Committee could meet on the same days as the Comprehensive Planning Committee to alleviate some of the travel required for co-chairs who attended both.

T. Dominique stated the committee could poll its members about their availability and then move the meeting date and time accordingly. G. Keys stated she was able to attend meetings in the morning or afternoon but noted she has regularly scheduled meetings in the morning on some days. G. Keys asked if a survey would be sent to the committee to poll them about preferred meeting times and availability. T. Dominique replied yes, a survey would be sent out.

T. Dominique asked if OHP could train individuals who were not familiar with the Zoom platform

N. Johns replied the OHP could host a brief training on Zoom before or after meeting times for those who are unfamiliar.

The committee discussed settings in which they felt remote access would be appropriate. G. Keys stated remote access should only be used when necessary, the privilege should not be abused. G. Thomas agreed and added that remote access should only be used when a member is outside of the EMA, like A. Thompson is currently. The committee agreed with G. Keys and G. Thomas' recommendations.

T. Dominique asked A. Thompson if the Nominations Committee will review remote access in their next meeting. She asked attendance be part of the discussion, specifically how attendance would be counted for those who use remote access. A. Thompson replied that was correct, they will review those topics in their June meetings.

Report of Staff: N. Johns stated the Integrated HIV/AIDS Planning Technical Assistance Group released their new Ryan White Part A Planning Council Primer. Copies are available in the office or online at www.careacttarget.org.

N. Johns informed the committee 2 parts of the EMA integrated care plan were recognized as exemplary by federal partners. The parts that were recognized were the community engagement and data access and sources sections.

Action Items: None

Discussion Items:

- **Finalize Retention Plan**

Motion: L. Jones moves, G. Keys seconded to table this discussion until more members were present.
Motion Passed: All in favor. Discussion tabled.

- **Racial Inequity**

N. Johns reminded the committee "Racial Inequity" was a "New Business" item on last month's committee agenda. The discussion comes from J. Malloy's public comment within the April HIPC meeting. He suggested the Planning Council and its subcommittee should discuss the racial inequities in healthcare, especially the recent racial bias issues in some of the large ASOs in Philadelphia, as noted in the report by the city's Human Relations Commission.

N. Johns displayed a video[1] about implicit bias and racial inequity in healthcare for the committee. The video was short, around 6 minutes long, and it identified some implicit biases of healthcare providers. Key takeaways from the video:

- Blacks are portrayed as lazy and/or violent in media/culture
- 70% of people have an anti-Black implicit bias
- 70% of physicians have an anti-Black implicit bias
- Humans categorize people immediately, this leads to implicit bias
- Normal human beings are prejudice, humans have been exposed to negative stereotypes that shape their prejudice of other groups

After the video the committee discussed mechanisms to lessen the impact of implicit bias. G. Thomas stated implicit biases often cause people to make generalizations about people. She referenced the opioid crisis; physicians now do not prescribe opioids to patients because of the current epidemic. Those who are

1. Visit https://www.youtube.com/watch?v=3KoTi3LRBXI for video

chronically in pain suffer because of implicit biases in healthcare. She stated she acknowledges the seriousness of the opioid crisis but there is still a use for pain killers in a medical setting.

T. Smith stated often people do not stop and talk about the fact we are all human beings. Implicit bias exists but yet people choose to ignore them. He stated the HIV epidemic wasn't just a black thing or white thing it's a human thing, too often its racially charged. He stated African Americans have a mistrust of the medical system which can explain the disproportionate risk of HIV infection in black MSM. He referenced the Tuskegee Experiment and the negative effects it had on African American's perception of healthcare.

G. Keys stated implicit bias is real, but she does not see it changing. People are set in their ways, and often something major has to happen to change someone's biases. A. Thompson agreed with G. Keys' comment. He stated implicit bias was hard to change but noted there's progress to be made in acceptable behavior. He suggested the committee could focus on making recommendations about acceptable behavior in the clinical setting. He stated not only physicians but patients also have biases of their own. These biases may be about healthcare as a whole, their provider, or something related. The committee needs to focus on how to change people's behavior instead of trying to fight their biases.

G. Thomas stated the people often do what they think and it's an involuntary process. A. Thompson stated everyone is free to think what they want but you can't say or do what you want. The real challenge is trying to get people to act fairly and become aware of their biases.

G. Keys mentioned in clinical settings she observed the differences in treatment between minorities and Caucasians. Often minorities are screened for STDs more frequently than Caucasians when the same set of symptoms are reported.

T. Smith stated implicit bias is rooted from when being unaware. People are often not culturally aware of other nationalities. People should try to understand the view point and cultural framework of others. He noted often doctors are put on a high pedestal in the black community and it is forgotten they are people as well.

M. Ross-Russell agreed with G. Keys and T. Smith's point. She stated implicit bias is real, and she has read many studies that provide evidence that implicit biases exist in healthcare. She shared a personal anecdote about bias and stated biases come from perception. People may not be aware of their perceptions or biases, and in some cases it may be appropriate to let people know when their behavior isn't acceptable. To A. Thompson's point, sometimes uncomfortable conversations need to be had about people's behavior. The healthcare setting is aware there are biases and to combat the issue there have been many cultural competency trainings. These trainings were helpful to some degree but failed to address biases overall. Maybe another training is necessary that focuses on directly addressing biases and perception.

G. Keys mentioned many patients may not address some of the biases they experience out of fear they will not receive the services they need. M. Ross-Russell added there's also a "that's what I deserve feeling" in healthcare. "Clients may accept less if they know the clinic they go to are free clinics."

G. Thomas asked how complaints could be made about physicians. T. Dominique replied often clinics do have a formal complaint process. N. Johns added complaints could also be sent to the Client Services Unit.

T. Dominique summarized the committee's discussion. She stated it seems that the recommendation thus far is try to find trainings that focus on biases and perception. N. Johns stated A. Thompson had a final

comment before he signed off the Zoom platform. A. Thompson asked if the committee is talking about changing people's behavior or changing provider structures. T. Smith stated too often people try to advocate for groups without having input for that group. When HIV was first identified the voices of MSM of color were not used in the planning process. He stated as humans we can advocate for groups but we need everyone at the table.

T. Dominique asked the committee if they wanted to make recommendations about changing biases from an individual view point or a structural one. The committee replied structural. M. Ross-Russell stated she agreed with the structural recommendation. First the committee would need to define what biases are and how to proceed with training going forward. Also, biases would need to be identified, it's difficult to identify a bias if you don't know you're being treated with bias.

G. Thomas stated trainings and techniques have been used in healthcare setting to fight implicit biases. The issue is people may not want to change their mindset. T. Dominique asked if G. Thomas was suggesting using performance measures instead of trainings to hold people accountable. G. Thomas replied yes. M. Ross-Russell stated the PDPH has been conducting "secret shopper" calls to try to measure provider performance. N. Johns agreed with G. Thomas' recommendation. With trainings people may be hyper aware after trainings but may forget about training materials after a short time. For things to stick individuals need to be reminded and held accountable.

T. Smith stated positive feedback was needed in the community. He stated sometimes it would be helpful if people from the affected community could be seen by minority physicians. There's nothing wrong with Caucasian doctors but it would be nice to see a doctor that could relate to you.

N. Johns stated she would convene with A. Thompson and provide him with the rest of the committee's feedback. She stated she would try to find trainings on stigma and also review focus group data on implicit biases.

T. Dominique suggested the committee should reach out to the Human Relations Commission to see if they have a training on implicit biases. If so, the committee should invite them to present to the Planning Council.

M. Ross-Russell added it may be useful if individuals take implicit bias tests so they can become aware of their own biases. With awareness people may be more cognizant of their behavior. N. Johns displayed project implicit, on harvard.edu and recommended the committee take their bias test.

M. Ross-Russell reminded the committee the notice of grant award has not yet been received. If the committee wishes to make instructions to the Recipient that required funding allocations the decisions would need to be made as soon as possible. Once the grant award is received the Planning Council will immediately move forward with the allocations process. N. Johns added the timeline for the committee to submit instructions to the Recipient would need to be submitted by July 2018.

T. Smith asked if there would be funding for CBOs to host the trainings that were discussed in this meeting. M. Ross-Russell stated if this was recommended by the HIPC to the Recipient funding may come from ether the capacity building or quality assurance budget. If there were not enough funds within those budgets then it would be on the budget of the organization.

N. Johns suggested the committee should prioritize this discussion before allocations. The committee will likely have the same agenda for June, and a survey will be sent out via email to poll members about their availability.

Old Business: None

New Business: None

Announcements: T. Dominique announced the Penn Center for AIDS Research Community Advisory Board (CFAR CAB) has opened nominations for the annual Red Ribbon Awards. They will accept nominations until July 15, 2018 for an outstanding policymaker, youth leader, faith leader, researcher, and/or community member doing amazing things in HIV in the Philadelphia EMA

N. Johns announced the HIPC, OHP and the Recipient will be on a panel about community planning at the Prevention Summit. She invited committee members to attend and participate in the panel.

Adjournment: Motion: G. Thomas moved, L. Jones seconded to adjourn the meeting at 3:37 pm. **Motion Passed**: All in favor.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar