HIV Integrated Planning Council
Meeting Minutes of
Thursday, September 12, 2019
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Juan Baez, Michael Cappuccilli, Keith Carter, Mark Coleman, Evette Colon-Street, Lupe Diaz (Co-Chair), Alan Edelstein, David Gana, Gus Grannan, Sharee Heaven (Co-Chair), Peter Houle, Gerry Keys, Brian Langley, Dena Lewis-Salley, Nhakia Outland, Pamela Gorman, Samuel Romero, Terry Smith-Flores, Gloria Taylor, Coleman Terrell, Jacquelyn Whitfield, Steven Zick

Absent: Janielle Bryan, Richard LaBoy, George Matthews, Nicole Miller, Joseph Roderick, Eran Sargent, Zsofia Szep, Gail Thomas, Melvin White

Excused: Katelyn Baron, Janice Horan, La'Seana Jones, Lorett Matus, Jeanette Murdock, Erica Rand, Clint Steib

Guests: Kailah King, Chris Chu (AACO), Ameenah McCann-Woods (AACO), Roberta Gallaway, Sarah Nash, Rob McKenna, Allison Byrd, Tyrell Mann-Barnes, Timothy Benston, Robert Woodhouse, Henry Bennet, Marilyn Martinez

Staff: Briana Morgan, Mari Ross-Russell, Nicole Johns, Sofia Moletteri

Call to Order:

S. Heaven called the meeting to order at 2:07 PM.

Moment of Silence/Introduction:

L. Diaz asked everyone to introduce themselves and share a favorite childhood memory of a motherly figure.

Approval of Agenda:
L. Diaz presented the September 2019 Planning Council meeting agenda for approval. **Motion:** G. Keys moved, P. Gorman seconded to approve the agenda. **Motion passed:** all in favor.

Approval of Minutes (*August 08, 2019*)
L. Diaz presented the August 2019 meeting minutes for approval. **Motion:** J. Whitfield moved, K. Carter seconded to approve the August 2019 meeting minutes. **Motion passed:** all in favor.

T. Smith-Flores said there was a problem with her attendance. L. Diaz established that after the correction to T. Smith-Flores's attendance, the minutes were approved.

Report of Co-Chairs:
C. Terrell reported that AACO received funding for the CDC End the Epidemic (EtE) Plan. He also reported that AACO was currently working on another EtE funding opportunity for care services.

C. Terrell was excited to report on Philadelphia's moment in the spotlight—HRSA filmed a recap of Philadelphia's approach to tackling HIV/Hepatitis C coinfection. B. Morgan played the video—

"Jurisdictional Approach to HIV/Hepatitis C Coinfection HRSA's Ryan White HIV/AIDS Program" on YouTube.[1]

Report of Staff:

—Resource Inventory Reports—
B. Morgan reported on the upgrades to the OHP website. The office included the blog as a subcategory on the OHP website that can be accessed from a tab at the top. B. Morgan mentioned the latest blog post by N. Johns about Health Equity. B. Morgan also reported that the service directory, also known as the resource inventory, has also been updated for more efficient searchability through the 400+ providers. She reminded the group that the service directory also includes non-Ryan White providers. She explained that the service directory can be navigated based on zip code, Medicaid, services, etc.

The website, B. Morgan explained, is now more accessible for mobile use. She suggested, however, that for anything Ryan White related the AACO helpline (1-800-985-2437) would be immensely helpful. K. Carter pointed out that you can also apply to the Planning Council on the website. B. Morgan agreed, explaining that there are many resources on the website such as meeting minutes, EPI profile, bylaws, etc.

N. Johns asked what people should do if they find something missing or incorrect in the service directory. B. Morgan said that even though all information on the website had been verified, organizations change from time to time. To report misinformation, she directed the group to the bottom of the website where it says "contact us" for email or phone call.

Presentation:

—Health Equity (David Saunders)—
D. Saunders introduced himself and explained that the goal for the day was to define health equity (hear it in people's own terms as well), discuss how race impacts HIV and health equity, visualize what success looks like, talk about incorporating Culturally Linguistic Appropriate Services (CLAS), and then review planning considerations.

D. Saunders told the group a bit about his educational and vocational life. Since 2007, he said the office's mission is to provide leadership to promote public awareness of health disparities, advocate for programs to eliminate health disparities, and collaborate with stakeholders to achieve measurable and sustainable improvement in health status of underrepresented populations. He emphasized the extensive amount of stakeholders and organizations involved.

D. Saunders explained that the full Health Equity Report had the entire action plan which aimed to achieve measurable impact by 2030 in health disparities. The goal of the OHE 2030 Action Plan involved the following:

> Providing Commonwealth-wide leadership to advance health equity; formalizing and maintaining community relationships and mutual partnerships to advance health equity across current and emerging communities; investing in the collection, analysis, meaningful use, secure sharing and accessible translation of data to advance health equity; continuously raising awareness of current and emergent health disparities; addressing and remediating structural inequities that have resulted from discriminatory policies and practices; improving living conditions where people

[1] "Jurisdictional Approach to HIV/Hepatitis C Coinfection HRSA's Ryan White HIV/AIDS Program," YouTube video, 5:12, posted by "HRSAtube," August 7, 2019, https://www.youtube.com/watch?v=NvxWP2M9240.

live, learn, work, and play; advancing health equity across sectors; establishing OHE by statute; expanding current health equity initiatives.

He asked everyone from the group to pair up at the tables and talk about how they would personally define health equity. After a bit of discussion, D. Saunders asked for definitions from the committee.

R. Gallaway defined health equity as fair and impartial healthcare regardless of how much money you make, how you look, or who you are. K. King defined health equity as "meeting people where they are at." She said that five dollars in one neighborhood might be a lot wherein another neighborhood it might only be a little. This, she explained, is the difference between equal and equity. Equality would be administering $5 to everyone, and equity would involve taking other factors into consideration for equal opportunity. D. Gana mentioned that accessibility is vital for health equity regarding transportation and where services are provided.

D. Saunders said the CDC defines health equity as everyone having the opportunity to attain their highest level of health. Another prominent definition involved giving everyone the opportunity to "attain his or her full health potential" and ensuring no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." A last definition he thought to be worth mentioning defined health equity as a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.

D. Saunders brought up how R. Gallaway had mentioned healthcare. D. Saunders pointed out that healthcare is a largely important but realistically small portion of health equity. This is because poverty, lack of jobs, poor education, etc. are all reasons for health disparities. They are all interconnected. For example, if someone starts with a bad education because of discrimination, this will likely put them behind in regards to accessing opportunities.

G. Grannan asked D. Saunders to discuss the healthcare system and its capitalist-based roots. G. Grannan expressed concern about health equity and how it may appear to others as an asset ready to be mined. He asked how one could ensure that it remained uncorrupted. D. Saunders recalled the last definition of health equity that he offered the group. He explained that a lot of health equity boils down to power and resources. The key, then, would involve ensuring that those with the power use the money correctly. For example, he continued, funneling money into public education would be an example of using money "correctly."

E. Colon-Street said that she felt the cultural and linguistic part of the health equity were missing from the definitions, because not everybody speaks the same language. There are all types of people, so service providers need to be more diverse in their outreach. D. Saunders said that she is very correct, and though it is not included explicitly in the definition, it is certainly a significant part of health equity.

D. Saunders reiterated how equality and equity are different. Some things need to be done differently for different people, since some people who are disadvantaged may need extra assistance. The problem with this, D. Saunders explained, is that people misunderstand the "need extra" part and think that is money being taken away from them, making the whole topic a bit controversial.

M. Coleman said that there is a huge issue with accessibility for people who are physically disabled, and he said that this is a part of equity and needs to be addressed. D. Saunders agreed. Health disparities, D. Saunders emphasized, are preventable and, just like M. Coleman mentioned, can and should be addressed. R. Gallaway asked him to give another example of a health disparity. D. Saunders explained that more

African American men die from prostate cancer than white men. He said that this is mostly because African American men get diagnosed later. Some men may choose not to seek medical help or simply may not have access to it.

D. Saunders asked the group to brainstorm on underlying causes of disparities. R. Gallaway responded with religion, G. Grannan said law, J. Baez said discrimination against LGBT, K. King said medical bias, E. Colon-Street said stigma, and K. Carter said language barriers.

R. Gallaway explained how some religions do not believe in certain lifestyles or seeing providers/going to the doctors. She voiced her concern around the matter, saying that this also affects others around them, e.g. other children when parents/guardians chose not to vaccinate their own children. She continued to say that sometimes people will pray instead for better health or cured cancer but not visit a doctor. She said this is especially prevalent with mental disability or illness, because in some cases it may be extreme taboo to see a psychologist/psychiatrist.

T. Benston countered, saying that in some ways religion can be helpful. He mentioned some diets for religion that can help with health. Some religion-based diets are mostly plant based—he said the American Diabetes Association is looking into the health benefits of such diets.

K. Carter added that underlying causes of disparities can also be gender-based and can contribute to health disparities in the same way that race does. T. Smith-Flores suggested that women may sometimes be better at keeping their health in check.

G. Grannan pointed out that religion isn't always negatively impactful for healthcare. One example was how circumcision in Jewish culture can have positive effects on people's personal health and possibly a public health impact as well.

D. Saunders asked the committee about how race impacts health. Everyone in the room paired up to discuss the question.

K. King said that different races/cultures define health differently and look at weight differently — foods that people eat, how they eat, in what settings they eat, etc. R. Gallaway explained that generally in African American culture, the larger you are, the more respect you get. She shared her experience of this being a foundation of what is taught for years. D. Saunders said it is cultural, but it is also a personal choice—you choose what you eat to an extent.

D. Saunders offered the idea that some factors may not be of any personal choice, e.g. lack of nearby resources. S. Romero said that genetics does not involve personal choice, an example being sickle cell disease which more heavily affects African American individuals. A. Edelstein agreed, bringing up Tay-Sachs disease, describing it as a recessive gene that heavily affects Jewish communities. M. Martinez mentioned how in some cultures, going to a doctor is not an acceptable way to heal. Instead, it is encouraged that individuals instead go to a healer. She said that throughout Philadelphia, there are many people who will not go a Western medicine doctor. D. Saunders said it was important for healthcare practices to take this into account.

K. Carter said that inherent bias regarding race and different ethnic groups also affects health. D. Saunders agreed and referred to disparities in maternal health for African American women as a prime example of this issue in the United States. D. Saunders mentioned how even medically, African American women are (falsely) seen to be able to endure more pain, and some providers aren't as interested in caring for African American women.

D. Lewis-Salley noted the common occurrence in African American communities where people don't usually trust doctors. D. Saunders agreed, adding that the distrust is not unfounded. T. Benston said that healthcare is often organized around white people, so when people of color go to hospitals and or other healthcare settings, it can feel exclusionary.

D. Saunders asked how health care disparity appears regarding HIV care. A. Edelstein noted that HIV often comes with shame because there is stigma, stereotypes, and bias attached. People don't view HIV in the same way as heart disease or cancer.

M. Coleman said that trauma can be a huge issue in the HIV community. When it is not addressed, it leads to drug use or chronic diseases. D. Saunders agreed and said it can even lead to heart disease and cancer. R. Woodhouse mentioned there was also a lack of empathy as many biases that come into play regarding HIV care.

M. Martinez said that in the Spanish and Caribbean communities, many are not able to miss work. Those who are in those predicaments and also HIV patients are unlikely to link to care because of unaccommodating hours. Another example of culture affecting health, M. Martinez mentioned, is that in some communities outside of the United States, using formula instead of breastfeeding is seen as a sign of wealth. Thus, passing HIV through breastfeeding can be a nonissue. However, in the States, she noted that many of her patients worry and say that not breastfeeding is irregular and might lead to shaming and eventual divulgence of their HIV status.

T. Smith-Flores identified lack of a solid educational foundation is definitely the basis of a lot of health disparities as well—in these scenarios, people may not know what they have access to.

D. Saunders explained that the group would now begin an agree/disagree activity where people had to walk from wall to wall depending on whether they agree or disagree with a statement.

He read the first statement: People's problems are their own doing and responsibility.

K. King disagreed and said that sometimes people make decisions and make choices based off of what they know—if they don't know their options, how can they make a better choice? R. Gallaway agreed and said that some people may have problems, but it is not up to other people to take on the weight of those issues. S. Romero said he disagreed and stated an example: because asbestos is present in public schools, it's his problem because it's "our" problem. K. Carter said that people's "own" problems are not necessarily always their "own" responsibilities, so it's a loaded conversation. Sometimes people's issues are out of their own control.

D. Saunders read the second statement: Obama is proof that the civil right era "fixed" racism.

P. Houle disagreed and mentioned how racism was brought to the forefront based on current events.

D. Saunders mentioned the key takeaways from the discussion around health disparities: (1) historical impediments linger, (2) in order to play "catch up" more focus is needed, (3) everyone deserves the right to be healthy, and (4) prevention is the key. D. Saunders brought up four points that he felt signified success in reducing health disparity. These points involved (1) when others understand the connection between poverty and HIV, (2) when new partners from the "outside" are brought in, (3) when more of those with lived experiences are empowered to help, and (4) when HIV disparities are reduced.

There was not enough time for the last, CLAS portion of his presentation due to other items on the HIPC agenda. He thanked the audience for their time.

Public Comment:

None.

Action Item:

—Research Approval Process—
L. Diaz said this portion would be tabled for the next meeting.

Discussion Item:

—Co-Chair Nominations—
M. Ross-Russell explained that when the Planning Council body integrated and included prevention group, HIPC decided to add additional co-chair seats, one of which was governmental co-chair. It was decided that the co-chair terms would be staggered, where one co-chair held the position for one year and the other for two years. This was so the co-chairs did not have to leave at the same time and cause major disruptions.

M. Ross-Russell announced that S. Heaven's term was up, so the council would have to look into nominating a new or the same co-chair. She identified the co-chair nominations as a thirty day process wherein the council needs 30-day notice before voting. The announcement that went out via email on Tuesday, September 10th, began the 30 day count. She said the council was now taking nominations for the co-chair elections. D. Lewis-Salley asked when the term was officially up—M. Ross-Russell said that at the October 2019 Planning Council, S. Heaven's term would be finished, and the next term would be for two years. D. Lewis-Salley asked whether or not S. Heaven would still be on the council regardless of reelection. S. Heaven said she would still be part of the council no matter the vote.

M. Ross-Russell listed some of the requirements for Planning Council co-chair: they must be a Planning Council member in good standing (attends meetings on a regular basis), they are on a subcommittee, and they must have been a member for at least a year. Mike asked S. Heaven if she had any intention of accepting a nomination for another term. S. Heaven agreed that she would accept if nominated.

P. Houle nominated S. Heaven, and L. Diaz seconded. B. Morgan explained that if a member nominates another member, the nominee must choose whether or not to accept. M. Ross-Russell said that the vote would be held in October, and those who accepted the nomination would be expected to give a short bio.

M. Ross-Russell said nominations should be sent to mari@hivphilly.org.

Committee Reports:

—Executive Committee—
L. Diaz reported that the Executive Committee planned on bringing their discussion around the Research Approval Process to today's HIPC meeting, but it was tabled for the October HIPC meeting instead. L. Diaz reported that the committee also discussed changing the Code of Conduct. B. Morgan recalled how the committee also discussed holding an evening HIPC meeting in spring to see if it would affect attendance. B. Morgan reported how there was also a mention of how people can join by phone for meetings (only applicable for subcommittee meetings). She said that there was some debate on whether or not this could be counted towards attendance. B. Morgan recalled the committee deciding on 1 time every 6 months could count as attending a meeting. A. Edelstein asked about voting via the phone. B. Morgan

said no one can currently vote by phone—to alter this, there would need to be a formal process to change the bylaws.

E. Colon-Street asked about the time for the hypothetical evening meeting. B. Morgan said that it would be 6 PM – 8 PM.

—Finance Committee—
No report.

—Nominations Committee—
M. Cappuccilli reported that Nominations Committee scored 15 applications and agreed to recommend 14, depending on whether or not some tax certifications are cleared.

—Positive Committee—
K. Carter reported on the evening meeting that occurred on Tuesday, September 10th from 6 PM – 8 PM with Dr. Acri and Dr. Moore. The next meeting would be Monday, October 7th, 2 PM –4PM.

—Comprehensive Planning Committee—
N. Johns reported that they would meet Thursday, September 19th, from 2 PM – 4 PM, and she said that the committee is also searching for a co-chair (a position open to anybody on the Planning Council).

—Prevention Committee—
B. Morgan reported that the Prevention Committee talked about access of services for youth. She said C. Steib brought data from a study done with his organization. The study focused on those accessing PrEP, and it was discovered that many people got PrEP after reporting sexual assault in the ER. The committee also discussed the Risk Behavior for Youth to gain insight into prevention for youth.

Old Business:
None.

New Business:
None.

Announcements:

N. Outland announced that she attended her first United States Conference on AIDS. She presented on PrEP and Navigation Services. She said she now had better insight into what is happening outside of Philadelphia. She also mentioned the large amount of patients who have HIV positive infants in Atlanta because of refusal to treat infants. She announced that there were a lot more presenters about women and HIV than she expected. An important topic, she noted, was that there is a disproportionately large amount of white women and men leading the EtE. She said this was also a topic of conversation in some presentations, especially around how women of color can feel more like leaders and empower themselves in healthcare work.

D. Gana announced that he was also at the conference. What he thought was especially significant within the conference was the mention of how southern states are non-Medicaid expanded states. He noted that in Alabama, there are rarely any people who live past 50 years old with HIV.

E. Colon-Street announced that there was going to be a 6th annual Gay Men's Awareness Day on Friday September 27th on Rutgers campus. She said that there was a registration and to talk to her if anyone was interested.

B. Morgan made an announcement for L. Matus who could not attend. L. Matus had wanted the council to be made aware of the new translation services for Congreso.

S. Heaven announced that Philadelphia's EMA and HOPWA are doing an amazing job. She thanked everyone for the good work they are doing as well as those who partnered with C. Terrell for the HRSA video from earlier. S. Heaven reminded everyone how forward their EMA is in the EtE and HIV services as a whole. L. Diaz agreed and said that at UCHAPS, she has come to see how forward the EMA is, even when people are saying that Philadelphia is not doing enough.

Adjournment:
Motion: E. Colon-Street moved to adjourn the meeting, D. Gana seconded. **Motion Passed:** the meeting at 4:18 PM.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- September 12, 2019 HIPC Meeting Agenda
- August 8, 2019 HIPC Meeting Minutes
- Article VI: Code of Conduct
- What is Health Equity – And What Difference Does a Definition Make?
- Infusing Health Equity into Care and Prevention of HIV Slides (*David Saunders*)
- Philadelphia EMA HIPC Description of Open Nominations Process
- Philadelphia EMA HIPC Research Approval Process