MEETING AGENDA

Thursday, September 12, 2019
2:00 p.m. – 4:30 p.m.

- Call to Order
- Welcome and Introductions
- Approval of Agenda
- Approval of Minutes (*August 08, 2019)*
- Report of Co-Chairs
    - Approach to HIV/Hepatitis C Coinfection in HRSA's RWHAP
- Report of Staff
    - Resource Inventory Report
- Presentation: Health Equity *(David Saunders)*
- Public Comment
- Action Item:
    - Research Approval Process
- Discussion Items
    - Co-Chair Nominations
- Committee Reports
    - Executive Committee
    - Finance Committee – *No report*
    - Nominations Committee – *Michael Cappuccilli & Sam Romero*
    - Positive Committee – *Keith Carter & Jeannette Murdock*
    - Comprehensive Planning Committee – *No report*
    - Prevention Committee – *Lorett Matus & Clint Steib*
- Old Business
- New Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next HIV Integrated Planning Council meeting is scheduled for
Thursday, October 10, 2019 from 2:00 – 4:30 p.m. at the
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107

HIV INTEGRATED PLANNING COUNCIL

HIV Integrated Planning Council
Thursday, August 8, 2019
2:00 p.m. – 4:30 pm.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Juan Baez, Michael Cappuccilli, Keith Carter, Mark Coleman, Evette Colon-Street, Lupe Diaz, Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan, La'Seana Jones, Gerry Keys, Dena Lewis-Salley, Nicole Miller, Jeanette Murdock, Nhakia Outland, Joseph Roderick, Eran Sargent, Clint Steib, Gloria Taylor, Coleman Terrell (AACO), Gail Thomas, Jacquelyn Whitfield, Steven Zick.

Excused: Katelyn Baron, Sharee Heaven, Janice Horan, Peter Houle, Lorett Matus, Erica Rand, Samuel Romero.

Absent: Janielle Bryan, Richard LaBoy, Brian Langley, George Matthews, Terry Smith-Flores, Melvin White.

Guests: Sharita Flaherty, Marie Jackson, Ronald Lassiter, Ameenah McCann-Woods (AACO), Marilyn Martinez, Sarah Nash.

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

Call to Order.

L. Diaz called the meeting to order at 2:08p.m.

Welcome and Introductions

L. Diaz welcomed everyone to the meeting and everyone present introduced themselves.

Approval of Agenda

L. Diaz asked for an approval of the agenda. **Motion**: M. Cappuccilli moved, J. Murdock seconded to approve the meeting agenda as presented. Motion passed by general consensus.

Approval of Minutes

L. Diaz asked for an approval of the meeting minutes for July 11, 2019. G. Gannon noted a typo in the "Medical Nutritional Therapy". The correction was noted. **Motion**: J. Whitfield moved, D. Gana seconded to approve the amended minutes. Motion passed by general consensus.

Report of Co-Chairs

L. Diaz announced that the PA Special Pharmaceutical Benefit Program (SPBP) had sent out an email to announce that contraceptives will be paid for by the program. She directed the group to see the updated SPBP formulary to see what contraceptives were covered.

L. Diaz also announced that Nominations Committee wanted people to know that HIPC members can apply for a leave of absence for up to 6 months for work, family or health concerns. M. Cappuccilli asked for clarity for how to request a leave of absence. L. Diaz noted that it can be in writing via email or in person to an OHP staff member.

Report of Staff

M. Ross-Russell announced the PA Office of Health Equity will present at the HIPC's September meeting.

Public Comment

No public comment.

Action Items:

Approval of Allocations Budgets

A. Edelstein directed everyone to the spreadsheets in the handouts. He explained that he would be reviewing the decisions from the three regional allocations meetings. Each region came up with three budgets – level, 5% decrease, 5% increase in funding. Each region had the opportunity to develop directives to the Recipient. He noted that these budgets need to be approved by the Council. He explained that Finance Committee met the previous week to review the allocations plans and the directives to the Recipient and the committee recommended approval as presented.

New Jersey Counties

A. Edelstein started with level funding budget in blue print. The NJ region voted to leave funding consistent with current FY2019 levels, with no changes in percentage allocated to each service category in FY 2020. For the 5% increase budget, he explained all the new funding would go into Medical Transportation and all other categories would remain at level funding amounts. For the 5% decrease budget, he explained the money allocated to Medical Transportation would stay level and all other categories were decreased proportionately. A. Edelstein noted that $111,279 would go to Medical Transportation in the increase scenario. A. Edelstein asked for questions or comments. There were none.

A. Edelstein called for vote on the motion. **Motion**: Finance Committee recommended that the three budgets for the 4 New Jersey Counties to be approved as presented. **Motion passed**: 19 in favor, 0 opposed, and 3 abstentions.

A. Edelstein explained the directive is about Legal and Other Professional Services. He read the directive to the group:

> "Determine which services are currently provided as "other professional services" with special attention given to assessing need and availability of the full range of allowable services within the HRSA service category."

He explained the Recipient (AIDS Activities Coordinating Office – AACO) will research how those services are provided and will report back. No discussion on the motion.

Motion: Finance Committee recommended the directive to the Recipient be approved as presented. Motion passed: 19 in favor, 0 opposed, 4 abstentions.

Philadelphia

A. Edelstein explained that the Recipient started a new method for providing services under Emergency Financial Assistance (EFA)- Pharma – changing from 30-day Rx to 14-day Rx during the current funding year. He further explained by doing this the EMA was meeting the need but also decreasing spending in

this service category, in other words more money was allocated to that service category than was needed so those funds can be re-allocated to another category. He pointed everyone to the level funding category, where $228,500 was moved from EFA- Pharma (in addition to the reallocation in March 2019) to Mental Health, Housing Assistance, DEFA – each with one-third of that total. He continued; the other services will be prorated at current percentages of the total FY2019 level funding. A. Edelstein reminded the group that there were shifts in funding between regions because of changes in the number of people living with HIV between the regions in the EMA. The service category dollars are allocated to each of the three regions by the region's percentage of the EMA's total of people living with HIV/AIDS. These percentages shift slightly from year to year.

A. Edelstein directed the group to the 5% increase budget and noted the funding is proportional increases across all funded service categories – after moving the money from EFA- Pharma and increasing the other three categories as in the level funding budget.

A. Edelstein directed the group to the 5% decrease budget and explained that the plan was to take the decrease from EFA-Pharma to offset some of the decrease, the remaining service categories would be reduced proportionately. D. Lewis-Salley asked about the decrease in EFA- Pharma. M. Ross-Russell noted that drafted budget for the 5% decrease was done without the reallocations the HIPC approved earlier in the year (which is why the EFA-Pharma category had more money that in the other draft budgets presented. A. Edelstein asked why this was done without using the level funding budget as the starting point, because the group that made the decisions was not intending to increase funding in EFA-Pharma. A. Edelstein explained the decrease budget was done on the current year's level funding budget; this does not reflect the reallocation from EFA-Pharma that happened in the beginning of FY 2019. M. Ross-Russell explained the first column reflects FY2019 level funding.

A. Edelstein stated that unless there is opposition, he suggested the 5% decrease budget be amended to be the level funding budget after the reallocations from EFA-Pharma approved at the beginning of FY 2019. B. Morgan explained that the friendly amendment needs to be made and approved.

Motion: D. Lewis-Salley moved to amend the motion to make the 5% decrease budget based on the FY 2019 level-funding budget and take $228,500 from EFA-Pharma to offset the $624,693 decrease, then reduce the remaining funded categories proportionally. A. Edelstein and D. Gana accepted the amendment. **Motion passed**: All in favor 19, 0 opposed, 4 abstentions.

Directive to the Recipient

A. Edelstein presented the directives developed in the Philadelphia regional allocations meeting.

> The Recipient as part of the Client Service Unit intake process should inform clients of the possibility of a "wellness check" should they fall out of care. The wellness check defined here is the follow-up PDPH does when they are notified by a service provided that a client has fallen out of care.

He asked for questions on the directive and there were none.

A. Edelstein read the second directive:

> The Recipient shall assess whether tobacco use prevents patients from receiving Ryan White services, specifically substance use treatment services.

Motion: A. Edelstein called for a vote about wellness check. **Motion passed**: 19 in favor, 0 opposed, 4 abstentions

A. Edelstein asked for a vote about the tobacco use directive. The group discussed the motion to make sure everyone understand. G. Thomas explained that she thought it was wrong to make people stop using tobacco during their recovery. The group agreed with her. L. Diaz explained the point of the directive is find out if that is being done so the HIPC and AACO can make sure it stops. A. Edelstein explained that the EMA only pays for outpatient substance abuse treatment. G. Gannon noted that even in outpatient treatment a client can be in the program for up to 12 hours, so having tobacco use prohibited in the program can cause barriers and harm to clients.

Motion: A. Edelstein called for a vote on the tobacco use directive. **Motion passed**: 19 in favor, 0 opposed, 3 abstentions.

A. Edelstein explained that a directive to the Recipient happened in the previous year, to investigate alternative methods of transportation (ride sharing and otherwise). The HIPC requested an update on that directive from 2018. No vote required for that request.

PA Counties

A. Edelstein noted that the PA counties also had the change in the time period for the Rx for EFA-Pharma as well. In the level funding budget, $108,000 (half of level funding for EFA-Pharma) should be decreased and reallocated as follows: 50% Ambulatory Care, 25% Mental Health, 25% Substance Abuse and the other services would be funded at current percentages.

A. Edelstein explained the 5% increase budget started from the previous level funding budget with proportional increase to all funded services, after the reallocation of EFA-Pharma funds to the three other services.

A. Edelstein explained the 5% decrease budget, $108,000 to be decreased from EFA-Pharma and all other services would be reduced proportionately according to level-funding budget percentages.

M. Coleman asked about access to pharmaceuticals outside of Philadelphia. A. Edelstein explained that this program is only for emergency medications and there are other programs to help people with access to medications outside of this one program. M. Ross-Russell explained that the PA Special Pharmaceutical Benefits Program (SPBP) covers pharmaceuticals and the formulary was robust. She explained that anyone eligible is able to receive them regardless of where they live in the EMA. C. Terrell noted that he wasn't aware of any information that people in suburban counties were not able to access medications. S. Rafferty explained the same program is accessed throughout the EMA by eligible PLWH. A. Edelstein explained that this program is for emergency or to bridge the time between health insurance coverage.

Motion: A. Edelstein called for a vote on the motion to approve all three budgets for the PA Counties as presented. **Motion passed:** 19 in favor, 0 opposed, 4 abstentions.

EMA Wide allocations

A. Edelstein pointed the group to the EMA-wide allocations and explained that those budgets needed to be approved separately because it includes Minority AIDS Initiative (MAI) funds – on the four columns to the right on the EMA-wide spreadsheets. C. Terrell explained that MAI is a special allocation of Ryan White funds for jurisdictions with an epidemic that disproportionately affects minority populations, the EMA focuses on disparities of people who inject drugs because of lower viral suppression and retention rates and minority youth – under ambulatory medical care and medical case management.

A. Edelstein asked for a vote for the EMA allocations which combines all the previously approved regional plans and includes MAI allocations. C. Terrell noted that the Planning Council Support budget is included in Systemwide Allocations – it is taken out of the Grantee Administration cap.

Motion: A. Edelstein called for a vote on the EMA-wide allocations as presented. Motion passed:19 in favor, 0 opposed, 4 abstention.

A. Edelstein recognized the OHP staff for their support of the HIPC throughout the allocations process. He noted that all the changes in the allocations process have been made to help people make better and more informed decisions. It is indicative of how OHP staff approach their work. He also recognized A. McCann-Woods for providing helpful information and being available for each regional meeting. L. Diaz thanked everyone for their hard work and participation in the allocations process.

Discussion Items:

HIPC Code of Conduct

M. Ross-Russell announced that the Executive Committee will be looking at the HIPC code of conduct at its next meeting. OHP staff reviewed the code of conduct in the bylaws and explained that it was really about handling a disruption during a meeting. OHP staff noted that there have been instances of conflicts in recent meetings where the code of conduct as written would not apply. There needs to be a formal code of conduct and how members treat one another. This will be codifying respectful engagement for the HIPC. This may be an individual policy or additions into the bylaws, that will be determined by the Executive Committee. L. Diaz asked if the council will deliberate about them. M. Ross-Russell explained the original code of conduct was written for a specific individual several years ago. It needs to be amended to include behavior of HIPC members. She asked the group if they had anything to offer for the Executive Committee's conversations. There was no discussion.

HIPC meeting times and community participation

M. Ross-Russell explained that changing the meeting times of the HIPC and Committees has come up at previous Executive Committee meetings and they wanted to have more information before making changes. OHP staff collected 60 surveys about community members availability for meetings between the Prevention Summit and Positive Committee – 42% of the participants said they were available on weekday evenings, 25% on weekday afternoon meetings. She explained that the Executive Committee previously discussed holding a quarterly HIPC evening. She noted that the CDC and HRSA project officers were asking about participation of younger adults in the planning process. She noted that some PLWH and other community members work or have other obligations in the afternoons and may not be able to make the HIPC's 2:00pm meetings. She noted that this conversation will also be considered by the Nominations Committee to adjust attendance requirements. She asked the group for questions or comments.

K. Carter noted that Positive Committee has had one evening meeting and will have another on Sept 10th. The June evening meeting had new people attend. J. Baez asked if there is a number goal to "more people". M. Ross-Russell noted that there is not a numerical goal. She noted that the meetings are open to the public but membership representation was something to consider. HRSA noted that men and YMSM are noted disparities in HIPC membership. She explained that the goal would be to increase membership. J. Baez said he supported evening quarterly meeting to increase participation of the most impacted communities. M. Coleman asked what was meant by "community". M. Ross-Russell explained that representation definitions are given to us by the federal agencies. We have an aging epidemic, but the new cases are among younger adults, specifically YMSM of color. She said that the HIPC was recruiting community that represents our epidemic. She elaborated that the HIPC needed representation on the planning council as members, but also needed to be reflective of the community.

A guest asked how HIPC is reaching out to Latino MSM. M. Ross-Russell said that HIPC generally works through providers/HIPC members who are in those communities. E. Colon-Street asked if committee meetings had to be held at the Office of HIV Planning. M. Ross-Russell explained that meetings have been held in other locations in the past. She explained that if it is trying to get community voices then it will be a listening session, town hall or something similar, not necessarily a committee meeting. She elaborated that if the meeting was about council business then they are usually held at the office. C. Terrell observed that the HIPC was assuming hours of the meetings are the barrier, but the HIPC should work on other ways and identifying barriers to participation. He noted that a time change was an experiment to see if that was a significant barrier to more community participation.

K. Carter asked if HIPC could explore remote participation. M. Ross-Russell noted that for committee meetings that works, but for HIPC meetings it would be logistically challenging. N. Outland asked if the community has been asked why people don't participate. She noted that the location might be a barrier. M. Ross-Russell noted that OHP and HIPC do outreach at various conferences, events, support groups, etc. J. Baez offered that the Nominations Committee discussed barriers to participation and retention of members. He explained that members were asked to recruit community members through their own networks and members have to do the work as well to get the word out about HIPC and the activities.

N. Johns noted that requests can be made to her or K. Carter to present about Positive Committee and other ways to participate to any community group or support group in the EMA. K. Carter noted that the cost of transportation is a big barrier to participation and HIPC has to work on ways to get people here when the cost of transportation is the barrier. J. Baez noted that Nominations Committee would love to hear ideas for other ways to recruit or combat barriers and invited members to the discussion at the next committee meeting.

Committee Reports

Executive Committee

L. Diaz is meeting right before Comprehensive Planning Committee the following Thursday.

Finance Committee

No report.

Nominations Committee

M. Cappuccilli reported that last month members who were in violation of attendance were noted and notified of their violation and offered a chance to appeal to Nominations Committee. Some members

appeals were reviewed at the committee's meeting. He explained that at September's meeting the committee would review applications for new members.

Positive Committee

K. Carter announced the next meeting was Monday, August 12th from 12 to 2pm and the September 10th from 6pm to 8pm. The September meeting will cover U=U and Mental health. He asked for anyone interested in attending to RSVP to ensure enough food and transportation reimbursements are ordered.

Comprehensive Planning Committee

No report.

Prevention Committee

C. Steib said that the committee got a report on new diagnosis among PWID, DEXIS, and discussed strategies on engaging youth. The committee's next meeting was August 28th 2:30-4:30.

Old Business

None

New Business

None

Announcements

C. Terrell announced that the PA Department of Health representative Christine Quimby had resigned from her position. He noted that she was big help to the council over the years. He noted that there is still open a position for a program analyst on city jobs' website. It requires HIV experience and Philadelphia residency.

He noted that the Partnership Clinic is not closed, even though Hahnemann is closed.

Adjournment

Motion: D. Lewis-Salley moved, C. Steib seconded to adjourn at 3:42pm. Motion passed by general consensus

Respectfully submitted,

Nicole Johns, OHP staff

Handouts distributed at the meeting:

- Meeting agenda
- Meeting minutes for July 11, 2019
- FY2020 proposed regional and EMA-wide allocations spreadsheets
- OHP meeting calendar

Article VI: Code of Conduct

Section 1. All persons attending any meeting of the Planning Council or one of its committees are entitled to participation as discussed in the bylaws. However, in the event that any person, regardless of Planning Council membership, is called out of order by the Planning Council or Committee Co-Chair/s during a meeting, the following actions shall be taken to restore order to the meeting:

a. First incident: The disruptive person/s is called out of order by the Co-Chair/s.
b. Second incident: The disruptive person/s is put on notice that he/she/they are out of order.
c. Third incident: The Co-Chair/s shall call a five minute recess of the meeting.
d. Fourth incident: The Co-Chair/s shall ask the disruptive person to leave the meeting.

May 2017

What Is Health Equity?

And What Difference Does a Definition Make?

What Is Health Equity? A Definition

For general purposes, health equity can be defined as:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. 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.

The following should be added when the definition is used to guide measurement; without measurement there is no accountability:

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

Introduction

Health equity is a cornerstone of the Robert Wood Johnson Foundation's (RWJF) Culture of Health Action Framework (*www.rwjf.org/en/culture-of-health/2015/11/measuring_what_matte.html*), which aims to achieve a society in which everyone has an equal opportunity to live the healthiest life possible. This summary contains highlights from ***What is Health Equity? And What Difference Does a Definition Make?***,[1] the first in a series of reports on health equity.

This summary and the longer report were developed to stimulate discussion and promote greater consensus about **what health equity means** in practical terms. **The goal is not for everyone to use the same words to define health equity, but to identify crucial elements to guide effective action.** Different definitions may be needed for different audiences. The definition presented here and in the full report meets several criteria, including being concrete enough to have specific action implications, being measurable to ensure accountability, and being conceptually rigorous and consistent with current scientific knowledge.

Definitions can matter. While differences between some definitions may represent stylistic preferences, others can reflect deep divides in values and beliefs that can be used to justify and promote very different policies and practices. Clarity is particularly important in the case of health equity because pursuing equity often involves a long uphill struggle that must strategically engage diverse stakeholders, each with their own agenda. Under those circumstances, if we are unclear about where we are going and why, we can more easily be detoured from a path toward greater equity; our efforts and resources can be co-opted, and we can become lost along the way.

1 The full report includes examples, resources, references to supporting literature, and a discussion of terms that frequently arise in discussions of health equity.

UCSF University of California San Francisco

Robert Wood Johnson Foundation

Equity and disparities

- Health equity and health disparities are closely related to each other.
- Health disparities are differences in health (or in key determinants of health) that adversely affect marginalized or excluded groups.
- Health equity is the principle or value that motivates us to eliminate health disparities.
- Disparities in health and in its key determinants are the metric for assessing progress toward health equity.

Key Concepts[2]

- **Health** means physical and mental health status and well-being, distinguished from health *care*.
- **Opportunities to be healthy** depend on the living and working conditions and other resources that enable people to be as healthy as possible. A group's opportunities to be healthy are measured by assessing the determinants of health—such as income or wealth, education, neighborhood characteristics, social inclusion, and medical care—that they experience. Individual responsibility is important, but too many people lack access to the conditions and resources that are needed to be healthier and to have healthy choices.
- **A fair and just opportunity to be healthy** means that everyone has the opportunity to be as healthy as possible. Being as healthy as possible refers to the highest level of health that reasonably could be within an individual's reach if society makes adequate efforts to provide opportunities.
- **Achieving health equity requires actions to increase opportunities to be as healthy as possible. That requires improving access to the conditions and resources that strongly influence health**—including good jobs with fair pay, high-quality education, safe housing, good physical and social environments, and high-quality health care—***for those who lack access and have worse health.*** While this should ultimately improve everyone's well-being, the focus of action for equity is with those groups who have been excluded or marginalized. A wide array of actions can advance health equity.
- Health equity and health disparities are closely related to each other. **Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities;** health disparities are differences in health or in the key determinants of health (such as education, safe housing, and freedom from discrimination) that adversely affect marginalized or excluded groups. **Disparities in health and in the key determinants of health are how we measure progress toward health equity.**
- **Health equity can be viewed both as a *process*** (the process of reducing disparities in health and its determinants) **and as an *outcome*** (the ultimate goal: the elimination of social disparities in health and its determinants).
- **Progress toward health equity is assessed by measuring how these disparities change over time.** The gaps are closed by special efforts to improve the health of excluded or marginalized groups, not by worsening the health of those who are better off.

2 In addition to examples, resources, and references, the full report defines terms that often arise in discussions of health equity, which may help to clarify these concepts.

- **Excluded or marginalized groups** are those who have often suffered discrimination or been excluded or marginalized from society and the health-promoting resources it has to offer. They have been pushed to society's margins, with inadequate access to key opportunities. They are economically and/or socially disadvantaged. Examples of historically excluded/marginalized or disadvantaged groups include—but are not limited to—people of color; people living in poverty, particularly across generations; religious minorities; people with physical or mental disabilities; LGBTQ persons; and women. Excluded or marginalized groups must be part of planning and implementing actions to achieve greater health equity.

- This list includes many groups and people. To be effective, an organization may choose to focus on selected disadvantaged groups. The depth and extent (multiple vs single disadvantages) of disadvantage faced by a group, and where maximal impact could be achieved are legitimate considerations in choosing where to focus.

- Some individuals in an excluded or marginalized group may escape from some of the disadvantages experienced by most members of that group; these exceptions do not negate the fact that the group as a whole is disadvantaged, in ways that can be measured.

- **Social exclusion, marginalization, discrimination, and disadvantage can be measured,** for example, by indicators of wealth (such as income or accumulated financial assets), influence, and prestige or social acceptance (for example, educational attainment and representation in high executive, political, and professional positions). They also can be measured by well-documented historical evidence of discrimination such as slavery; displacement from ancestral lands; lynching and other hate crimes; denial of voting, marriage, or other rights; and discriminatory practices in housing, bank lending, and criminal justice.

- **A commitment to health equity requires constant monitoring** not only of average levels of health and the resources needed for health in a whole population, but also **routinely comparing how more and less advantaged groups within that population are faring on those indicators.** Average levels of health are important but they can hide large disparities among subgroups of people.

  - Measuring the gaps in health and in opportunities for optimal health is important not only to document progress but also to motivate action and indicate the kinds of actions needed to achieve greater equity.

- **Discrimination is not necessarily conscious, intentional or personal; often it is built into institutional policies and practices** (for example, policing and sentencing practices, bank lending procedures, and school funding depending heavily on local property taxes) that have inequitable effects whether or not any individual now consciously intends to discriminate. This is called *structural* or *institutional* discrimination. (See examples, next page)

What are the Essential Features of an Effort to Achieve Health Equity?

1. It addresses the underlying social inequities in opportunities and resources needed to be healthy—such as good jobs with fair pay, quality education and housing, safe environments and medical care—that contribute to worse health in excluded or marginalized groups of people. This will almost always require cross-sector efforts.

2. Ultimately it should benefit everyone, but it is systematically targeted to produce the greatest health benefit for disadvantaged groups, who are worse off both on health and on opportunities to be healthy.

3. It evaluates its efforts not by measuring average impact on the health of a whole population, but by measuring both (a) change in the selected outcomes among disadvantaged groups and (b) the size of gaps between disadvantaged and advantaged groups. Average impact is important from a public health perspective, but it does not reflect equity.

Examples of institutional or structural discrimination

- Racial residential segregation is an example. Racial segregation is the product of deliberately discriminatory policies enacted in the past. Even though it is no longer legal to discriminate in housing, many people of color continue to be tracked into neighborhoods with limited opportunities for health based on poor quality schools, housing, and services in general; poor employment prospects; and exposure to physical and social health hazards, including social norms and role models that can kill hope. These places lack the resources required for optimal health.

- Voter registration requirements in some states, such as showing a birth certificate, may discriminate against immigrants, who are less likely to have the necessary documentation despite meeting federal voter qualifications.

- Non-violent, first-time criminal offenders who can pay a large fee may qualify for "diversion," resulting in not going to jail and having the offense removed from records. This means that people with low incomes are far more likely to serve jail time and have criminal records than more affluent people who have committed similar or worse offenses.

- Evidence has shown that unconscious bias is strong, widespread and deep-rooted, and could potentially take a heavy toll on health, considering current knowledge of how our bodies respond to stress, particularly chronic stress, leading to chronic diseases.

The full report is available at
www.rwjf.org/WhatIsHealthEquity

It includes:

- A definition of health equity to guide action and research
- Key steps toward health equity
- Principles to guide efforts toward health equity
- Terms that often arise in discussions of health equity
- Examples of advancing health equity
- Resources
- References

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Photos: Page 1—Tyrone Turner; page 2—Janet Jarman and Matt Moyer; page 4—Matt Moyer.

Infusing Health Equity into Care and Prevention of HIV

David Saunders
Director, Office of Health Equity

September 2019

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Goals For Today

- Defining Health Equity
- How Does Race Impact Health Equity
- What Does Success Look Like
- Incorporating CLAS
- Planning Considerations

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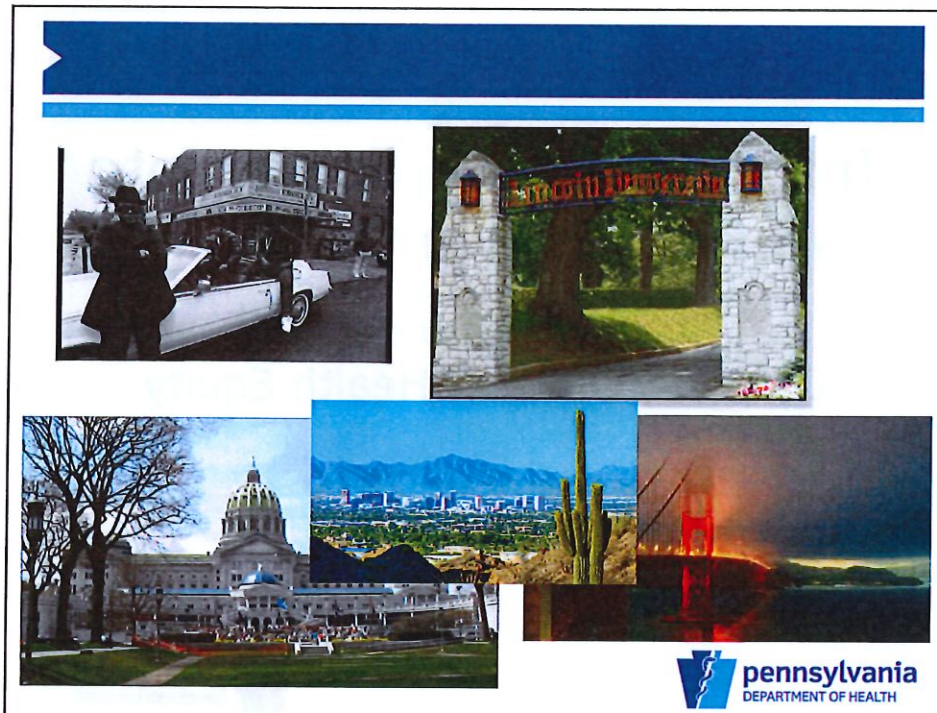

OHE Mission

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

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OHE 2030 Action Plan

- Provide Commonwealth-wide leadership to advance health equity
- Formalize and maintain community relationships and mutual partnerships to advance health equity across current and emerging communities
- Invest in the collection, analysis, meaningful use, secure sharing and accessible translation of data to advance health equity
- Continuously raise awareness of current and emergent health disparities
- Address and remediate structural inequities that have resulted from discriminatory policies and practices
- Improving living conditions where people live, learn, work, and play
- Advance health equity across sectors
- Establish OHE by statute
- Expand current health equity initiatives

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So What Is Health Equity?

- At your table come up with your best definition?
- Don't cheat!

Activity

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Defines health equity as everyone having the opportunity to attain their highest level of health.

CDC

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Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

OMH

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Health equity means that everyone has 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.

WHO

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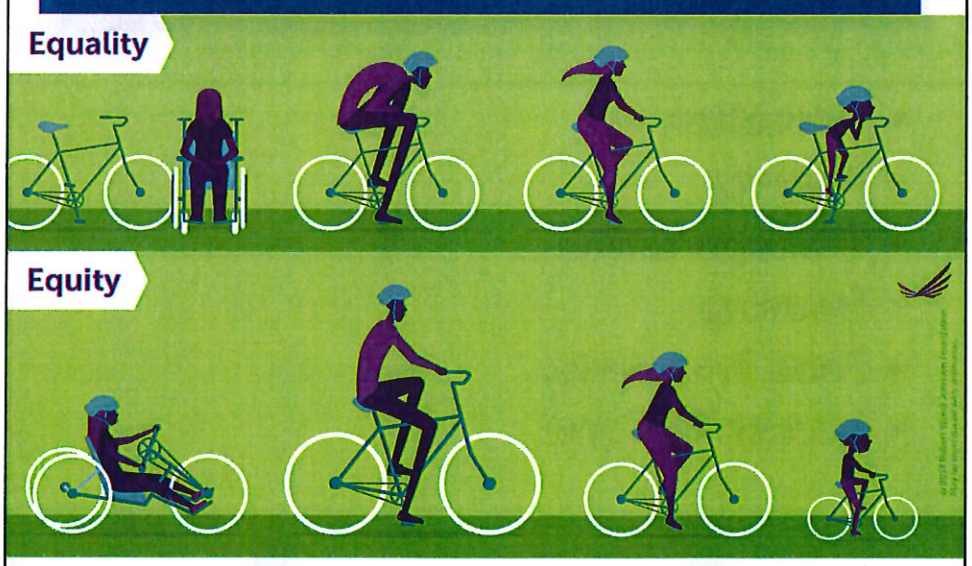

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Health Disparities

- Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

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Underlying Causes of Disparities

- Education
- Poverty
- Transportation
- Housing
- Food Insecurity
- Access To Care

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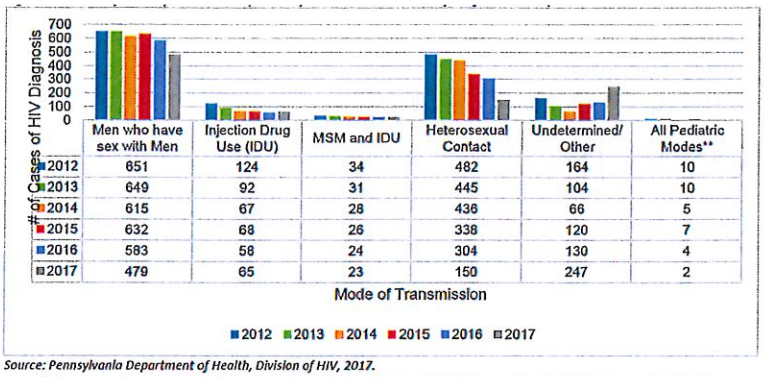
HIV



	Men who have sex with Men	Injection Drug Use (IDU)	MSM and IDU	Heterosexual Contact	Undetermined/ Other	All Pediatric Modes**
2012	651	124	34	482	164	10
2013	649	92	31	445	104	10
2014	615	67	28	436	66	5
2015	632	68	26	338	120	7
2016	583	58	24	304	130	4
2017	479	65	23	150	247	2

Source: Pennsylvania Department of Health, Division of HIV, 2017.

Report Note: Figure does not include the number of coagulation disorder or transfusion received transmissions, as there were zero reported between 2012-2017

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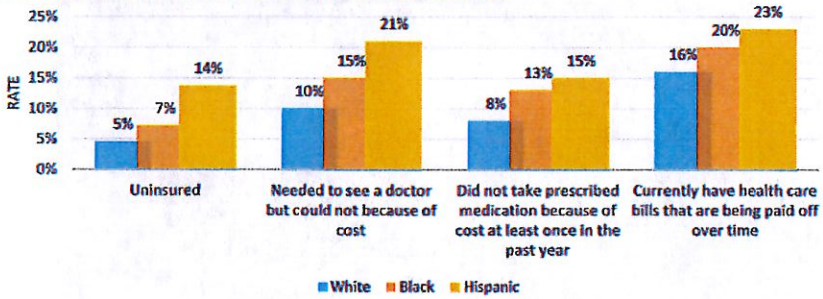
Access to Quality Health Care

Figure 15. Racial Disparities in Ability to Pay for Health Care, Pennsylvania, 2016



Source: Uninsured rates from 2016 American Community Survey[4]; rates for other variables from 2016 Pennsylvania Behavioral Risk Factor Surveillance Survey. Data for other races are unreliable.

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Black White and Brown

- How does ones race impact their health?
- Pair up and discuss
- Report back

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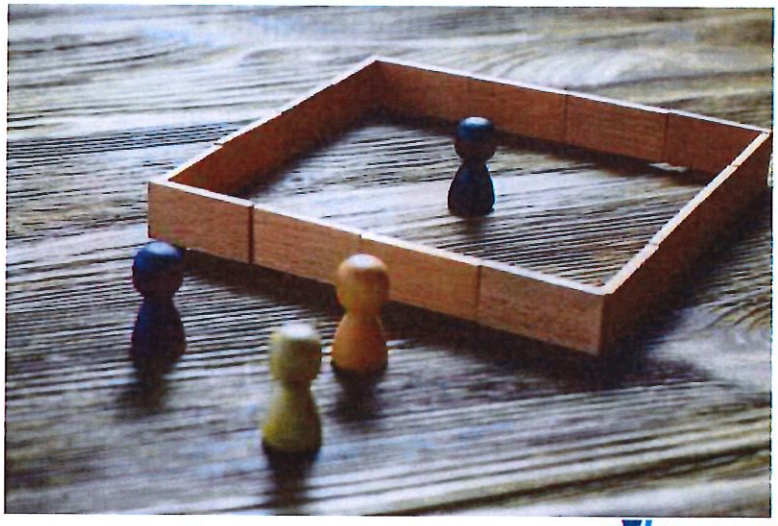

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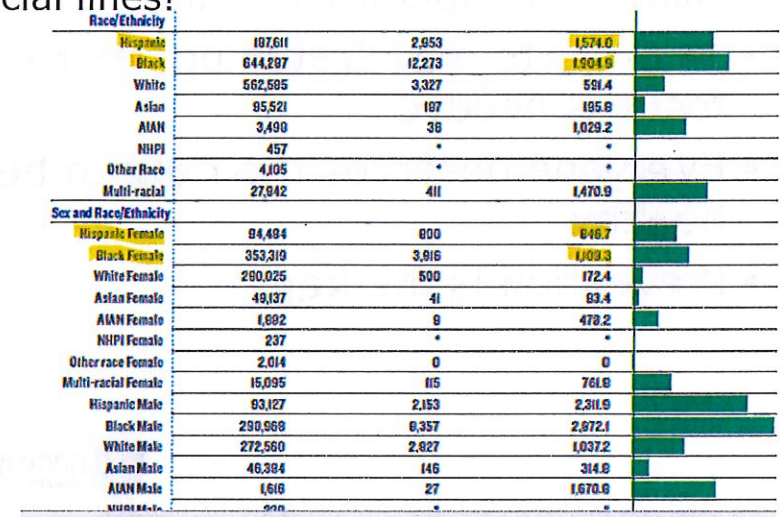
Why does race matter?

- Because HIV Disparities tend do go along racial lines!



Race/Ethnicity			
Hispanic	187,611	2,953	1,574.0
Black	644,287	12,273	1,904.9
White	562,595	3,327	591.4
Asian	95,521	187	195.8
AIAN	3,490	36	1,029.2
NHPI	457	*	*
Other Race	4,105	*	*
Multi-racial	27,942	411	1,470.9
Sex and Race/Ethnicity			
Hispanic Female	94,494	800	846.7
Black Female	353,319	3,916	1,108.3
White Female	280,025	500	172.4
Asian Female	49,137	41	83.4
AIAN Female	1,692	8	473.2
NHPI Female	237	*	*
Other race Female	2,014	0	0
Multi-racial Female	15,095	115	761.9
Hispanic Male	93,127	2,153	2,311.9
Black Male	290,968	8,357	2,872.1
White Male	272,560	2,827	1,037.2
Asian Male	46,384	146	314.8
AIAN Male	1,618	27	1,670.6
NHPI Male	220	*	*

Agree or Disagree

- Peoples problems are their own doing and responsibility
- Obama is proof that the civil rights era "fixed" racism
- Other peoples problems are not mine and do not affect me

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Key Takeaways

- Historical impediments linger
- In order to play "catch up" more focus is needed
- Everyone deserves the right to be healthy
- Prevention is the key

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How Will You Were Successful?

- When others understand the connection between poverty and HIV
- When new partners from the "outside" are brought in
- When more of those with lived experiences are empowered to help
- When HIV disparities are reduced

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Q/A Part 1

Break

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CLAS

Culturally and Linguistically Appropriate Services

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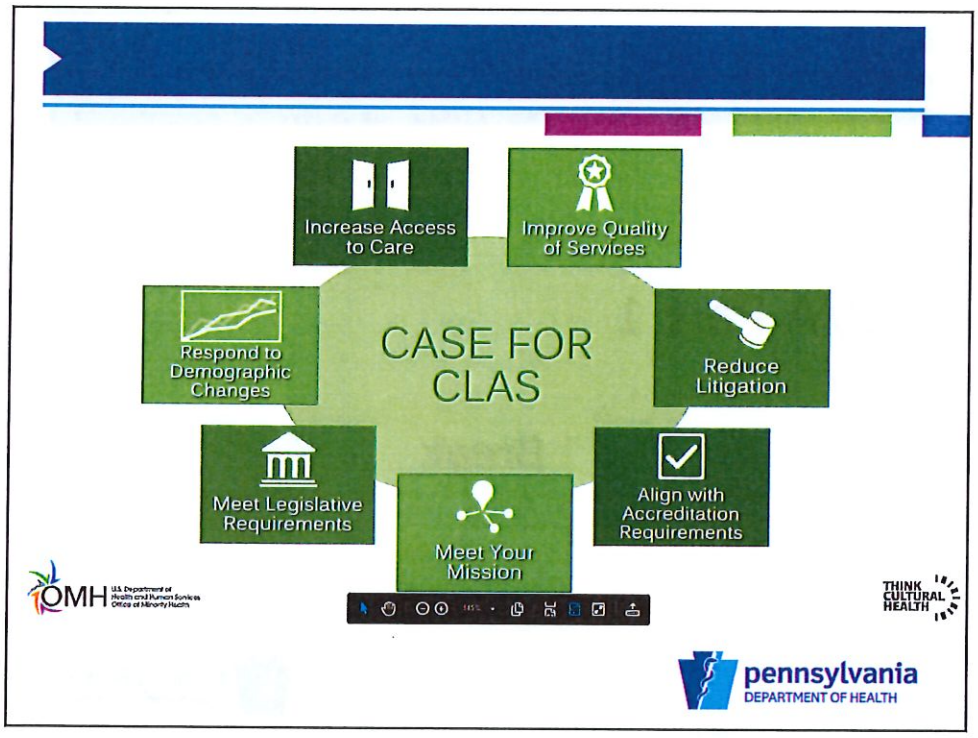
CASE FOR CLAS
Increase Access to Care
Improve Quality of Services
Respond to Demographic Changes
Reduce Litigation
Meet Legislative Requirements
Align with Accreditation Requirements
Meet Your Mission
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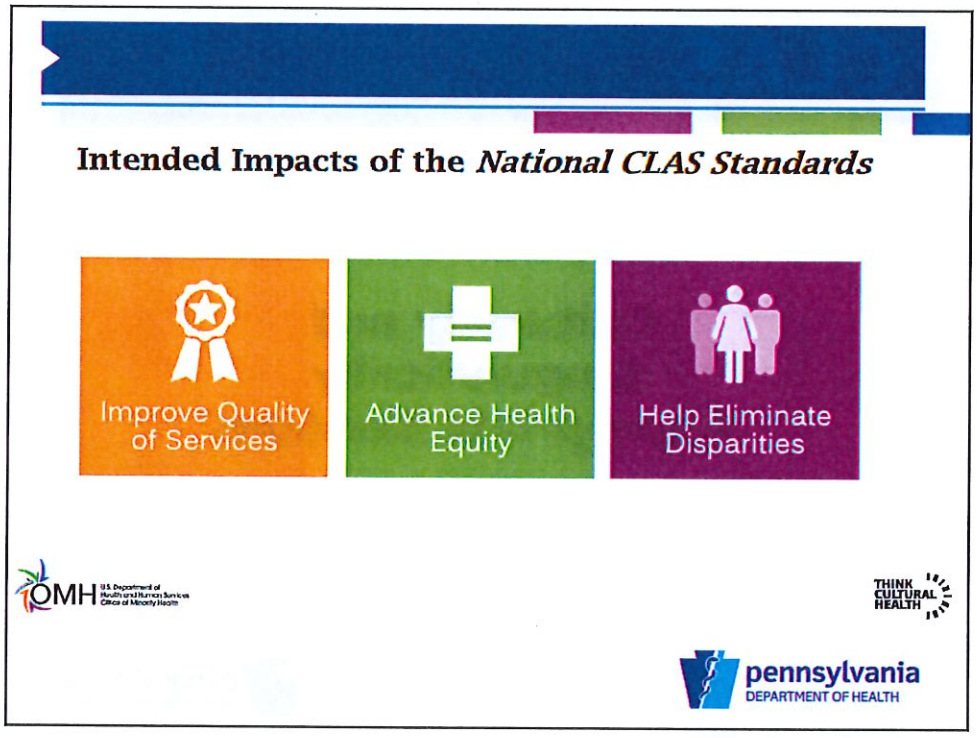
Intended Impacts of the National CLAS Standards
Improve Quality of Services
Advance Health Equity
Help Eliminate Disparities
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Principle Standard

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages health literacy, and other communication needs

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Theme 1

OMH U.S. Department of Health and Human Services Office of Minority Health

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Governance, Leadership, and Workforce

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

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Theme 2

OMH U.S. Department of Health and Human Services Office of Minority Health

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Communication and Language Assistance

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

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Theme 3

OMH U.S. Department of Health and Human Services Office of Minority Health

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Engagement, Continuous Improvement, and Accountability

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

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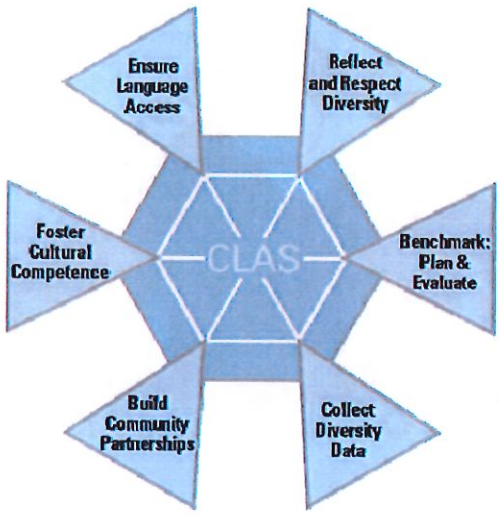
Making CLAS Happen



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CLAS Action Steps

- Break up into 6 groups
- Determine how can each one of the pillars be addressed
- Report back

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Suggestions

- Institute a Health Equity Committee
- Focus on workforce development
- Broaden partnerships (include the community at the table)
- Review internal policies and systems that may negatively effect the health of those you serve

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You have questions

I have answers

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Tools

- National Partnership for Action to End Health Disparities
  - The National Stakeholder Strategy
    - https://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286
- SAMHSA-HRSA Center for Integrated Health Solutions
  - Health Disparities
    - https://www.integration.samhsa.gov/clinical_practice/healthdisparities
- Public Health Institute
  - Guiding Principles for Health Equity and Social Justice
    - https://www.phi.org/resources/?resource=guiding-principles-for-health-equity-and-social-justice
- National Equity Project
  - https://nationalequityproject.org/
- National Institute for Children's Health Quality
  - A Resource to Increase Health Equity and Address Implicit Bias
    - https://www.nichq.org/sites/default/files/resource-file/Implicit%20Bias%20Resource_Final_0.pdf
- Trust for America's Health
  - Racial Healing and Achieving Health Equity in the United States
    - https://www.tfah.org/wp-content/uploads/2018/02/TFAH-2018-HealthEquityBrief.pdf

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Tools

- Association of State and Territorial Health Officials
  - Foundational Practices of Health Equity
    - http://www.astho.org/Health-Equity/Foundational-Practices-for-Health-Equity/
- Race Forward
  - Ready for Equity Toolkit
    - https://www.raceforward.org/practice/tools/workforce-development-racial-equity-readiness-assessment
  - Local and Regional Government Alliance of Race & Equity: Racial Equity Core Teams
    - https://www.racialequityalliance.org/wp-content/uploads/2018/11/RaceForward_CORETeamsToolkit-10.2018.pdf
- deBeaumont Foundation
  - Building Skills for a More Strategic Health Workforce: A Call to Action
    - https://www.debeaumont.org/news/2017/building-skills-for-a-more-strategic-health-workforce-a-call-to-action/
- The National Academies of Sciences, Engineering Medicine
  - Communities in Action: Pathways to Health Equity
    - http://nationalacademies.org/hmd/Reports/2017/communities-in-action-pathways-to-health-equity.aspx
  - Exploring Equity in Multisector Community Health Partnerships
    - https://www.nap.edu/read/24786/chapter/1

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Philadelphia EMA HIV Integrated Planning Council

Description of Open Nominations Process

Revised 8 May 2003 (updated April 2018)

The following steps shall be utilized to solicit, review, recommend, and appoint new members to the Philadelphia EMA HIV Integrated Planning Council. It is expected that this process will be utilized at least annually.

Step One. Solicitation of Members

The Office of HIV Planning advertises the availability of seats on the Planning Council through local media outlets and through distribution of applications at places where interested parties, particularly consumers, are likely to have access to them. The application shall include open-ended questions, an HIV disclosure form (for those applying for relevant seats), and conflict of interest information (including the Council's policy and disclosure form).

Step Two. Application Review

The Planning Council's Nominations Committee solicits members for and appoints an application review panel from among members of the Planning Council in good standing. The panel shall be comprised of no fewer than six members and shall reflect the demographics of the epidemic locally. At least 50% of the panel members must be HIV-positive. *The review panel shall recommend applicants for membership twice during the planning cycle, once in the spring and once in the fall period.* Utilizing objective criteria, each panel member completes an independent review of each *blinded* application reflecting whether or not an applicant should be appointed to the Planning Council. The review panel members evaluate each of the applicant's responses on the application separately, utilizing the following criteria:

Understanding of the Planning Council
Skills/Experiences of the Applicant Relative to HIV Care
Representational Needs of the Planning Council
Applicant's Clarity regarding their contribution to the Planning Council

Each panel member then scores each of the applicant's responses based upon the following range:

4=Clearly fulfills this criteria.
3=May fulfill this criteria.
2=May not fulfill this criteria.
1=Clearly does not fulfill this criteria.

The panel shall also consider the list of categorical seats that are to be filled, paying attention to demographics of the epidemic locally. The panel may consider additional documentation including, but not limited to, meeting attendance records for applicants seeking appointment for an additional term. Each panel member submits his or her ratings to the Office of HIV Planning staff. The staff tabulates results and develops a score sheet showing each reviewer's ratings for each applicant along with a cumulative rating for each applicant. The staff convenes a meeting of the review panel to discuss the applications and ratings. In assembling its recommendations for membership, the panel shall also consider the list of categorical seats that are to be filled, paying attention to demographics of the epidemic locally, as well as the applicants' cumulative rating.

The list of candidates, along with the group's overall rating for each, is then sent to the CEO (Chief Executive Officer for the Part A grant award) or the CEO's designee for consideration. The review panel may make additional recommendations to the CEO (such as a recommendation for representation by geographic area, recommending candidates for specific seats, etc.). This application review step may require more than one meeting of the review panel. If a member of the panel is applying for membership, s/he shall not review his/her own application nor be present during discussion of his/her candidacy.

Step Three. Review and Appointment by CEO or CEO's Designee

The CEO or designee reviews the panel's recommendations and, after full consideration, makes all appointment decisions. Each applicant is notified as to whether or not s/he is appointed and for what term length. Candidates not selected for appointment remain in the applicant pool for future consideration.

Step Four. Filling Vacancies

The CEO or designee fills vacancies from among candidates whose applications have been reviewed by the Council's review panel. If a vacancy arises for which there are few qualified applicants, the review panel may solicit additional applications for review and recommendation to the CEO or designee, utilizing the process described above. Applications may be submitted throughout the year; the application review panel may be convened as needed to review these applications so that candidates may be considered when filling vacancies.

Guidance and Considerations for Membership & Recommendation

- *Membership on the Planning Council shall not exceed more than two members of the same affiliation. The review panel shall consider applicants' affiliation(s) as an additional guidance of the nomination*

process, if there are more than one applicant and/or member of the same affiliation. (Spring 2007)

- *Determination of applicants' area of representation: determination is based on whether the applicant represents their place of employment/the work that they do/their area of interest or as an individual. (April 2008)*

- *Sub-committee attendance policy (Article VI, Section 5): individuals who are in violation of the attendance policy will be removed from Planning Council. The Nominations Committee shall oversee and track the sub-committee attendance record noting members' attendance status and forwarding the notation to the respective sub-committee for further action. Co-chairs of the respective sub-committee will determine the individual's participation/contribution level and take appropriate action(s), with the removal of member carried out by the Nominations Committee. (May 2008)*

- *The committee shall recommend applicants for membership to the CEO or designee for official appointment of membership, understanding that the CEO or designee may or may not appoint all recommended applicants. During this process, recommended applicants shall attend an orientation and at least one scheduled RWPC meeting prior to their official appointment process. (February 2009)*

- *The committee may have a separate membership waiting list for unaligned consumers and others (i.e. providers). The waiting list would place qualified applicant(s) on "hold" until vacancy is available on the Planning Council. Applicants on hold will need to have attended meetings prior. (April 2009)*

- *Any resignation from members shall be reported to the Nominations Committee for formal documentation. (March 2010)*

- *Based on the attendance policy, members in violation will be removed. However, they will be given an opportunity to schedule an appeal in front of the Nominations Committee. The committee will require members who qualify for the appeal to commit and attend the next consecutive 5 council and sub-committee meetings in order to re-instate their membership (if the appeal is approved). (December 2017)*

Philadelphia EMA HIV Integrated Planning Council

Research Approval Process

August 2019

Purpose. On occasion, researchers may request the participation of the Planning Council when conducting their projects. This participation may include presentations to the Planning Council, soliciting feedback from the Planning Council, approval of letters of acknowledgement, or other tasks that involve the Planning Council as a whole.

Basic Criteria for Research Projects. Any research projects must meet current standards for research. The Planning Council may only participate in research projects that fit with the purpose and availability of the Planning Council. The Planning Council will not participate in any research projects that interfere with their ability to uphold their regular responsibilities. Preference is given to local research projects.

Process for Obtaining Planning Council Participation in Research Projects. OHP staff will review all requests to ensure they meet the minimum criteria. Any research project that does not meet the minimum criteria will be declined. Once it is determined that a project meets the minimum criteria, it will move on to the Planning Council. It is preferable for researchers seeking support to attend a Planning Council meeting, present on the research project, and allow the Planning Council to vote on their participation. However, in some rare instances, a decision may be required before the next meeting of the Planning Council. In these instances, the Planning Council Co-Chairs will meet to make a decision on behalf of the Planning Council. At the next regular meeting of the Planning Council, the Planning Council will vote on whether to confirm or override the decision made by the Co-Chairs.