HIV Integrated Planning Council
Meeting Minutes of
Thursday, January 09, 2020
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Daniel Angelis, Susan Arrighy, Juan Baez, Keith Carter, Mark Coleman, Lupe Diaz (Co-Chair), Alan Edelstein, Roberta Gallaway, David Gana, Pamela Gorman, Gus Grannan, Sharee Heaven (Co-Chair), Janice Horan, Kailah King-Collins, Brian Langley, Dena Lewis-Salley, Tyrell Mann-Barnes, Dr. Marilyn Martinez, Kenya Moussa, Sarah Nash, Nhakia Outland, Erica Rand, Clint Steib, Gloria Taylor, Terrell Coleman (Co-Chair)

Absent: Timothy Benston, Sade Benton, Janielle Bryan, Evette Colon-Street, Richard LaBoy, Jeanette Murdock, Joseph Roderick, Szep Zsofia, Steven Zick

Excused: Katelyn Baron, Allison Byrd, Michael Cappuccilli, Sharona Clarke, Peter Houle, Gerry Keys, Lorett Matus, Samuel Romero, Gail Thomas, Jacquelyn Whitfield

Guests: Chris Chuu (AACO), Ameenah McCann-Woods (AACO), Desiree Surplus, George Wilson, Shoma Chisom, Elise Borgese, Terry Smith-Sanchez, Viviann Schorle, Kathleen Obrien, Debra D'Alessandro, Michael Batos, Renee Cirillo, Blake Rowley

Call to Order:
L. Diaz called the meeting to order at 2:10 PM.

Introduction:
L. Diaz asked for everyone to introduce themselves with their name, area of representation, and favorite part of the cake.

Approval of Agenda:
L. Diaz presented the January 2020 Planning Council agenda for approval. **Motion:** K. Carter motioned, D. Gana seconded to approve the agenda with amendment. **Motion passed:** all in favor.

Approval of Minutes (*December 12, 2019*)
L. Diaz presented the December 2019 meeting minutes for approval. K. Moussa proposed an amendment to change her listed absence to excused. **Motion:** K. Carter motioned, A. Edelstein seconded to approve the December 2019 meeting minutes with the proposed amendment. **Motion passed:** 20 in favor, 0 opposed, 3 abstentions.

Report of Co-Chairs:
S. Heaven reported that the March 12, 2020 Planning Council meeting would take place in the evening from 6 PM – 8 PM. This was the regular date (second Thursday of the month) moved to a later time. The purpose of the evening meeting was to see if it positively impacted attendance.

Report of Staff:
N. Johns reported that there would be a webinar on January 28th about resource allocation and would feature a presentation from M. Ross-Russell about the Philadelphia EMA's regional reallocation

process. The webinar would be on TargetHIV.org which also had informational resources for Planning Council members and recipients. The webinar could also be accessed after the 28th in the website archive. N. Johns recommended registering for the webinar to receive all needed information.

She then reported on the January 23rd webinar about consumer participation in the Planning Council through the Planning CHATT website. The webinar would spotlight Atlanta and San Francisco EMAs to discuss strategies for including and amplifying community voices. N. Johns said the office would share both webinars with the council via email.

D. Law reported that Planning Council members are required to join at least one subcommittee. Everyone must sign up for a subcommittee by informing S. Moletteri. Whoever did not sign up for a subcommittee would receive a personalized email to sign up. She reported that spring 2020 membership applications were also being accepted.

Public Comment:
None.

Presentations:
—Social Determinants of Health (OHP)—
N. Johns explained that she was invited to present the following information to Temple Undergraduate students in a week-long class about HIV and thought it would be an appropriate presentation for HIPC as well. The class was engaged and had already watched videos from the 80s and 90s about ACT UP and other local activism to Philadelphia. Her presentation focused less on data and more on definitions and theories. She noted that K. Brady would share data at the February 2020 HIPC meeting. N. Johns described her presentation as context for next month's data.

N. Johns described social determinants as the conditions in which people work, learn, and play. As planners, it is necessary to recognize what people need to live healthy lives and how those needs are not always medical. She noted how there are great systems in place for people to get access to care and services, yet there are still barriers to engagement with such services.

N. Johns defined social determinants as the conditions in the places where people live, learn, work, and play and how they affect a wide range of health risks and outcomes.

She directed attention to the Kaiser Family Foundation Chart. She noted that the chart broke Social Determinants into categories: Economic Stability (employment, income expenses, debt, medical bills, support), Neighborhood and Physical Environment (housing, transportation, safety, parks, playgrounds, walkability, zip code/geography), Education (literacy, language, early childhood education, vocational training, higher education) Food (hunger, access to healthy options), Community and Social Context (social integration, support systems, community engagement, discrimination, stress), and Health Care System (health coverage, provider availability, provider linguistic and cultural competency, quality of care).

N. Johns emphasized the social contexts portion of the chart, explaining that people are meant to be connected with each other and how isolation can have negative effects, including health and wellbeing.

N. Johns pointed to the diagram from the Institute for Clinical Systems Improvement. She explained that 40% of social determinants are out of a person's control and 10% is environment, both of which can be traced back to zip code. Only 30% is health behaviors but is often the main focus in discussions about health and wellness, and 20% is health care. M. Coleman asked if 30% included behavioral and mental health/support groups. N. Johns responded yes, since behavioral health falls under socioeconomic factors and social support. However, it could also overlap with health behaviors such as drug use, smoking, wearing seatbelts, hydration, etc. C. Terrell noted that 30% is where there are the most concentrated efforts, but it is not the majority of what determines a person's health. He expressed the importance of acknowledging the system in which we live and addressing how it presents barriers.

N. Johns said that association between health and socioeconomic status is causal. For example, a person in poverty may not have access to resources which is a cause for ill health. It is often overlooked that the privilege of economic benefits leads to better health.

N. Johns read the slide about how neighborhood affects health: refer to slide "Our neighborhood affects our health" for more information. She explained that there is a vast difference between neighborhoods that are only separated by a few blocks in Philadelphia. If someone is in a neighborhood where they do not feel safe, that may limit their mobility and how they access services or do other things that they do not view as necessary. She added that physical inaccessibility can do the same—e.g. if someone uses a wheelchair yet the sidewalks are unwalkable. There is also a sense of fatalism that occurs when existing in an environment that does not have many resources. Such environments cause stress make people feel lost to a pattern they are unable to change, often causing people to turn to harmful coping mechanisms. G. Wilson added that people often become a product of their environment and repeat unhealthful behaviors.

N. Johns read the slide about poverty: refer to slide "Poverty – coping and HIV risk" for more information. There is a lot of energy and emotional bandwidth exerted when facing poverty which may lead to harmful coping mechanisms. G. Grannan commented on how poverty is often expensive. N. Johns agreed, explaining that buying in bulk may end up being cheaper, but those living in poverty may not have enough money all at once or ability to transport large goods. K. Obrien added that poverty is recursive, especially if there are loans involved.

N. Johns noted how rising rents and lack of public resources are growing concerns for everyone, not just PLWH (people living with HIV). There are many individuals in housing that are constantly fearful of any circumstances that may cause them to lose their housing. Even if people own their homes, increase in property taxes can push people out.

N. Johns read a quote from Dr. Tukufu Zuberi:

> "It is not a question of how a person's race causes disadvantage and discrimination. The real issue is the way society responds to an individual's racial identification. Racial identity is not about an individual's skin color. Race is about the individual's relationship to other people within the society."

N. Johns said that regarding racial segregation and discrimination, Philadelphia is the most segregated big city in the United States.

N. John reiterated the negative health impact of stress, especially stress related to racial discrimination. The correlation between racial discrimination related stress and risk behaviors was identified in a study involving straight, Black men and the definitions of every day racism (e.g. crossing the street, being followed around in stores). HIV is concentrated in poor and Black communities, and mass incarceration affects poor people of color, especially Black men, the most. Mass incarceration removes people from their communities. K. Carter noted that removal breaks up families, and B. Langley added that it adds stress to the community as a whole. S. Arrighy added that it is expensive to be incarcerated.

N. Johns said that those returning home from incarceration are often vulnerable to being lost to care and facing reincarceration. There is also medical mistrust within minority communities, causing many myths around HIV and HIV treatment *because* of history rooted in discrimination.

In addition to other social discrimination and marginalization, N. Johns listed HIV stigmas: racism, sexism, heteronormativity, sex negativity, classism, transphobia, and criminalization. K. King-Collins listed ageism as a prominent stigma as well for youth and seniors. D. Angelis acknowledged the stigma of sanism. He explained that therapists' cultural backgrounds most often do not match the backgrounds of the people they are serving. This causes miscommunication due to a lack of understanding.

N. Outland commented on how clients and therapists sometimes make assumptions with each other which can make connection difficult. Sometimes, a therapists' practices do not align with the client, so there is a need to help the client identify a helpful and appropriate practice. D. Angelis said there is still a need for more therapists with perspective and positivity. M. Batos agreed that many people doing clinical work are disconnected from the community they are serving. He noted the importance of education encouraging people early on to pursue fields in their own neighborhoods or communities. K. King-Collins added that lack of access prevents people from staying in their communities, because those who get access to higher education or therapy may decide to "get out" instead. M. Martinez suggested bringing different age groups together to forge strong connections—it might be an effective way to address disparities. Such connections could be forged through shadowing, volunteer work, etc.

K. Carter stated that all humans bring their own inherent bias. He questioned what strategies would work best to get people to acknowledge and worth through their biases. K. King-Collins agreed that biases can be dependent on the time and place of your environment and mentioned that there are different levels of bias. She added that providers often have such biases and makes assumptions of patients' needs before even talking to the patient. R. Gallaway said that people who are expressing bias in an overtly negative fashion may be projecting, in that they are truly expressing "self-biases." This happens because those with the self-bias make the assumption that people also hold that bias against them.

K. King-Collins identified the length of federal HIV initiatives as an issue. Public health initiatives should be sustained for 5-10 years, not 2-3 years. If the initiatives took place over longer periods of time, it could turn into a more generational initiatives and allow for sustainability. They need more time to run their course. T. Mann-Barnes agreed that if the system is not built to fund or support certain populations, even good programs will not sustain. Therefore, it is often a systemic issue of not addressing social determinants and prioritizing programs/communities that puts a halt to attempts for sustainable action.

M. Martinez suggested bringing more stakeholders within meetings to ensure diversity and representation. K. Carter emphasized the importance of looking into HIV activism's history. He felt it was important to make sure POC were lobbying and focusing on inclusivity to bind themselves together.

Regarding generational gaps, K. King-Collins noted how there is a disconnect between older PLWH and those who are newly diagnosed. Newly diagnosed PLWH could benefit from connecting with PLWH long term. It could allow them to feel more powerful and promote change. S. Arrighy added that such a connection could also get people into care more quickly.

D. Angelis said that education and providing resources will allow patients to have the same information as their therapists, effectively helping people improve their mental health. He added that bringing a friend to HIPC meetings and personally sharing information is also important. K. Carter said that it is sometimes up to the patients as well to educate themselves. K. Moussa added that people have to be willing to learn, so there need to be support systems in place to assist with learning.

P. Gorman pointed out that education is important for sustainability of any plans and initiatives. She mentioned how patients often report knowledge of resources despite the fact that patients may have lapse in medication and miss transportation. She felt that providers needed to listen to clients to find opportunities for sustainability. G. Grannan said that education can be an excellent tool, but policy change is what ensures sustainability and understanding for the communities being served.

C. Steib said that policy needs to reflect the social determinants of health as well as acknowledge any possible consequences. For example, HIV testing used to be targeted testing before it was routine. He recalled that a white, young man continually came through his ER with no HIV tests whatsoever due to the targeted testing policy. When the policy changed, he was tested with a positive result. D. D'Alessandro said identifying effective policy is important, but there are also issues with the economic sustainability aspects. She added that it's important to identify solutions by bringing people into community planning, as well as sharing results of community studies *with* the community.

B. Morgan highlighted the importance of bringing friends and colleagues to the March 2020 evening meeting for HIPC so people can get more involved with their community. D. D'Alessandro asked if the office would provide dinner. K. Carter responded that they would.

Discussion Item:

—Ending the HIV Epidemic (EHE)—

C. Terrell reported that the EHE draft plan was completed and submitted on December 30th, 2019, to the CDC. He reported that they would share the draft plan with the Planning Council members for feedback and that J. Williams would be working on engaging the community. He said there would also be an EHE discussion at the January 16, 2020 Comprehensive Planning Committee meeting.

J. Williams said that the infection rate in Philly had been declining for ten years, but there was still a lot of work to do within certain populations. He reported that New York announced they would end the HIV epidemic in the timespan of 12 months to 2 years. C. Steib invited J. Williams to St. Christopher's to talk to the team, and J. Williams reminded HIPC that he was interested in engaging with as many stakeholders as possible.

Committee Reports:

—Executive Committee—
None.

—Finance Committee—
None.

—Nominations Committee—
S. Heaven reported that the Nominations Committee was accepting applications for spring 2020 membership. The committee would do a presentation at the March 2020 HIPC evening meeting. She reported that the committee also discussed review of applications and the issue with the clearances act as a barrier. C. Terrell responded that HIPC members were appointed by the mayor, and HIPC must abide by the policy in place for mayoral appointments. S. Heaven said the committee takes clearances as a barrier into consideration, but they cannot currently change the policy though they are looking into making the process easier.

B. Morgan noted the reoccurance of this issue—people often forget they need to complete the clearances, they do not feel comfortable entering personal information, they have trouble with the form itself, those from the suburbs do not think they have to fill it out, etc.. M. Batos asked if it was possible to apply to the council if the applicant does not work at an agency. N. Johns said that HIPC is open to anyone who is interested and has relevant experience. L. Diaz said that members do not represent agencies, they represent the community. N. Johns added that the HIPC application takes about 15 minutes on average.

C. Terrell said that the RW Project Officer and CDC Project Officer had taken note of representation issues within the planning body, so recruitment of diverse communities is needed.

S. Heaven reminded council members that all members need to join a subcommittee, because they will be in violation of council rules if not joined to a committee by the third meeting. She said to call or email S. Moletteri to join a committee.

—Positive Committee—

K. Moussa reported that the committee would meeting on January 13th and discuss rules and policy, the Positive Committee 20th anniversary project, and community planning for the year.

—Comprehensive Planning Committee—
G. Grannan said they would meet at their regular time in January (January 16th) but did not meet in December 2019. N. Johns said there would be a detailed EHE presentation during the meeting—anyone who wanted to learn more were encouraged to attend or even listen in.

—Prevention Committee—
C. Steib said meeting would be on January 22nd from 2:30-4:30PM.

Old Business:
None.

New Business:
None.

Announcements:
D. Gana announced that any documents (checks, contracts, etc.), make sure you right down the full year—2020, not just 20. S. Arrighy asked if there was a THRIVERS was meeting. K. Carter said that there would be someone to discuss the THRIVERS meeting at the next Positive Committee.

D. Angelis announced that Social Security Administration had proposed a rule that would alter when and how often people had to reapply for disability. There was an option for public comment online.

N. Outland announced that the PA Coalition of Domestic Violence was holding a webinar on February 26th, 2020. On February 16th, there would also be a fashion show in Germantown. The tickets were $25, and all proceeds go back into the community through organizations such as Our Way and Mazzoni and focus on services for trans women.

K. King-Collins announced that there was a docuseries called *Sex Explained* that explored a lot of relevant topics around sex education and childbirth. This was accessible through Netflix.

Adjournment: S. Heaven called for a motion to adjourn. **Motion:** D. Lewis Salley motioned, D. Gana seconded to adjourn the January 2020 HIPC meeting. **Motion passed:** all in favor. The committee adjourned at 4:04 PM.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- January 2020 HIPC Meeting Agenda
- December 2019 HIPC Meeting Minutes
- January/February 2020 Meeting Calendar
- Ending the HIV Epidemic in Philadelphia: DRAFT: December 30, 2019