Connecticut HIV Planning Consortium

19 May 2021 Meeting Summary

Location:	Zoom virtual meeting		
Date:	19 May 2021	**Recorders:**	Michael Nogelo/Dave Bechtel
Start Time:	9:22 a.m.	**End Time:**	10:26 a.m.
Presiding Chairs:	Nilda Fernandez, Dante Gennaro, Barry Walters		
Attendance:	See end pages for roster of CHPC members and public participants		

MEETING AT A GLANCE

- CHPC Co-Chairs announced: a) that the CHPC endorses Governor Lamont's condemnation of hate crimes against Asian Americans; b) that CHPC members voted to approve the April 2021 meeting summary; and c) highlights of the ongoing work of each CHPC committee.
- Dante Gennaro delivered a "knowledge build" segment on the CHPC's use of presentations to build shared understanding, common language, and deeper knowledge on topics most relevant to developing the next five-year plan.
- Deidre McDaniel delivered a presentation on strategies for addressing health inequity.
- CHPC committees conducted virtual meetings from 11:00 a.m. to as late as 12:30 p.m.

CALL TO ORDER and MOMENT OF SILENCE

CHPC Co-Chair Barry Walters called to order the Connecticut HIV Planning Consortium (CHPC) at 9:22 a.m., offered tips to help create a productive virtual meeting environment, and introduced his fellow CHPC Co-Chairs Nilda Fernandez and Dante Gennaro.

Mr. Walters led participants in a moment of silence to remember those who have been lost to HIV – including former Connecticut Department of Public Health (CTDPH) staff member Pamela Foster – and to support those who are living with and affected by HIV.

Gina D'Angelo spoke a tribute to Pamela Foster, who worked for many years in HIV Prevention at the City of Bridgeport and the City of New Haven before joining the Prevention team at CTDPH and serving as a highly-regarded Contract Manager. Pam supported programs, built strong relationships, and held people accountable for doing good work. Pam was passionate about her work with the Syringe Service Programs, and organized the Janis Spurlock Women of African Decent Conference, which focused on the health and wellness of African-American women. Ms. D'Angelo remembered Pam as a quiet, vibrant, humble, and kind person with a big smile and quick wit who made tremendous contributions to Connecticut.

CHPC LEADERSHIP ANNOUNCEMENTS

Mr. Walters reviewed the agenda for the day's meeting.

Mr. Walters explained that the CHPC is a statewide HIV prevention and care planning body that exists to reduce the rate of new infections and to help those living with and affected by HIV/AIDS connect to services. The CHPC's vision is to help end the HIV epidemic and connect individuals living with or affected by HIV/AIDS or other diseases such as Hepatitis or Sexually Transmitted Infections (STI).

Ms. Fernandez expressed the CHPC's endorsement of Governor Lamont's condemnation of hate crimes against Asian Americans.

Ms. Fernandez explained that the CHPC uses a statewide integrated HIV prevention and care plan to move toward the CHPC's vision of ending the HIV epidemic. Connecticut is in year five of its five-year plan. Due to the COVID-19 pandemic, however, the CHPC's federal funders have extended the life cycle of the plan by one year. By May 2022, the CHPC should be working toward finalizing its goals, objectives, and priority implementation strategies to: a) End the HIV epidemic; b) Reduce Hepatitis and sexually transmitted infections (STI); c) Reduce HIV-related stigma; d) Strengthen the healthcare workforce; and e) Help its service delivery partners – especially nonprofits adjust to a changing landscape.

Ms. Fernandez announced that:

- The April 2021 CHPC meeting summary had been approved by a virtual vote.
- The CHPC Membership and Awareness Committee (MAC) will help plan a pilot project to enhance statewide coordination of a national awareness event to help community partners tap into existing resources and energy at the national and local levels.
- The CHPC Needs Assessment Projects (NAP) Team will coordinate the delivery of a training on confidentiality, patient privacy, and HIPAA in late May. More trainings are being planned.
- The CHPC Quality and Performance Measures (QPM) Team continues its work on enhancing the statewide indicators to include areas such as STIs and Hep C, and to find ways to assess and monitor the impact of stigma. QPM has also begun to organize a quality improvement conference that will occur in the fall.
- The CHPC Getting to Zero (G2Z) Committee recently hosted two stakeholder engagement groups on topics related to recommendations by the statewide G2Z commission. The G2Z Committee will begin building digital resource kits to support work in the areas of Routine HIV Testing and strengthening Sexual Health Education / STI prevention programs.
- Everyone is welcome to choose a committee to attend.

KNOWLEDGE BUILD: CHPC STRATEGIES FOR ADDRESSING HEALTH INEQUITY

Mr. Gennaro reminded the group that the CHPC and its Executive Committee is using presentations during 2021 to build shared understanding, common language, and deeper knowledge on topics most relevant to developing the next five-year plan. The next plan must place a sharper emphasis on addressing certain topics and strategies, including: a) Integrating Hep C / STIs; b) Embracing sex-positivity; c) Promoting status-neutral care; d) Reducing health inequalities; and e) Reducing stigma. Mr. Gennaro stated that achieving shared understanding does not mean everyone will agree. Common language and terms allow CHPC participants to communicate more effectively. These issues will take years to navigate. The CHPC's intent is to help equip participants to feel more comfortable engaging in these discussions at the CHPC and in their communities.

CHPC PRESENTATION: STRATEGIES FOR ADDRESSING HEALTH INEQUITY

Table 1 and Table 2 show the results of an interactive poll on participants' recent health equity training and observations about changes in the way the healthcare system addresses health inequities.

Table 1.

Question	Yes	No	Don't Know
In the past 12 months, have you attended a health equity workshop or training?	29	26	3

Table 2.

Question	High	Medium	Low	No Change
In the past 12 months, have you seen meaningful change in the way our healthcare system addresses health inequities?	4	20	25	9

Mr. Gennaro introduced Deidre McDaniel, President and Founder of Health Equity Resources and Strategies (H.E.R.S.), LLC (Maryland) to discuss how reporting of disparate rates in health among marginalized communities has become normalized and accusatory due to an emphasis on the "risky behaviors" of a population, versus the development of strategies to address the structural and social determinants that contribute to poor health outcomes. The presentation discusses the root causes of health inequities and its impact on health outcomes and provides a framework for addressing health inequities head-on.

Ms. McDaniel introduced herself and explained that she is a licensed certified medical social worker with experience working in inpatient hospital settings, state and local government agencies, and non-profits. Her foundation for addressing health inequities comes from over 20 years of working in a variety of settings and building an understanding of how unequal treatment can impact individuals, organizations, and communities through clinical practices and institutional systems. As the President & Founder of H.E.R.S., she assists organizations with building cultures of equity in their service delivery and organizational practices.

Ms. McDaniel warned participants that the presentation may cause emotional distress due to the inclusion of historical events that may be disturbing or traumatizing to some participants.

Ms. McDaniel introduced the principle of Sankofa, which originates from the Ah-kan tribe in Ghana and when translated means "We must return and claim our past in order to move toward our future." Ms. McDaniel explained that, in the spirit of Sankofa, the purpose of the presentation would be to go back and look at the history of medicine and the victimization of marginalized groups and how it impacts health outcomes today.

Ms. McDaniel encouraged each participant to think about their own multiple identities and how those identities shape their experiences in their current roles. Ms. McDaniel stated that our identities impact our views and points of reference, which in essence influences our work.

Ms. McDaniel provided definitions of several key terms to foster collective understanding. Slides 7 and 8 of Ms. McDaniel's presentation include detailed definitions of terms such as racial equity, health equity, health disparities, health inequities, and structural inequities.

Ms. McDaniel quoted Michael Patton, who said "We have reduced the culmination of a person's life down to bullet points and then make our judgments and assumptions based on those bullet points." Ms. McDaniel explained that, without consideration of the context and structures in which people exist or the stressors that are placed upon them, there is danger in doing this because judgments and assumptions lead to biased and inequitable practices and the normalization of disparities in care practices and overall health.

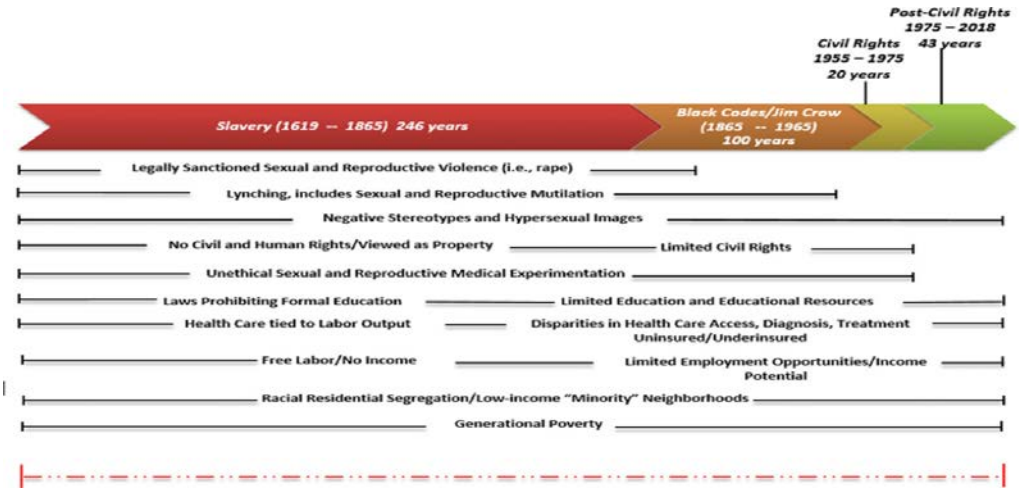
Ms. McDaniel shared a range of statistics illustrating health disparities impacting populations including African Americans/Blacks, Hispanics/LatinX, Asians/Pacific Islanders, and the incarcerated. Ms. McDaniel stated that these statistics are so well-known that many people have come to normalize them and to think they are normal and unpreventable. Ms. McDaniel suggested that hearing such statistics should instead send a clear message that interventions for marginalized groups should be of the utmost priority; yet due to racist and biased ideologies these statistics have become normalized and accepted as an attribute of race. However, as race is a social construct, these outcomes cannot be deemed as an acceptable consequence.

Therefore, policies and practices must be developed using an equity lens to address these disparate rates. Research out of the National Institutes of Health suggest that culturally appropriate, tailored interventions may help communities respond to the unique needs of people in—or at the intersections of—these groups.

Ms. McDaniel quoted Dorothy Roberts' book, *Killing the Black Body: Race, Reproduction and the Meaning of Liberty*: "The primary function of racial ideologies is to create a justification for the perpetuation of a racist social structure." Ms. McDaniel explained that racist ideas and practices exist as a means to continue racist systems and structures. Therefore, it is important to understand the detrimental effects of racism in order to dismantle it. Ms. McDaniel stated that the National Academy of Sciences, Engineering and Medicine's Committee on Community-Based Solutions to Promote Health Equity acknowledges that U.S. history was shaped by the impacts of past slavery, Indian removal, lack of rights for women, Jim Crow segregation, periods of nativist restrictions on immigration and waves of mass deportation of LatinX populations, eugenics, the internment of Japanese Americans, Chinese exclusion policies, the criminalization of "homosexual acts," and more.

Ms. McDaniel explained that historical trauma is, "a collective complex trauma inflicted on a group of people who share a specific group identity or affiliation" (Evans-Campbell, 2008, p. 320) that manifests from the past treatment of certain racial and ethnic groups. This is another form of structural (i.e., systemic) racism that continues to shape the opportunities, risks, and health outcomes of these populations today (Gee and Ford, 2011; Gee and Payne-Sturges, 2004; Heart et al., 2011). (National Academy of Sciences, 2017) Ms. McDaniel then provided detailed historical examples of the oppression of four marginalized communities in the U.S.: a) Native Americans; b) Asian Americans (a widely misunderstood group in the U.S. due to a lack of awareness of the immense diversity within the Asian American culture as well as the "model minority" stereotype); c) LatinX people (whose existence and experience in the U.S. is inextricably connected to immigration policy); and d) African Americans (including a particularly cruel history of oppression related to medicine). See slides 12-15 of the presentation for details.

Ms. McDaniel shared a diagram extracted from an article on the historical review of racism, African American women, and their reproductive health. The diagram (shown below) provides a timeline of key historical and contemporary racial and social experiences of African Americans in the U.S. from the institution of slavery in 1619 to post-civil rights 2018. Of particular interest is the correlations of the long-term effects of slavery across what we know today as the social and structural determinants of health. Of critical importance is that the diagram starts with the introduction of slavery and, as it moves through the centuries, the effects of slavery are interwoven into every aspect of the African American experience.



Ms.McDaniel provided a personal example to give perspective, sharing that her father-in-law was born in 1926 and died in 2017; his father was born in 1899; and his grandfather was born enslaved in 1840. When her children learned about enslavement, therefore, it was not only from the literature, but also from person narratives from their grandfather.

Ms. McDaniel said intersectionality is a prism for seeing the way in which various forms of inequality often operate together and exacerbate each other.

Ms. McDaniel turned to the impact of historical and current oppression on health outcomes, arguing that it is almost impossible to separate who we are and what we believe from what we do in our roles. It is our history and lived experiences that shape us and make us who we are, so if we want to do things differently, we have to be intentional in order to dismantle history's oppression on outcomes.

Ms. McDaniel stated that, as it relates to the intersectionality of race, gender, and sexual orientation and the impact of the history of oppression in medicine on health outcomes, it manifests today as discrepancies in patient management and treatment protocols. Ms. McDaniel presented several specific examples of how these discrepancies disproportionately affect marginalized racial groups, people who use drugs, and sexual and gender minorities. People who inject drugs, for example, are often viewed as criminals rather than as having a medical issue that requires treatment. Stigma and mistrust in the healthcare system may prevent people who use drugs from seeking HIV testing and treatment. Sex workers face stigma, poverty, and lack of access to healthcare and other social services due to the illegal nature of exchanging sex for money or drugs.

Ms. McDaniel said that, to confront inequalities in healthcare, we must make sure that we have systems in place that promote equity. Policies can be neutral in language and vague in implementation, however, and therefore too broad to make a revolutionary impact. Ms. McDaniel noted that Dr. Nabila El-Bassel stated that a coordinated, collaborative approach that integrates health and human rights is integral to addressing the needs and cultural barriers of marginalized communities and that we need to ensure that these communities are effectively represented in research efforts and healthcare.

Ms. McDaniel said strategies for achieving equity within agencies should focus on:

- **Workforce:** a) Diverse and inclusive teams at all levels; b) Frequent and ongoing equity trainings for staff and clinicians on racial and health equity, anti-racism, and cultural humility, among other topics; c) Open and transparent communication of care practices, policies, and procedures in a respectful and unbiased manner, to every client; d) Translation services that extend beyond an interpreter to all written communications including resource listing, discharge protocols, and electronic medical records; e) Policies and protocols that hold employees accountable for inequitable practices, as well as policies, protocols, and mechanisms that support employees who report inequitable practices.

- **Clinical practices:** a) Data collection done in an equitable manner in order to gain a good understanding of outcomes (e.g., data disaggregated by race and gender to gain a better understanding of specific trends in patient outcomes, providing patients the options to self-identify as it relates to race and gender as opposed to only providing limited pre-populated selections or determining the necessity of data points for service provision); b) Standardization of care using evidence-based practices proven to positively impact outcomes; and c) Engaging patients and capturing patient voices (e.g., including patients on interdisciplinary care coordination teams, committees that reflect the diversity and intersectionality of patient populations).

- **Organizational culture:** a) Equity in one department is a start, but equity within the entire organization is transformational; b) Assessment of leadership and policies in terms of diversity, equity, and accountability; c) Examining current policies for bias and neutral language; and d) People living with HIV and their families should be considered as experts in not only care coordination, research, and service interventions but also organizational culture as they are the ones that are impacted by inequity at all levels.

Ms. McDaniel shared several strategies for community engagement, including: a) Listening to clients/patients; b) Inclusion in the development of standards for equitable and respectful care; c) Conducting group discussions and listening sessions routinely to gather patient/client/community level information on strengths and gaps; d) Membership on equity committees; and e) Inclusion in coordination of care.

Ms. McDaniel closed the presentation by sharing a quote from Beth Glover Reed: "We must guard against unintended consequences that can create or sustain injustice and power imbalances and must strengthen forces that can promote social transformation to a more just society and societal processes."

Table 3 and Table 4 show the results of an interactive poll on the effectiveness and impact of the presentation.

Table 3.

Question	Yes	No	Don't Know
Did the presentation today help you expand or enhance your knowledge about health equity?	54	2	1

Table 4.

Statement	Strongly Agree	Agree	Disagree
The presentation today will help the CHPC use a more intentional approach to develop strategies (in its next 5-year plan) that address health inequities.	33	23	1

OTHER BUSINESS

Mr. Walters invited CHPC members and public participants to introduce any other business in the chat.

- Taylor Edelmann announced that Apex Community Care, StayWell Health Center, and Waterbury Health Department are collaborating on a National HIV Testing Day (NHTD) event in Waterbury on Friday, June 25 from 10 am to 2 pm. Other agencies that provide various support services will participate as well.
- Mr. Walters said many events will take place in June, including NHTD celebrations and pride events.

Mr. Walters invited participants to forward other important information to CHPC leaders or staff to be shared with the CHPC distribution list.

ADJOURNMENT

Mr. Walters encouraged all participants to complete a 1-minute survey to share any feedback on how to improve virtual CHPC meetings. The survey can be accessed by scanning a QR code on the slide or by clicking a link in an email sent to all participants after the meeting. Mr. Walters thanked everyone for a productive meeting, and adjourned the meeting at 10:26 a.m.

CHPC ATTENDANCE RECORDS *(1 = present; 0 = absent; arriving late is counted as an absence for official records)*

First Name	Last Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Victor	Acevedo	1	1	1	1	1					
Melanie	Alvarez	1	1	1	1	1					
Laura	Aponte	1	0	1	1	1					
Erma	Benedetto	1	1	1	0	1					
Thomas	Butcher	1	1	0	1	1					
Gigi	Chaux	1	1	1	1	1					
Brian	Datcher	1	1	1	1	0					
Xavier	Day	1	1	1	1	1					
Martina	De La Cruz	1	1	1	1	1					
Natalie	DuMont	1	1	1	1	0					
Taylor	Edelmann	0	1	1	1	1					
Stephen	Feathers	1	1	1	1	1					
Nilda	Fernandez	1	1	1	1	1					
Carl	Ferris	1	1	1	1	1					
Jose	Figueroa*	0	0	0	-	-					
Dante	Gennaro	1	1	1	1	1					
Tawana	Guadarrama	1	1	1	1	1					
Cynthia	Hall	0	1	1	1	1					
Marcelin	Joseph	1	1	1	1	1					
Reggie	Knox	1	1	1	1	1					
Ronald	Lee**	1	1	1	-	-					
Debra	Lombardo	1	1	1	0	0^					
Luis	Martinez*	0	0	0	-	-					
Waleska	Mercado***	-	-	-	-	-					
Mitchell	Namias	1	1	1	1	1					
Peta-Gaye	Nembhard	1	1	1	1	0					
Clara	O'Quinn	0	1	0	1	1					
Bob	Sideleau	1	1	1	0	1					
Jeffrey	Snell****	0	1	0	-	-					
Roberta	Stewart	1	1	1	1	1					
Barry	Walters	1	1	1	1	1					
	TOTAL	24	27	25	23	22					
	PERCENTAGE	80%	90%	83%	85%	85%					

*Discharged after missing third meeting of 2021
**Deceased
***On leave while CHPC meetings are virtual
****Resigned
^Attended the main CHPC meeting but did not attend a committee meeting

PUBLIC PARTICIPANTS (*1 = present)*

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Alford, Claudia	1									
Allen, Whitney			1	1	1					
Amadour Bueno, Fabio			1	1	1					
Birth, Sheila			1							
Bonelli, John			1							
Boone, Joyce			1							
Brown, Jean		1	1	1	1					
Buchelli, Marianne	1	1	1	1	1					
Cifuentes, Alberto			1							
Cisneros, Max			1							
Cobbs-Lomax, Darcey					1					
Cole, Christopher	1									
Croasdale-Mills, Angelique	1	1	1	1						
Cruz, Ginger	1									
D'Angelo, Gina	1	1	1	1	1					
Danvers, Karina		1								
Davidson, Daniel	1		1		1					
Del Vecchio, Christina	1	1	1	1	1					
Demidont, A.C.	1	1								
Diaz, Luis	1	1	1	1						
Diaz-Olivares, Yanira			1							
Dones-Mendez, Dulce	1	1	1		1					
DuVerger, Patrick					1					
Faye Wilson, Lynda					1					
Ferraro, Linda				1	1					
Figueroa, Jessica			1							
Floyd, Letrell	1									
Francis, Shannon			1		1					
Gaines, Tia				1						
Gowell, James	1									
Grodzki, Dawn					1					
Henriquez, Wanda	1									
Heron, Venesha	1	1	1	1	1					
Hong, Grace	1	1								
Hulton, Daniel	1	1	1	1	1					
Irizarry, Luis			1	1						
Janssen, Doug		1			1					
Jean-Baptiste, Clunie	1	1	1	1	1					
Jones, Coley	1	1	1	1	1					
Kelly, Pat		1								
Kenny, Will	1				1					
Kominske, Angela	1									
Kotey, Dionne	1	1	1	1						
Krol, David					1					
Lane, Stuart			1							
Linardos, Heather	1		1	1	1					
Lopez, Aurelio				1						
Lorenzo, Maria		1		1	1					
Magaña, Luis	1	1	1	1	1					
Mairena, Oscar		1	1							
Major, Susan	1	1	1	1	1					
McDaniel, Deidre					1					
McDavid, Kiana	1	1		1	1					

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
McMullen, Fran	1				1					
McNair, LaTonya			1							
McNulty, Caitlyn				1						
McPherson, Loretta			1	1						
Menard, Sarah					1					
Mierzwa, Sharon			1		1					
Milano, Deb					1					
Mitchell, Gabrielle	1			1						
Moore, Kelly		1	1		1					
Moranino, Marlene	1	1								
Morgan, Nicole					1					
Mott, Erika		1	1	1	1					
Muñoz, Consuelo	1	1	1		1					
Navarro, Damaris					1					
N, Joe	1									
Novis, Steve	1		1	1						
Ortiz, Iris					1					
Ostapoff, Michael	1	1								
Pawlow, Dustin	1	1								
Pierre-Louis, Luje	1	1	1	1	1					
Pollard, LaJeune			1							
Quettant, Francesca	1									
R, Rich	1									
Ramirez, Katherine					1					
Ramos, Alyssa	1									
Rose, Jacquelyn					1					
Rodriguez, Joselyn				1	1					
Rodriguez-Santana, Ramón	1	1	1	1	1					
Romanik, Christine	1	1	1		1					
Ruiz, Angel	1	1	1	1	1					
Salazar, Juan	1									
Scott, Aaron				1	1					
Sergeon, Tajae			1	1	1					
Smith, Khelsey	1	1	1	1	1					
Speers, Sue	1	1	1	1	1					
Tengatenga, Cecil		1								
Thuillier, Antoinette	1									
Vargas, Jennifer	1	1	1	1	1					
Vazquez-Yopp, Melinda	1	1	1		1					
Velez, Idiana	1	1								
Virgen, Roman				1						
Warren-Dias, Danielle	1	1		1	1					
Witherspoon, Sadie					1					
Wimbish, Roselyn	1	1								
Unidentified participants	8	4	2	1	1					
TOTAL COUNT	**58**	**44**	**48**	**40**	**53**					