HIV and Hepatitis Community Planning Group

Meeting Minutes

November 8, 2018

HIV & HEPATITIS COMMUNITY PLANNING GROUP MEMBERS **in attendance*								
Julie	Baker	x	Steven	Kleppe	x	Sonia	Reyes-Snyder	-
Donald	Baxter	x	Douglas	LaBrecque	-	Conner	Spinks	x
Sue	Boley	x	Roger	Lacoy	-	Roma	Taylor	-
Colleen	Bornmueller	x	Jeffrey	Moore	x	Pamela	Terrill	x
Megan	Campbell	x	Sara	Peterson	-	Mark	Turnage	-
Tim	Campbell	x	Marty	Reichert	-	Kathy	Weiss	x
Kathryn	Edel	x	Claudia	Robinson	-	Samantha	Willey	x
Linnea	Fletcher	x	Theresa	Schall	x	Biz	McChesney	x
Kevin	Gabbert	-	Shane	Scharer	x			
Greg	Gross	x	Sarah	Ziegenhorn	x			
Holly	Hanson	x	Jordan	Selha	-			
LeeVon	Harris	x	Michelle	Sexton	x			
Tami	Haught	x	Carter	Smith	x			
Daniel	Hoffman-Zinnel	x	Samantha	Smith	x			
Health Department Staff: *Jamesetta Mator, Dustin Wagner, Kate Hoskins, Kathy Dooley, Nicole Kolm-Valdivia, Katie Herting, Cristie Duric, Al Jatta*								
Guest(s): *Sherry Jansen, Brittany Bronemann, Kurt Berke, Michael Bates, Rina Chaudhary, David Yurdin, Brandi Steck, Betsy Richey, Andy Beeler*								

Call to Order

Colleen Bornmueller called the meeting to order at 9:00 a.m.

Roll Call

Colleen Bornmueller facilitated roll call. Biz McChesney gave updates regarding two organizations (Iowa Harm Reduction and University of Iowa HIV Program) who were recognized by receiving community awards. Biz spoke about members who are absent today and member resignations.

Test Agenda

No changes were made to the agenda.

Ground Rules and Agenda Review

Biz reviewed the group agreements, the agenda, and the goals of the meeting.
Goal 1: Discuss progress on select goals and objectives in the HIV and HCV plans
Goal 2: Discuss departmental and policy initiatives
Goal 3: Participate in discussion regarding HCV treatment access
Goal 4: Participate in conference planning break-out discussions
Goal 5: Receive an update on ad hoc committee work

She also reviewed the handout folder contents.

1. HIV #Language Matters: Using preferred language to address stigma
2. Words Matter: Health Equity Terminology
3. Health Equity Activities at IDPH
4. Moving Upstream: Examining the path to racial inequities and wording towards elimination
5. Bureau of HIV, STD & Hepatitis Health Equity Overarching Activities
6. Disrupting Racism Strategic Plan General Overview
7. Disrupting Racism Strategic Plan: Goal 1 Change Systems
8. Disrupting Racism Strategic Plan: Goal 2 Change hearts, minds, and behavior
9. Disrupting Racism Strategic Plan: Goal 3 Promote Healing From Racism
10. Checkouts

Approval of August Minutes

Colleen Bornmueller facilitated the approval of the August 9, 2018, minutes. No corrections or additions were made. Tami Haught motioned to approve the minutes. Tim Campbell seconded the motion. Motion carried. Minutes were approved.

Review of August Check-outs

Colleen Bornmueller facilitated the review of the August 9, 2018, check-outs. No corrections or additions were made.

Generally, participants were pleased to hear about current and future HIV prevention and care programs and plans. Many commented positively on the short presentations and felt there was a good balance between presentations and break-out group discussion. Many felt Randy Mayer's presentation about medical cannabidiol was informative. It was recommended that Randy have a standing segment to provide information/department updates. There were multiple comments regarding molecular surveillance. Members appreciate information on molecular surveillance. However, some stated the topic is confusing and that they had concerns about how it will be used.

There were several who commented they would like to be more informed of new projects at IDPH and would like to have more discussion on the front end of new projects. Some members noted that working in small groups encourages feedback. Some participants felt like they were not being consulted as a member, just merely being informed.

There were requests for more information/presentations about medical cannabidiol, Rural Outreach Liaisons (ROLs), the pharmacy plan, the condom distribution plan, the strategic plan, PrEP uptake, and drug user health. Also, it was mentioned to have consumers provide presentations from their perspective. Many commented on the importance of using people-first language. Some members want more basic program/project information included in presentations (background info).

A participant noted that the Holiday Inn is not LGBTQ affirming and recommended a different venue for conferences. A participant felt health equity was stagnant and needed to be addressed. Most commented that receiving minutes and presentations by email was fine and like receiving them earlier than usual and more than once.

Unfinished Business

Bureau Update

Presented by Biz McChesney

Biz spoke for Randy who is out of the country. The Client Services Coordinator position in the Ryan White Program is vacant, and applicants are being reviewed. There are also two positions open in the Office of Medical Cannabidiol, a manager position and clerk position.

Synergy for Integrated Planning Leadership Application Update

Presented by Biz McChesney

Iowa's application was not accepted. There are a lot of CPG groups across the country that are trying to merge their care and prevention planning groups, and it was thought this factored into Iowa not being chosen to participate.

CPG Bi-monthly Email Feedback

Presented by Biz McChesney

To improve delivery of information to CPG members, there will be an email message sent to CPG members every other Friday. Currently, the Ryan White care program contractors receive *Monday Messages*, testing contractors receive *Tuesday Tidbits*, and bureau staff receive *Wednesday Wisdoms*. The CPG email will include updates/information relevant to community planning (and may be named *Fun Facts Friday*).

National Updates

Presented by Biz McChesney

Murray Penner, Executive Director at the National Alliance for State and Territorial AIDS Directors (NASTAD), has resigned. NASTAD is a national organization that provides technical assistance and support to state health departments for HIV and hepatitis prevention and care. This is a new era for NASTAD as there will be a national search for a new director.

HIV #Language Matters: Using preferred language to address stigma
Words Matter: Health Equity Terminology

Presented by Tami Haught and Jamesetta Mator

Tami provided an overview of people-first language document (*HIV #Language Matters: Using preferred language to address stigma)* and gave the example of using "people living with HIV" rather than the term "HIV infected." Tami commented that stigmatizing language has been used for a long time, and it is easy to continue to use it. We all must keep reminding ourselves to use people-first language that is not stigmatizing. Tami suggested that we have cards that we can hold up if someone is using stigmatizing language (at CPG meetings). She said that people need a gentle reminder not to use stigmatizing language. The committee agreed, and a card reading, "Use People First Language," will be added to members meeting packets.

Jamesetta mentioned that we should be mindful of the difference between HIV and AIDS, as well. David Yurdin mentioned not to use "end-stage HIV" as this may be stigmatizing. Sarah Ziegenhorn talked about being able to apply this same language to people who use drugs or inject drugs as well as people living with hepatitis. Holly Hanson commented that people at the office are copying the language-first document and hanging in in their office space. Holly asked about the term "sero-discordant", which is on the list. Tami wasn't sure why this term may be stigmatizing. Carter Smith commented that "sero-discordant" may have a negative connotation to the relationship. Pamela Terrill asked how "mother-to-child transmission" could be stigmatizing. Tami mentioned that this term may imply blame. Conner Spinks commented that mother is a gendered term and may not apply to everyone.

Greg Gross recommended that this document be shared widely through all modes. Biz mentioned inclusion of the documents to the welcome message for new employees. Samantha Willey commented that it is a struggle to use the right language and that people should be encouraged to stop labeling. Linnea Fletcher commented that the "unprotected sex" line (referencing PrEP

therapy) could actually encourage young people to have sex without a condom. Conner Spinks recommended the use of simple language. Conner added that perceived risk of having sex without condoms is dependent on the health goals for each person, and that we should meet people where they are. Sue Boley commented to help people who don't speak English and require interpreters and that interpretation should be culturally appropriate.

Jamesetta provided an overview of the *Words Matter* document (*Words Matter: Health Equity Terminology).* Jamesetta said this was a dynamic document and that new ideas can be added. Conner Spinks commented about racial consciousness and offered the question, "Where is the language around hegemonic populations?" Conner added that the focus is unknowingly centralizing the hegemonic perspective. Jamesetta mentioned the word "empowerment," which implies that one group has the power. Sarah talked about the groups that she sits on and the creation of health equity. Sarah spoke about defining what health equity is and who should be framing it, and that maybe the people at the center with implied power should not be the group that is defining the terms and conditions.

Molecular Surveillance and Cluster Analysis

Presented by Jessica Morris

Jessica talked about the *Outbreak Detection and Response Plan* that is being developed by IDPH. Jessica described how genotypes are analyzed, the characteristics of the data, and how data are used. Jessica talked about how these data can be used to inform health equity in a community. Jessica mentioned that there was a Webinar for testing sites and working with health equity.

Conner Spinks asked about queer men of color, the concern about informed consent, and the consequences of a reporting a communicable disease of public health significance. Conner asked what information is being provided to the client about molecular surveillance being an added tool to map out possible infections. Conner added that this analysis may instill fear in clients about getting tested. Jessica answered that genotype data has been provided to the department for years and that practitioners have been doing this testing to determine medication resistance and what type of medication to prescribe. Conner clarified her question and wanted to know if clients are aware that this type of analysis is being done as a result of the testing. Al Jatta added that the genotype analysis will help to identify partners in a cluster and to increase awareness of HIV statuses. Jessica added that they will be working with the disease intervention specialists (DIS) and case managers to use this information appropriately in the community.

Tami Haught added that the CDC has undermined state department professionals because the rollout of this policy excluded talking to people with HIV. The whole program is a problem because data have been collected without informing the clients. In Michigan, there is a case where the data are being subpoenaed. The CDC did not consider the impact this program would have on HIV criminalization, increasing violence among populations, increase stigma, and safety of people. The information is supposed to be secure and there was a security breach in Tennessee. This information is not being protected, and Iowa should have a moratorium on this

program until these issues have been addressed. Jessica responded that Iowa has data security and protections already in place to avoid what has happened in other states. The plan is to use the data to improve prevention and care of people with HIV. People always have the right to refuse a partner services interview.

Jessica asked the group for feedback on how to engage the community more. Holly Hanson recommended to slow the process down so the community can get involved. Nicole added that, based on webinar feedback, the CDC will be making changes to the program. Samantha Smith commented that the molecular surveillance visuals from the prior presentation to the CPG were very helpful in understanding how the process works. Jessica will add the presentation to the CPG email. Tim Campbell mentioned that the information from the webinar was advanced but the additional information provided at CPG was helpful to understand the CDC webinar.

Donald Baxter commented that he feels that he is fairly knowledgeable about HIV surveillance but did not know that viral loads were reported to the IDPH. He disagreed that there are protections in Iowa to prevent what has happened in other states and argued that the law can change and not be in the best interest of the people affected. Sarah suggested that a case study be provided at the next CPG meeting. Everyone agreed this was a good idea. Carter Smith questioned that, if the laws change, will the new law apply to previously collected data? How will IDPH protect these data?

Al Jatta commented that the focus is on the genetic data. Name, date of birth, race, ethnicity, birth sex, HIV/AIDS diagnosis, and vital status are collected. Genotype data were reportable by law since 1998. There has been no security breach because of the security measures in place. There are only three people who have access to the data, one of which has "read only" access. What goes to CDC is restricted to DOB and soundex code (a generated code). If CDC wants to know anything else they have to make a request to IDPH. CDC only has access to aggregate data. This should be understood in the context of this discussion. We will be analyzing the genotype data of the virus in a client's blood to determine if that person belongs to a bigger group where people may also have HIV. Tami Haught commented that she is furious with the CDC for not recognizing the importance of engaging and informing PLWH about this program. Nicole added that the goal is to be transparent and the process in Iowa with be slowed down to accommodate engagement of the community.

Public Relations and CHAIN Efforts

Presented by Tami Haught and Jamesetta Mator

Tami reported that there are so many things that we need to advocate for partnership on. CHAIN has not met much since 2014 when the HIV criminalization law was modernized. CHAIN needs to be on the hill now more than ever before and the group needs to bird-dog presidential candidates. The group has been asked to partner with IHRC and the Haggarty group on non-medical switching. There are so many issues around hepatitis C and CHAIN will depend on CPG members Shane Scharer and Dr. LaBrecque to inform legislatures. Tami will be sending out a doodle to get members re-engaged and energized to attend a day on the hill. There may be

enough money left to pay for hotel expenses. Tami is looking for ways to raise money and recruit support for CHAIN. Tami would love to hear from CPG members about issues to discuss. Sarah Ziegenhorn added that the Day on the Hill is January 22, 2019 from 1:30 to the end of day. It will be advertised as Opioids, HIV, and Hepatitis day on the hill. There will be tabling and IHRC can pay for PITCH members to travel and for food. Greg Gross remembered that having lunch set up in the rotunda helped to engage legislatures. Sarah has reserved the rotunda and will provide coffee and donuts.

Community Co-Chair Vote Update

Presented by Colleen Bornmueller

Colleen provided an update on the committee co-chair vote. The agenda was revised and an email was sent out notifying the group that Roma Tayler has been nominated in addition to Greg Gross. It was felt the both should be heard in person so the vote will be postponed until February when both can be present.

CPG Feedback-Guiding Interim Strategic Plan

Presented by Biz McChesney

Biz provided an overview of how the small group feedback from August's CPG meeting was used to inform the strategic plan. Biz walked through a spreadsheet and explained how feedback from the small groups and incorporated into plan. Holly Hanson pointed out that the client level, systemic level, and organization level are new ways to look at the plan. Holly envisions doing a write up of the different columns by levels and hopefully this will allow people to think things through, be more deliberate with putting the plan together, and getting all of the feedback incorporated. Holly added that a lot of work has been done and funding has changed so the plan needs to be updated now more than ever.

See spreadsheet for more details.

New Business

Health Equity Activities at IDPH

Presented by Betsy Richey

Betsy shared IDPH's efforts to incorporate health equity into health programs. Betsy provided an explanation of what health equity is and provided examples of how health equity should be considered in different populations across Iowa. Betsy presented the goals and strategies of how IDPH is working to improve health equity into existing structures.

Conner Spinks wondered if sexual orientation, gender of sexual partners, and immigration status could be data points to address health inequities. Betsy answered that the department has taken the first step in looking at the data in different ways. One consideration is the trust of the community in terms of the data that are collected and how their use could negatively affect the community. Daniel Hoffman-Zinnel asked about the data resources. Betsy answered that data

resources include the HIV registry, birth and death registry, and the Behavioral Risk Factor Surveillance System (BRFSS) data. Some are easy to manipulate in terms of behaviors and outcomes. Daniel asked if there are plans to always include these sources of data and how sex and gender are defined. Betsy answered that sex and gender identity are asked in BRFSS. Betsy said the LGBTQ health resource provides guidance on how to collect sex/gender data. Tim Campbell asked if data are needed, can different programs be tapped for data? Betsy answered that the department tries to partner when it can to get data. The department is still trying to identify gaps in existing data resources to determine what is needed and who to partner with. Greg Gross asked how input was collected when creating the plan. Betsy answered that it depends on the program and that there is varying input but the department is working to make inclusiveness a part of the process. Greg asked about accountability and incentives? Betsy answered that it depends on the program and how health equity is incorporated. All contracts are equipped with performance measures addressing health equity and using data to identify disparities.

See slides for more information.

Moving Upstream: Examining the path to racial inequities and wording towards elimination

Presented by Jamesetta Mator and Nicole Kolm-Valdivia

Nicole presented data on people diagnosed with HIV or STDs compared to Iowa demographic data, and how some populations are disproportionately impacted. Jamesetta and Nicole presented on factors affecting disproportionate rates, including poverty, residential segregation, legislation, attitudes, historical trauma, immigration, and incarceration. Jamesetta covered the underlying causes that impact these factors, to include homophobia and transphobia, racial and HIV-related stigma, and racism. Nicole covered some recommendations for providing equitable care.

Sue Boley mentioned that 75% of people with tuberculosis (TB) are foreign born. Individuals diagnosed with TB who are also an immigrant may not qualify for Medicaid, so they have limited access to treatment. In this circumstance, a person basically needs to be hospitalized to receive medication. In one instance, an agency worked with a person to get insurance through the ACA. The agency agreed to do bloodwork for free until client met the deductible. The client completed treatment, hospitals did blood analysis, and then the client received bill for $9,000 (the hospital billed for difference that Medicaid would not cover even though the hospital said the costs would be covered). Theresa Schall added that cultural beliefs impact retention in care, and that a family's beliefs may impact a person's ability to seek medical care. Sarah Ziegenhorn commented on overdose prevention work for agricultural workers. It was thought that this group did not engage in illicit drugs, but there are few data to support this. Donald Baxter added that city planning and zoning also contributes to segregation. Carter Smith noted that banks in some locations in Iowa will restrict mortgages to individuals based on rate of return.

See slides for more information.

Bureau of HIV, STD & Hepatitis Health Equity Overarching Activities

Presented by Holly Hanson and Jamesetta Mator

Jamesetta provided 2017-2021 plan successes and next steps.

See slides for more information.

Conner asked about what is referred to as "women" Jamesetta responded that this term refers to any person who identifies as a woman. Holly added that a specific focus will be on women coming from different places and how viral suppression can be achieved within this population.

Sub-recipient & Community Health Equity Activities

Carter Smith provided an overview of Siouxland Community Health Center (SCHC) activities. SCHC has a multi-pronged approach. First, internal processes and job descriptions are written to make sure these elements are appropriate for the projects and initiatives at SCHC. Hiring practices include ensuring members of the staff are involved in interview process to make sure new hires are a good fit for the agency. Staff is involved in the community and attend community events. SCHC is working on social determinants of health, identifying barriers to accessing healthcare, and coming up with solutions. Community partners have applied for Part B supplemental funding to conduct testing to priority populations. SCHC is offering a wide array of services. There is less stigma accessing the prevention program. Brandi Steck (HIV Program Director at SCHC) is working with a community coalition so they have a voice. The Title X program is including youth in conversations. SCHC is working with Planned Parenthood of the Heartland and prioritizing marketing efforts to focus on higher risk populations. Staff is having honest conversations about client needs, trauma-informed programming, and encouraging a diverse staff. SCHD has been working with faith communities and put together church fans with a scripture on one side and testing information on the other side. This has been a successful way of marketing services.

Greg Gross reported that The Project of Primary Health Care started a prevention advisory board this year that includes transgender and other community members. The advisory board meets once a month and is extending its presence in community. The Project conducts outreach at cultural events. The Project has changed hiring practices and includes interview questions about health equity as well as being welcoming and affirming. How interviewees answer has impacted the decision to hire. Job descriptions have changed, which take educational degree out of the picture and now consider experience equivalency. The Project is being more mindful of hiring people who are representative of minority populations. There is now health equity training for staff. Iowa (The Project) is one of 27 states participating in Project ECHO. Based on viral suppression data, people who are most impacted by HIV/AIDS are identified. The Project is participating in regional affinity groups to develop quality improvement initiatives and trying to get more input from populations to inform programs. The Project is also trying to get peer workers.

Kathryn Edel presented on the health equity activities of Johnson County Public Health (JCPH). Kathryn talked about how she sometimes struggles with the concept of "health equity" because it's often used as a blanketed phrase. JCPH has developed a health equity statement and vision of health equity for the entire department. As a social worker, Kathryn has explored what health equity means on an individual level; for instance, being self-aware of what role privilege plays and how this may impact a conversation with a client. Kathryn believes as a social worker, it is important to think about how to level power dynamics, uphold clients' rights to bodily autonomy, engaging in a way that gives the client a sense of agency over their body and life, while acknowledging that the client is the expert. On a programmatic level, JCPH is figuring out ways to address health equity to reach the community it serves better. The department is identifying organizations, such as the Iowa Harm Reduction Coalition, who already have a rapport with populations such as PWID. JCPH understands that members of marginalized communities should inform the work that the department does. At a department level, staff is getting better at understanding how health equity relates to the work that is done and how people are hired. JCPH's leadership is looking internally at who is already at the table to decide how to move forward.

LeeVon Harris reported that The Project of the Quad Cities (TPQC) has hired a client services coordinator who will be a field worker. The goal of this position is to meet people where they are and provide what is needed.

Julie Baker provided a Primary Care Association (PCA) update. Five federally qualified health centers (FQHCs) participated in Project Catalyst, an initiative in collaboration with the Iowa Coalition Against Domestic Violence (ICADV) and IDPH. It is funded by Futures without Violence, and focuses on the impact intimate partner violence and human trafficking have on health. Key components of the 3½ hour training are how LGBTQ+ are disproportionately impacted by intimate partner violence (IPV) and human trafficking (HT), and how people experiencing IPV and HT have higher rates of HIV and STD infections and substance use disorders. Trauma-informed care and practices are also integrated into the training.

PCA designed a welcome poster and Safe Zone stickers for FQHCs to display in waiting areas, at entrances, etc., illustrating an inclusive environment for all community members. PCA also provides culturally informed educational materials to the Federally Qualified Health Centers (FQHC) based on the patient populations of their clinics.

A variety of cultural sensitive trainings are being planned for FQHCs in the upcoming year including: Culturally Sensitive Care for Persons who Inject Drugs as part of the expanded HCV programming being offered at five FQHCs; continued offering of LGBTQ+ and Collection of Sexual Orientation and Gender Identity trainings; Trauma-Informed Practices and Responses for employees experiencing IPV and HT; and Mental Health First Aid training for interested health centers. Social Determinants of Health initiatives also continue among the FQHCs.

Disrupting Racism Strategic Plan General Overview

Presented by Jamesetta Mator and Holly Hanson

Holly and Jamesetta provided and overview of the Disrupting Racism working group, guiding principles and beliefs, and draft plan.

See slides for more information.

Small Group Activity

Disrupting Racism Strategic Plan: Goal 1 Change Systems **Jamesetta provided overview of Change Systems, including structural and institutional racism.**	
Discussion Questions	Notes
What are we missing?	• Including language within RFPs requiring organizations to be more representative of the populations they serve • Working at the executive level (Top-down approach) • How do you hold administrators accountable? • Identify the right person who can approach higher level staff within organizations • Opportunities, available resources, and a marketing strategy • Address tokenizing (Objective B) • Partner organizations • Communications • How can we operate outside the rules of our funding? • Define the scope of how far we will look into best practices • Objective B Strategy 2: create a pathway to recruit a more diverse candidate pool • Educate organizations on resources for CPG members that address barriers (webinars)
How does systemic racism show up in your agency?	• Outreach workers are not diverse – case managers are majority white women • "Difficult clients" – lots of charged language and implicit bias • Reflected throughout agency • Midwestern politeness • Administration turning blind eye • Disproportionate clients • Agency has all white staff (95% of staff) • White savior complex manifest itself on all levels • Getting more people who are impacted • Agency does not allow staff to know job applicants race/ethnicity, which makes it hard to hire diverse staff

	• Leadership is not racially/ethnically diverse, and neither is Human Resources • No cultural sensitivity trainings for staff, only at leadership level • How agencies recruit • Requiring state ID • Hiring practices – "someone knows someone"; lack of hiring opportunities • leadership
How is systemic racism addressed within your agency?	• It's not • Peer support system for each population that is of that population • Utilize community leaders from each community • Dealing with diversity on performance levels • Add "life experience" in job descriptions • Diversity and inclusion committee • Training opportunities for staff • Focusing on/addressing retention of minoritized people in the work place • Conversations • Involve leadership
How can we hold agencies accountable?	• IDPH having a meeting with contracted agencies – training on expectations (HR) • Engaging with people you serve • Helping agencies recognize they do not know it all • Continue to advocate for different hiring practices • Continue to provide high quality services regardless of the work environment • Post job announcements in places to reach minoritized populations – ask your staff!!! • Lead by example (agencies differ by size and structure) • Attach funding as incentive (adding or taking away) for organizations to address inequities
Do you have suggestions on how opportunities for minoritized populations can be implemented?	• Ensure minoritized people are a part of the conversation • Intentional about placement of jobs • Hiring practices – need more people at the top who "get it" • Flexibility in the work space to retain • Talk to agencies with very diverse staff what their best practices are • One agency is having an open house for World AIDS day and will have their open jobs posted
Do you have suggestions of other minoritized people from your community who should be	• Advertise/promote in certain groups (new letters, places of worship) • Organizational staff (minority staff) (at PHC)

at the table (providing suggestions and guidance for the Disrupting Racism workgroup plan)?	
Are there other strategies you would add?	• Hiring practices • Attach funding to support implementation of health equity
Disrupting Racism Strategic Plan: Goal 2 Change hearts, minds, and behavior **Greg Gross provided an overview of Goal 2 objectives and strategies.**	
Discussion Questions	Notes
What are we missing?	• Objective B strategy 3 – space to practice what was learned in training • Objective A strategy 1 – who is it collected from and how; mindful of body language as well • Objective C Strategy 2 – marketing firms with race experience • Consistency across organizations – utilize people first language • Internal policies • Awareness of person-first language • Providers feeling personally attached while listening to clients identify problems • More life experiences videos • Missing the relationship aspect • All staff should have ongoing training on the impacts of racism • Restate cultural competency to cultural sensitivity and cultural humility (consider not using the term cultural competency)
How does interpersonal racism show up in your agency?	• Language barriers – assume needed services - shuffled through wrong services • Assume people don't speak English • Targeting populations – not using person first language • Underlining questions • Microaggressions • Have "professionalism" pulled on them • Tokenism • Overly helpful to minority populations to the point of overkill and make them uncomfortable • Lack of people of color in the work place • White fragility dominates the conversation • People of color are not recognized or centralized

	• Comments during discussions of patients/clients • Which patients issues get taken seriously
How is interpersonal racism addressed within your agency?	• Not addressed • Tolerated without being stood up to • Champions who call it out when they see it happening • Having conversations • Gentle corrections • Having rules in place • Staff diversity training program (6hr, 1 year) • Challenge each other and create a culture where open dialogue can occur • Broaden trainings offered to accountants, other staff
Do you have suggestions of trainings, speakers and other resources?	• Focus on commonalities • Empathy based trainings • Include all staff in trainings – not just providers • Undoing Racism training • Dr. Jennifer Harvey, Drake University, book on how to raise white kids • Read a book on white fragility (audiobook) • Social justice network in Omaha • Have this as a main topic, plenary, at the next HIV conference • Racism-related simulation such as walking the line (privilege walk) • Jamesetta or other 1:1 consultation – to keep agencies up to date with information • Like a HIPAA compliance officer, have a health equity compliance officer • Be more accountable with each other • Create safe space – how to solve conflicts, active listening skills • Survey of clients of gaps and services • Trainings specifically tailored regionally • Asking the right questions • Including different experiences in trainings
Are there other strategies you would add?	• Bring awareness where there is an issue • Focus on white people – need to understand how it exists to create buy in
Disrupting Racism Strategic Plan: Goal 3 Promote Healing From Racism **LeeVon and Jamesetta provided overview of Goal 3.**	
Discussion Questions	Notes

What are we missing?	• Mission statements at different organizations – have organizations acknowledge racism in mission statements as well as discuss health equity • Addressing intersectionality • Internalized, unconscious beliefs of white staff • Objective B: don't limit it to just service providers • Feels inappropriate for a majority white staff to say we are going to help you heal – focus on the trauma-informed principles • Awareness • Having conversations • Acknowledgement • The focus is just on HIV and not HCV and STD
Do you know of any healing methods that can be utilized?	• Network for conversations/space to have conversations • Follow-up to conversations and the impact of the conversation on the organization • Finding resiliency within experience and being able to talk about it • Behavioral health consultants used to promote healing • Having staff who have experienced the trauma of racism • Be careful not to make assumptions • Implementing trauma informed care in all aspects of work to create a safe space • Needs to be very specific to each population (US vs. foreign born black) • Talk • Overcome your fears • Open to hearing/listen and not get angry • Surveying patients and clients before and after – and past experiences (intake form) • List of principles • Ability to identify internalized language – e.g., I know it's gross that I share needles
Who else could we work with to implement these strategies?	• Monsoon – they work with Asian/Pacific Island women • Administration • Human Resources • Community partners • Community leaders • Families • Schools • PHC disparity group – working with a women's group • ID helpers or advocates • Storytelling and when to use it
Are there any other strategies you would add?	• Peer support networks

	• Sharing with clients that they are a product of their environment, acknowledge it, and figure out how to move on from it and continue • How to incentivize peoples time • Over sampled and underserved • Explore other barriers that stop minoritized people from participating in CPG and other organizations

Conner Spinks – doesn't think allies will be effective when so much work still needs to be done. Goals 1 and 2 should be prioritized. Holly commented that this is presented at the individual level first for this reason. Jamesetta talked about who will be providing healing messages or getting service providers to recognize that they may be the ones who are perpetuating racism.

Committee Reports

1. Gay Men's Health Committee

   Biz McChesney reported that the group did not meet last night and there was no opportunity to meet with Jacob to get updates.

2. Quality Management

   Theresa Schall reported that the group is still focusing on youth and people who are Black/African American and now trying to reach out to agencies across the state to see what activities are going on to address these populations. The Rural Outreach Liaisons (ROLs) will be participating in some activities to address this and will report back on the IDPH regional calls.

3. Trauma-informed care

   Holly Hanson reported that re-hiring for the vacant Trauma-informed Care position is on hold until further notice. Dustin Wagner, the new Special Projects Manager, started with the HIV Special Projects Division. A cross-sector trauma-informed leadership team has been meeting and getting to know each other. This team is in the beginning stages of developing a statewide plan for trauma-informed care across sectors.

Other Business

Checkout Completion

Colleen Bornmueller asked members to complete and turn in their check-out forms.

Call to the Public

No comments from the public.

Announcements

None

Adjourn

Samantha Willey motioned to adjourn the meeting. The motion was seconded by Tim Campbell. The motion was approved. The meeting was adjourned at 3:55 pm.

Respectfully submitted,

Cristie Duric