Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

INTEGRATED STRATEGIES COMMITTEE (ISC) MEETING AGENDA

WEDNESDAY FEBRUARY 22, 2023 – 1:00PM TO 3:00PM

ONLINE MEETING VIA ZOOM

Note: all times are approximate

1:05 pm	**1. Call To Order and Moment of Silence** **2. Welcome and Introductions**
1:10 pm	**3. Review and Approve the Agenda for February 23, 2023** **4. Review and Approve the Minutes from January 25, 2023**
1:15 pm	**5. Check-In – How are YOU!?**
1:20 pm	**6. Health Equity Position Paper Discussion**
1:45 pm	**7. Other Business** - **Child Care Standard Update** **8. Future Agenda Items** - **EHE Update**
2:00 pm	**9. Announcements & Adjournment**
NEXT INTEGRATED STRATEGIES COMMITTEE (ISC) MEETING:	**MARCH 22, 2023** **1PM – 3PM** **ELECTRONIC MEETING VIA ZOOM**

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INTEGRATED STRATEGIES COMMITTEE (ISC)
MEETING MINUTES

WEDNESDAY, JANUARY 25, 2023 - 1:00PM

ZOOM CONFERENCE AND VIDEO CALL

ELECTRONIC – ONLINE MEETING

ATTENDEES/ROLL CALL

COMMISSIONERS	PRESENT	ABSENT	COMMITTEE MEMBERS	PRESENT	ABSENT
Camara, Farima		X	Givens, Phyllis		X
Cauthen, Melvin	X		Mitchell, NaToya		X
Clark, Lamont (Govt. Co-chair)	X				
Gomez, Ana		X			
Gutierrez, Anthony		X			
Hutton, Kenya	X				
Keita, Rama		X	**COMMUNITY PARTNERS/GUESTS**	**PRESENT**	**ABSENT**
Ollinger, Joshua		X	Jordan, Alexandra	X	
Pettigrew, Ken		X	Taliaferro, Tiffany	X	
Wallis, Jane	X		**CONSULTANTS**	**PRESENT**	**ABSENT**
			Osei, Alexis		X
			Seiler, Naomi	X	
			Turner, Taylor	X	
			Washington, Mekhi	X	
RYAN WHITE RECIPIENT STAFF	**PRESENT**	**ABSENT**	**COMMISSION SUPPORT STAFF**	**PRESENT**	**ABSENT**
Coleman, Ashley		X	Bailey, Patrice	X	
Delao Hernandez, Jose		X	Johnson, Alan	X	
Olejemeh, Christie	X				
Orban, Julie	X				
HAHSTA STAFF	**PRESENT**	**ABSENT**			
Cooper, Stacey	X				
Wimberly, Ashlee	X				

HIGHLIGHTS

NOTE: This is a draft version of the January 25, 2023, Integrated Strategies Committee (ISC) Meeting Minutes which is subject to change. The final version will be approved on February 22, 2023.

AGENDA

ITEM	DISCUSSION
Call to Order	Jane W. called the meeting to order at 1:06 pm followed by a moment of silence and introductions.
Review and Approval of the Agenda	Jane assumed the motion to adopt the meeting agenda for January 25, 2023. The agenda was adopted as is.
Review and Approval of the Minutes	Jane assumed the motion to approve the meeting minutes for the December 14, 2022, meeting. There were no corrections to the minutes. The meeting minutes were approved as presented.
Check – In	Melvin C. shared that his excitement to focus on his role after covering two positions for the last couple of years was short-lived as the program manager for client services recently resigned. The position has been posted internally this week and will be posted externally if no internal candidate is found. As of today, Jane's organization just extended their footprint to offering prevention services in Philadelphia.
Position Papers Discussion	***Health Equity Position Paper*** Naomi S. and Mekhi W. provided updates on the Health Equity Position Paper. Mekhi noted that the surveillance data points to the 2021 DC Health Surveillance Report and citations. Julie O. noted that the 2022 Surveillance Report will be released in early February. Mekhi walked through the newly developed nine-page Executive Summary. The committee recommended condensing the Executive Summary. Lamont suggested two paragraphs per content area and then a separate summary of positions document. Naomi suggested the committee review the draft COHAH Equity work plan/action plan adapted from the paper within the month.
Service Standards Review	None noted.
Service Standards Discussion	***Child Care Service Standards*** Dr. Christie O. noted that the health standard committee is scheduled to meet next week. The Ryan White Program is planning some community engagement with Ryan White Providers to do a survey to gauge interest and client need for Child Care Services.
Integrated Planning	Julie noted that she will present on the Integrated Plan at the February General Body Meeting.
Other Business	None noted.
Future Agenda Items	Equity Paper Child Care Service Standards Update (if applicable)

	EHE Update (March) – Invite other Jurisdictions to meetings.
ANNOUNCEMENTS/OTHER DISCUSSION	Lamont reminded everyone that COHAH has an open call for membership. COHAH is especially seeking Women living with HIV in Maryland and Virginia. Please invite guests to the General Body meeting and committee meetings.

HANDOUTS

- January 25, 2023, Integrated Strategies Committee Meeting Agenda
- December 14, 2022, Integrated Strategies Committee Meeting Minutes

MEETING ADJOURNED	**1:41 PM**	**NEXT MEETING**	**WEDNESDAY, FEBRUARY 22, 2023 1:00pm to 3:00pm ZOOM CONFERENCE AND VIDEO CALL**

Executive Summary: Advancing HIV Health Equity by Addressing Social Determinants of Health in the DC EMA

Introduction

The Washington DC Commission on Health and HIV (COHAH) supports action to address the significant disparities in the impact of HIV across racial and ethnic lines. This executive summary provides an overview of HIV disparities in the DC region and outlines policies, principles, and activities that the Commission supports to promote health equity. COHAH has focused on the specific role of key social determinants of health driving HIV inequities: employment, housing, transportation, food, medical care, medical mistrust, HIV stigma, and education. COHAH's full report provides further detail on these issues, as well as descriptions of local programs and providers already working to address these gaps.

Health and HIV Inequities Nationally and in the DC Region

Among the estimated 1.2 million people living with HIV (PLWH) in the United States in 2019,[1] prevalence was highest among Black, Multiracial, and Hispanic people, with rates three to seven times higher than white people.[*] Nationally, Black men who have sex with men (MSM) experience the highest number of HIV diagnoses of all subgroups, despite making up a small proportion of the total population.

These same health inequities are observed across the DC region. For example, in 2021, 63.9% of people newly diagnosed with HIV in DC were Black[2] as were 79.5% of people newly diagnosed in Prince George's County.[3] People of Hispanic/Latinx descent also made up a significant portion of the newly diagnosed in 2021, accounting for 13.9% of newly diagnosed people in DC and and 29.7% of new diagnoses in Montgomery County, Maryland.[4] In Northern Virginia in 2021, 45% of people newly diagnosed with HIV were Black, while 26% were Hispanic/Latinx and 13% were white.[5]

Employment

Research suggests that PLWH experience unemployment at three times the national rate,[6] due to factors including stigma, restrictive policies, and disease progression.[7] Unemployment is associated with lack of testing for HIV, delayed HIV diagnosis, and delayed access to active anti-retroviral therapy (ART), with the most significant delays in ART initiation found in poverty-stricken areas.[8] In the DC EMA, lower-income communities and communities experience the highest rates of unemployment, which puts them at an increased risk for HIV complications, lower rates of medication adherence, and an increased risk of homelessness, depression, and poverty.[9]

[*] In this executive summary and the full report, COHAH may use different terms to describe specific populations of people, depending on the terms used in source materials such as state surveillance reports or peer-reviewed articles.

COHAH supports the following principles, positions, and activities regarding employment for people living with or at risk of HIV in the DC EMA:

Federal, State, and Local Policies.
COHAH supports:

- Efforts to improve coordination between Departments of Health and Departments of Employment Services
- Mandatory paid family and medical leave to improve access to medical care and recovery from illness for PLWH and those at risk.
- Enforcement of anti-discrimination protections in the workplace, including related to actual or perceived HIV status, substance use disorder, and other types of workplace discrimination that impact PLWH and those at risk

Service Delivery and Programming
COHAH supports:

- Efforts to ensure that health care and social service providers have information on employment assistance services, including whether these services are accepting new clients
- Targeted efforts to link people who are undocumented, people who are chronically unhoused, young Black and Latino gay men, and transgender women with employment services
- The development of procedures (such as warm handoffs) and allocation of resources to ensure that social service providers are successful in enrolling clients in employment assistance services
- The provision of employment assistance in multiple languages
- Evaluations of the effectiveness of general employment services for PLWH and at risk of HIV, and identification of employment services overlap with programs administered by health departments and HOPWA
- Further research on the use of HIV testing services to facilitate linkage to employment services and efforts to expand testing to people who are unemployed

Housing

For people living with HIV(PLWH), a lack of safe and stable housing can be a significant barrier to accessing HIV care and has been associated with poorer access and adherence to antiretroviral therapy, incomplete viral suppression, and greater risk of HIV transmission.[10,11,12,13] Conversely, stable housing can improve health outcomes, reduce overall healthcare costs, and is positively associated with keeping up with medical treatments and appointments and with viral suppression.[14,15] Unfortunately, PLWH experience homelessness at a rate three times higher than the general population,[16] due in part to the costs of HIV care and higher rates of unemployment.[17]

DC has one of the highest rates of homelessness in the country, and more than half of DC-area renters spend more than 30% of their income on housing.[18,19] In Northern Virginia, 67% of low-income families spend more than half of their income on housing, with Black families, Hispanic families, and immigrant families most likely to be severely burdened by housing costs.[20] In Maryland's EMA counties, and particularly in Prince George's County, both renters and

homeowners experience a high housing cost burden, with the greatest need concentrated among people of color.[21]

COHAH supports the following principles, positions and activities regarding housing for people living with or at risk of HIV in the DC EMA:

Federal, State, and Local Policies

COHAH supports:

- Efforts to increase the rent ceiling for Ryan White-funded direct housing assistance from 50% FMR to 80% FMR
- Federal, state, and local efforts to fund housing and enact protected classes in jurisdictions beyond DC for aging people (especially ages 40-60), people with accessibility needs, transgender people, and undocumented people
- Removing federal, state, or local policy barriers to transitional and short-term housing (e.g. employment or sobriety requirements, instead implementing a "housing first" approach)
- The enactment of tenant protections, including requiring a court hearing before foreclosure, mandated right to counsel, and sealing or expunging eviction cases after two years, in jurisdictions beyond DC

Service delivery and programming

COHAH supports:

- Sharing information about tenants' legal protections to PLWH and people at risk of HIV
- Improved coordination between state and local health departments and HOPWA
- Providing government agencies with more latitude to service undocumented people
- Education for Ryan White-funded housing programs to ensure they understand that HUD's housing programs do not condition receipt of HOPWA services on immigration status or screen applicants for immigration status

Transportation

Transportation issues can also present significant obstacles to service utilization for PLWH. HIV-positive individuals who experience transportation vulnerability are less likely to receive HIV-related medical and ancillary care.[22, 23] Increasing access to public transportation and expanding medical service provision in underserved areas can better help PLWH access and maintain care.

In the District, transit issues are most prevalent among residents from Southeast DC, particularly those who live east of the Anacostia River in Wards 7 and 8, both with the highest prevalence of HIV in DC. Approximately 91% of people who live in Wards 7 and 8 are Black (compared to 42% citywide),[24] and residents of these wards face longer travel times, fewer metro stops, higher bus ridership and overcrowding, and lower bus reliability.

COHAH supports the following principles, positions and activities regarding transportation for people living with or at risk of HIV in the DC EMA:

Federal, State, and Local Policies

COHAH supports:

- Free or subsidized public transportation, as well as selected rideshare services for low-income individuals to access medical and supportive care
- Policies that facilitate telehealth, mobile clinics, and home-based HIV and STI testing
- Access to free or subsidized Wi-Fi access for low-income individuals to access telehealth when in person services are challenging to reach

Service Delivery and Programming

COHAH supports:

- Efforts to improve the availability and ease of use of non-emergency medical transportation
- Efforts to establish one-stop shops for health care and social services
- COHAH supports further research into the impact of telehealth services in facilitating access to HIV prevention and care

Food

Food insecurity affects about 11% of all Americans,[25] and between a quarter to a half of all PLWH.[26] Food insecurity can lead to adverse HIV clinical outcomes, including non-adherence to ART increased risk of transmission, and incomplete viral load suppression.

DC's 2017 consumer needs assessment found that more than one in three respondents reported lacking enough money for food or other necessities at some point during the year.[27] Wards 7 and 8 have the highest levels of food insecurity and some of the highest concentrations of HIV-positive individuals in the DC area.

COHAH supports the following principles, positions and activities regarding food insecurity for people living with or at risk of HIV in the DC EMA:

Federal, State, and Local Policies

COHAH supports:

- Advocacy for policies that address the needs of LGBTQ+ individuals, youth, and unhoused individuals
- Expanded access to medically tailored meals through Medicare and Medicaid
- Additional funding for programs that address food insecurity among PLWH and people at risk of HIV
- Flexible timelines and documentation standards to decrease administrative burden experienced by individuals attempting to access federal and local food access programs

Service Delivery and Programming

COHAH supports:

- Efforts by hospitals and health centers to screen PLWH and people at risk of HIV for food insecurity and other health-related social needs
- Efforts by hospitals and health centers to create a standardized, closed-loop referral procedure for referring clients to food access organizations

- Targeted outreach to populations vulnerable to food insecurity, including Latinx households who may have limited their utilization of SNAP and WIC due to the prior Administration's public charge rule

Insurance and other Factors Impacting Access to Medical Care

The ability or inability to access medical care is a major factor in driving the health of PLWH or at risk of HIV. In multiple studies, PLWH have reported that barriers to accessing health care include insufficient insurance coverage, substance use, mental health issues, cognitive or physical impairments, and distance to reach HIV care providers.[28,29,30,31] Conversely, the presence of insurance, case management, and a positive relationship with healthcare providers have been associated with improved engagement in HIV care and care retention.[32,33]

Racial disparities in insurance coverage in the DC EMA largely mirror national trends. Despite high rates of overall insurance, there are stark disparities in coverage based on race, ethnicity, and income, with Hispanic/Latinx people and people earning below 138% of the federal poverty level most likely to be uninsured.

Accessing mental and behavioral health services is a particular challenge for PLWH, who experience mental illness and substance use disorder at significantly higher rates than the general population.[34,35]

Within HIV service organizations, insufficient funding, suboptimal training, reliance on passive outreach strategies, lack of patient navigation, and difficulty collaborating between medical providers and community-based organizations (CBOs) can hinder access to care for underserved populations.[36]

COHAH supports the following principles, positions and activities regarding access to medical care for people living with or at risk of HIV in the DC EMA:

<u>Federal, State, and Local Policies</u>
COHAH supports:
- State and local public insurance programs for uninsured individuals who are not eligible for Medicare or Medicaid, such as people who are undocumented immigrants
- Telehealth reimbursement parity to improve access to services
- Policies and models of care that remove administrative barriers to accessing health care and decriminalize and/or destigmatize sexual health and behavioral health

<u>Service Delivery and Programming</u>
COHAH supports:
- Efforts to reduce barriers to mental health/SUD provider participation in Ryan White and Prevention funded programming
- Models of care that assure cultural competence and language access among health care and social service providers for multilingual populations
- Research into approaches adopted by other jurisdictions to increase or support the behavioral health/SUD workforce

Medical Mistrust and HIV Stigma

Another major factor hindering access to medical care is medical mistrust. Rates of medical mistrust are higher among Black and Latinx communities,[37,38,39] reflecting personal and generational experiences of mistreatment and racism.[40] Medical mistrust may be informed by a number of factors, including systemic racism, which may manifest as a lack of funding or attention toward the health of people of color or other groups.[41] It may also be informed by historical trauma, such as the enslavement of African Americans, the genocide of Native Americans, and other forms of oppression, cultural destruction, and displacement.[42]

HIV stigma is another important barrier to HIV care. Stigma may be internalized (HIV stigma felt by PLWH) or experienced on interpersonal, institutional, and structural levels. Homophobia, transphobia, racism, classism, and negative views of people who inject drugs can feed into HIV stigma.[43]

COHAH supports the following principles, positions and activities regarding medical mistrust and HIV stigma for PLWH or at risk of HIV in the DC EMA:

Federal, State, and Local Policies

COHAH supports:

- The development of a plan, which may overlap with jurisdictions' Ending the Epidemic goals, to identify and promote evidence-based policies to reduce HIV stigma
- The creation of accountability measures (including funding implications) to promote the adoption of best practices for stigma reduction and trust building
- Replication of Virginia's CAP advisory board across EMA jurisdictions

Service Delivery and Programming

COHAH supports:

- Expand provider networks to ensure that people who feel stigmatized by or mistrustful of their provider can seek care elsewhere
- Integration of community health workers into client care teams to address mistrust and assess social needs
- Efforts to promote transparent, patient-centered care, including spaces where people feel comfortable accessing testing and prevention services
- The creation and dissemination of a self-assessment tool for Ryan White and health department prevention funded providers to determine how they evaluate and address stigma, paired with a patient assessment to identify best practices and areas of improvement for stigma reduction and trust building
- Initiatives to hire healthcare providers and staff who reflect the communities being served, including people who can provide translation services
- Diverse leadership of Ryan White and Prevention-funded health care providers and community-based organizations

- Further research into existing cultural competence/humility and hiring practices in the DC EMA, how providers are held accountable, what assessments are performed, and whether these practices are effective
- Efforts to examine the origins of the medical mistrust narrative and ensure that understanding of medical mistrust is community-led
- Further research on stigma and mistrust surrounding HIV testing, substance use, and behavioral health

Education

Research shows that greater educational attainment is associated with higher rates of HIV testing, increased rates of viral suppression, and improved adherence to ART in some individuals.[44,45]

Aside from broader associations with educational attainment, specific education about sex and HIV in school and community settings can also improve health among youth and adults. Comprehensive sex education has been shown to reduce sexual risk behaviors, such as unprotected sex and having sex with multiple partners.[46] However, not all states require comprehensive sex education in schools.[47] Even where offered, sex education may not be inclusive to all minority groups and sexual orientations.[48] In some studies, students of color, including Hispanic and Black students, were less likely to report having received HIV education than white students.[49]

COHAH supports the following principles, positions and activities regarding HIV and sexual health education for people living with or at risk of HIV in the DC EMA:

Federal, State, and Local Policies

COHAH supports:

- Equitable education policy when implementing health education standards nationwide
- Education departments holding LEAs and schools accountable for sexual health education requirements
- The use of health department funding for upstream patient outreach and education for youth on how to access services and testing
- The inclusion of health education in jurisdictions' Ending the Epidemic Plans

Service Delivery and Programming

COHAH supports:

- The Whole School, Whole Community, Whole Child (WSCC) model for education and efforts to provide sexual health education using culturally and linguistically appropriate approaches
- Sexual health education in schools, particularly CDC-funded education, based on the National Sexuality Education Standards
- Better integration of health department and education department policies and goals
- A greater emphasis on education about HIV testing, including in school-based health education.

- Initiatives to increase the emphasis on education about sexual health for all Ryan White and Prevention-funded providers in the EMA
- Research into how authority and reporting for sexual health education initiatives from school agencies (such as OSSE) and health agencies (such as DC Health) overlap
- Research into other promising programs in the EMA that are helping to educate youth about sexual health and HIV prevention, including current CDC-funded school-based education projects

Conclusion: COHAH's Next Steps

In addition to the positions outlined above, COHAH intends to redouble its efforts to promote health equity in the DC region by focusing on the key social drivers of health underlying disparities in HIV acquisition and access to services. Specifically, COHAH will work to ensure that our needs assessment process and Priority Setting and Resource Allocation processes gather information on, and steer resources to, gaps in these areas. We will also work to identify innovative programs in the EMA that serve people in ways that promote health equity. Finally, COHAH will reach out to service providers and agency officials working across these topics to identify needs and opportunities to promote access to care, treatment, and prevention services.

[1] https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
[2] https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-Annual-Surveillance-Report_0.pdf
[3] https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Prince-George%27s-County-Fact-Sheet--2021.pdf
[4] https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Montgomery-County-Fact-Sheet--2021.pdf
[5] Virginia HIV Surveillance Annual Report. Data Reported 2020-2021. 2022. https://www.vdh.virginia.gov/content/uploads/sites/10/2022/05/HIV-Annual_Report_Update_2021.pdf
[6] People Living With HIV. The GAP Report 2014. https://www.unaids.org/sites/default/files/media_asset/01_PeoplelivingwithHIV.pdf.
[7] People Living With HIV. The GAP Report 2014. https://www.unaids.org/sites/default/files/media_asset/01_PeoplelivingwithHIV.pdf.
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