

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ADVISORY COMMITTEE ON MINORITY HEALTH**

**EXECUTIVE SUMMARY**

**August 22–23, 2019  
Rockville, Maryland**

**Advisory Committee on Minority Health**

Winston F. Wong, MD, MS, FAAFP, Chair  
Sheri-Ann Daniels, EdD, MSCP, BS, CSAC  
Linda D. Bane Frizzell, PhD, MS (by teleconference)  
Raul I. Garcia, DMD, MMedSc  
Gregory J. Maddox II, MD, MS  
Sela V. Panapasa, PhD  
Veronica G. Parker, PhD, BS  
Beverly Patchell, PhD, APRN, PMHCNS-BC  
Veronica Vital, PhD, MSN, BSN, RN  
Kimberlydawn Wisdom, MD, MS  
Clyde W. Yancy, MD, MSc

**Federal Staff**

CAPT Felicia Collins, MD, MPH, Deputy Assistant Secretary for Minority Health, Office of Minority Health, U.S. Department of Health and Human Services  
Tammy Beckham, DVM, PhD, Director, Office of Infectious Disease and HIV/AIDS Policy, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services  
Donna Hubbard McCree, PhD, MPH, RPh, Associate Director for Health Equity, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention  
Violet Woo, MS, MPH, Designated Federal Officer, Office of Minority Health  
CAPT Samuel Wu, PharmD, Office of Minority Health  
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**Invited Presenters**

Daniel D. Driffin, MPH, Deputy Executive Director, Living Room; Cofounder, THRIVE Support Services  
Ayn N. Whyte, MS, STD/HIV/AIDS Prevention Program Director, Albuquerque Area Indian Health Board  
Ben Cabangun, MA, Managing Director of Capacity Building, Asian & Pacific Islander American Health Forum  
Daniel Ramos, MPHE, Strategic Alliances Specialist, Puerto Rico Primary Care Association, San Juan, Puerto Rico  
June Gipson, PhD, EdS, President and CEO, My Brother's Keeper  
Gabriel Maldonado, MBA, Founder & Chief Executive Officer, TruEvolution

**Day One—Thursday, August 22, 2019**

## **Call to Order, Welcome and Introductions**

### **Landscape of Meeting**

*Winston Wong, MD, Chair, Advisory Committee on Minority Health*

Dr. Wong called the meeting to order, and Advisory Committee on Minority Health (ACMH or Committee) members introduced themselves. Dr. Wong reminded the audience that the objectives of the ACMH are to:

1. Develop collaboration and teamwork among Committee members in order to assist the Office of Minority Health (OMH) in its mission of meeting programmatic objectives; and
2. Provide guidance to the Deputy Assistant Secretary for Minority Health on the development of policies, programs, and practices that help to eliminate racial and ethnic health disparities in areas identified by the U.S. Department of Health and Human Services (HHS) Secretary and OMH.

The meeting objectives were to develop actionable recommendations for the Office of the Assistant Secretary for Health (OASH) to support the HHS *Ending the HIV Epidemic Initiative* to:

1. Broaden community engagement to better identify HIV-related unmet needs and drive community plan development; and
2. Identify ways to reduce stigma and discrimination for individuals from racial and ethnic minority and American Indian/Alaska Native (AI/AN) populations to maximize HIV prevention, diagnosis, and treatment.

### **OMH Welcome and Updates**

*CAPT Felicia Collins, MD, MPH, Deputy Assistant Secretary for Minority Health, OMH*

CAPT Collins welcomed Committee members. She acknowledged that their expertise well positioned ACMH to develop recommendations to help reduce disparities in HIV within racial and ethnic minority and AI/AN communities. She reviewed the vision of OASH of leading America to healthier lives and the mission and functions of OMH.

For Fiscal Year (FY) 2020, OMH is enhancing its focus on the identification of successful practices for reducing health disparities and the sustainability and spread of these practices within racial and ethnic minority and AI/AN communities via interactive quality improvement (QI) processes. OMH wants to support States, Tribes and Territories in applying the same QI processes to any new emerging public health issue to address health disparities.

CAPT Collins provided an overview of the *Ending the HIV Epidemic: A Plan for America (EHE Initiative)*. Led by OASH, the current *EHE Initiative* will target resources to 48 counties with the highest HIV burden plus Washington D.C.; San Juan, Puerto Rico; and seven States with a substantial rural HIV burden. Within those jurisdictions, OASH plans to help communities engage in activities that help eliminate racial and ethnic disparities in HIV incidence and prevalence, accessing and engaging in HIV care, and achieving HIV viral load suppression.

CAPT Collins also highlighted the Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) that OMH developed in 2000 and updated in 2013. The National CLAS Standards were developed to address the need for health services that are both respectful and responsive to patients' language needs and cultural beliefs. These standards help providers understand and address cultural, social, and linguistic issues in a way that promotes patient satisfaction and improved health outcomes.

## **I. Ending the HIV Epidemic: A Plan for America**

*Tammy Beckham, DVM, PhD, Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP), Office of the Assistant Secretary for Health*

Dr. Beckham provided an overview of the federal cross-agency *EHE Initiative*. She provided data regarding the costs of HIV in terms of lives lost and healthcare expenditures. Recently, progress has stalled in combating the HIV epidemic, and the number of new diagnoses has not decreased over the past several years. About 400,000 additional Americans will be diagnosed with HIV over the next 10 years if robust initiatives and interventions are not implemented soon.

The *EHE Initiative* was announced in February 2019 to end the HIV epidemic in the next decade. The goals are to reduce new HIV infection by 75 percent in five years and to reduce new infections by at least 90 percent in 10 years. Phase 1 will focus efforts in those geographic regions with the highest HIV burden to achieve the 5-year goal. During the following five years, Phase 2 will widely expand efforts to achieve the 10-year goal. Phase 3 activities will maintain the number of new infections to fewer than 3,000 per year using intense case management.

OIDP has allocated and utilized \$30 million of the Minority HIV/AIDS Fund (MHAF) for FY 2019 activities that lay the foundation for the FY 2020 kickoff. Dr. Beckham provided an overview and current status of these FY 2019 activities, which are being conducted in collaboration with other partners in the federal government. Federal partners have visited over 70 percent of the targeted jurisdictions to meet and listen to stakeholders to ensure that the EHE Initiative is community driven. Other FY 2019 activities include:

- **Development of community plans:** The Centers for Disease Control and Prevention (CDC) and Indian Health Service (IHS) will work with the jurisdictions identified in Phase 1 to develop community plans so that plans are already in place for FY 2020. CDC released a Notice of Funding Opportunity (NOFO) in June 2019 for jurisdictional planning effort with a target award date of September 2019;
- **Scientific activities:** The National Institutes of Health (NIH) plan to fund Centers for AIDS Research to develop a data analysis and visualization system, or dashboard, to enable the tracking of progress nationally and per jurisdiction; and
- **Prevention through Active Community Engagement (PACE) Program:** The United States Public Health Service (USPHS) Commissioned Corps have been deployed to HHS regions 4 (Atlanta), 6 (Dallas), and 9 (Los Angeles) and are dedicated to working on the *EHE Initiative*.

The planned FY 2020 activities include four projects that are summarized below.

- The Jumpstart Initiative will include lessons learned from pilot projects and will be supported by \$1.5 million from MHAF. These activities are supported by CDC and will

take place in Baltimore, Maryland; East Baton Rouge, Louisiana; and DeKalb County, Georgia. The IHS will support activities for American Indian populations in Cherokee Nation and Oklahoma.

- HRSA has released three NOFOs recently around the *EHE Initiative* with a target award date of March 2020:
  1. Ryan White HIV/AIDS Program Parts A and B will award \$55 million across the jurisdictions identified in Phase 1;
  2. Technical Assistance Provider will include one award of \$3.75 million and
  3. Systems Coordination Provider will include one award of \$1.25 million to assist in coordinating and integrating the awardee's initiative plans.

*Donna Hubbard McCree, PhD, MPH, RPh, Associate Director for Health Equity, Division of HIV/AIDS Prevention (DHAP), CDC*

Dr. McCree provided an overview of the epidemiologic basis for ending the HIV epidemic in general. She also presented data on the communities identified for the *EHE Initiative*, based on the National HIV Surveillance System database of adults and adolescents 13 years and older. The data provide clear evidence that the rate of new infections disproportionately affect black and Latino gay and bisexual men as well as black heterosexual women. The following data populations were reviewed.

- HIV Incidence: There were an estimated 38,700 new HIV infections in 2016. The most disproportionately affected are black and Latino gay and bisexual men. From 2010 to 2016, there was no change in the rate of new HIV infection for blacks overall, but an increase among Latinos. Black, heterosexual women were also disproportionately affected. Incidence data shown as percent of population also demonstrate these disparities.
- HIV Prevalence: There were an estimated 1.1 million people living with HIV/AIDS (PLWHA) in 2016 but only 86 percent of PLWHA had a diagnosed infection. In other words, 1 in 7 PLWHA did not know they were infected with HIV. Blacks and Hispanics/Latinos were disproportionately undiagnosed PLWHA. The majority of HIV transmissions were through those who were unaware of their HIV status or were aware but not in care.
- Diagnosis of HIV infection among persons who may have been infected for a number of years: In 2017, 38,739 diagnosed with HIV infection among which 1 in 5 were among women and 67 percent were from men who have sex with men (MSM).
- HIV Surveillance Report from 2012 to 2016: Data reflect a 9-percent decrease of HIV diagnosis in women, 25-percent increase in white people who inject drugs, and a stable rate in MSM.

Dr. McCree also discussed how racial and ethnic disparities are not due solely to differences in behaviors among these populations.

- Social determinants are believed to play a large role in rates of HIV among the more affected populations. Thus, efforts to reduce racial and ethnic disparities in HIV should also address social determinants of health (SDOH), such as lack of health insurance, inadequate transportation, unstable or lack of housing, pervasive HIV-related stigma,

barriers to HIV care and treatment, and racism and discrimination (including homophobia and transphobia).

- Differences in HIV rates are also seen based on geographic location. Southern states (2016) account for 38 percent of the U.S. population but bear the highest burden of HIV infection, reflecting 51 percent of the annual HIV infections, 45 percent of PLWHA, and 50 percent of undiagnosed HIV infections.

## **II. Rethinking Community Engagement**

The following four subject matter experts were invited to present their experience in engaging their respective communities with programs that address HIV.

### **African-American Communities**

*Daniel D. Driffin, MPH, Deputy Executive Director, Living Room; Cofounder, THRIVE Support Services*

Mr. Driffin cofounded and established the Transforming HIV Resentment into Victories Everlasting (THRIVE) System, a community-based organization (CBO), addressing the lack of support for blacks living with or at risk for HIV/AIDS in the Atlanta, Georgia area. THRIVE is also an active member of the [HRSA supported] Ryan White Part A Program. THRIVE provides after-hours support to answer questions on various topics, such as medical adherence, the AIDS Drug Assistance Program and how to disclose HIV status to sexual partners and others. Since its establishment in 2015, THRIVE has grown from serving 45 to 950 black gay men connected to an online support system, with an additional 3,400 people supported across the southeast. Currently, the support system is comprised of a network of auxiliary groups that support multiple facets of the continuum of life beyond HIV.

Based on the experience of creating solutions for unmet needs in the community, Mr. Driffin described his efforts and multiple initiatives to engage the community in movement toward health equity and healthier lives.

- He created a post on his Facebook page asking viewers to “define community engagement” and received several comments. These comments include:
  - Trust. Health Departments are not going to end the HIV epidemic through talking “at” the community four times per year.
  - To drive the epidemic toward an end, the community must create, implement, and evaluate new programs and integrate them into the community system;
  - Love; and
  - Ending the “dis-ease” of systems.
- The challenge is to define what communities look like at home. People “in the room” do not mirror the communities they are looking to serve, such as transgender men and transgender women and the younger population. Inclusion matters. In addition, persons assumed not to be at risk should be included or else there is not much movement toward equity and healthier lives.
- Needed efforts and initiatives include communicating to, listening to, and understanding the culture of the community; media campaigns that depict positive images of members of the community; surveys on engagement; availability of services during nontraditional

business hours, including crisis services for housing and meals; and developing a workforce that reflects the community.

***Mr. Griffin offered the following suggestions to the Committee as it considers community engagement activities:***

- Invite MSM community members to the table as decision-makers and evaluators as program plans develop;
- Continue financial and personal investments within communities;
- Ensure that small start-up CBOs are included in grants as consultants or project leads;
- Consider nontraditional partnerships to reach the target population; and
- Encourage emerging leaders by providing resources to develop additional skills that can be reinvested into the community.

### **American Indian/Alaska Native Communities**

*Ayn N. Whyte, MS, STD/HIV/AIDS Prevention Program Director, Albuquerque Area Indian Health Board, Inc.*

Ms. Whyte provided an overview of the Albuquerque Area Indian Health Board, Inc. (AAIHB), a 100-percent Indian-owned and tribally-run organization that serves communities in New Mexico, southern Colorado, and west Texas and includes five consortium tribes. The AAIHB's mission is to advocate on behalf of American Indians (AIs) for the delivery of quality healthcare services that honor spiritual and cultural values. The STD/HIV/AIDS Prevention Program is one of multiple AAIHB programs serving the area's AI population. Ms. Whyte shared how AI communities are typically 10–20 years behind in knowledge, education, and access to medical interventions. For example, pre-exposure prophylaxis (PrEP) was just recently added to tribal formularies.

Ms. Whyte described barriers and challenges to addressing HIV in AI communities and multiple initiatives implemented by the AAIHB to involve the community. The barriers included:

- Experienced trauma, which is often inter-generational and negatively affects cultural identity;
- Loss of cultural identity toward sexuality post-colonization. For example, when a young woman comes of age, there traditionally is a four-day celebration to honor womanhood. However, subsequent to many mothers being forced to attend boarding school, this tradition has been disrupted. Instead of a celebration upon entering womanhood, shame has been associated with a young woman's first menses. As such, the traditional cultural identity is lost;
- Stigma of HIV creating fear and denial in the community;
- Lack of training on sexual health education;
- Community prejudice and discrimination against people who they think are at risk for HIV;
- Community insensitivity to HIV issues;
- Lack of provider resources; and
- Community engagement in behavior that may put them at risk for HIV.

The communities were engaged in initiatives, such as developing culturally-guided HIV information, offering rapid HIV and hepatitis C testing services at the community level, supporting indigenous ideology that promotes positive sexual health messages, and developing healing-centered approaches to dismantle historical trauma. These promising initiatives in AI/AN communities are focused on reinforcing supportive and loving relationships within AI/AN families and communities.

***Ms. Whyte offered the following suggestions to the Committee as it considers community engagement:***

- Communicate with AI/AN leadership to become knowledgeable of how tribal government structures varies across communities;
- Understand the culture of how AI/AN individuals relate to one another;
- Normalize screening as part of overall wellness;
- Provide warm handoffs to treatment and care service providers after screening/diagnosis;
- Offer culturally guided PrEP navigation services; and
- Educate, endorse, and promote “Undetectable means Untransmittable” (U=U).

**Asian American, Native Hawaiian and Other Pacific Islander Communities**

*Ben Cabangun, MA, Managing Director of Capacity Building, Asian & Pacific Islander American Health Forum*

Since 1993, Mr. Cabangun has managed an HIV portfolio comprising cooperative agreements to provide technical assistance (TA) and training to HIV CBOs, health departments, and community health centers throughout the nation, in cooperation with CDC. He gave an overview of data suggesting that Asian American, Native Hawaiian and other Pacific Islander (AANHPI) populations, particularly gay and bisexual men in these communities, are disproportionately impacted by HIV. Barriers to diagnose include:

- AANHPIs are a vastly under-tested population. Health providers believe AANHPIs are at low risk for HIV infection and do not offer HIV tests. As such, the data fail to support HIV as an issue in AANHPI communities;
- AANHPIs are afraid to get tested for infectious conditions for fear of rejection by family and community. A public service advertisement for Hepatitis B screening addressed the fear that is associated with disease diagnosis. In the San Francisco based program, the campaign “Hepatitis B Free” utilized a public service announcement that asked, “Which one deserves to die?” while displaying a picture of a cross-section of Asian Americans. This particular approach was extremely successful in encouraging Asians to seek screening;
- there is a lack of targeted HIV testing campaigns or funded strategies for AANHPIs. Out of 88 CDC grantees, only 1 was funded to work with AANHPIs (in Los Angeles); and
- based on more than 25 years of experience as capacity-building providers in this sector and in working with national partners implementing HIV prevention programs in AANHPI communities, the greatest barrier to engaging AANHPI communities in ending the HIV epidemic stigma. In these communities, a culture of silence leads to a culture of ignorance, which produces fear, stigma, and discrimination that in turn continues the cycle of silence.

To address the barriers surrounding HIV stigma, CBOs are working to co-locate testing services with social venues that are frequented by gay and bisexual AANHPI men. Screening in such venues is driven by nontraditional stakeholders such as bartenders, bar promoters, and bouncers and is conducted in VIP lounges instead of mobile tents or clinics.

***Mr. Cabangun made the following recommendations to the Committee as it considers community engagement:***

- Increase AANHPI representation in HIV PrEP research and demonstration projects;
- Provide targeted funding to combat the HIV stigma as a primary strategy to AANHPI engagement in services across the HIV continua. For example, increase AANHPI presence in marketing and media related to structural interventions, such as condom distribution;
- Increase TA and training for CBOs and Health Departments (HDs) to enhance the integration of cultural practices and linguistically enhance the accessibility of HIV navigators across the HIV continuum;
- Integrate cultural practices into HIV PrEP campaigns and navigation services, including a culturally and linguistically competent workforce for awareness and services across the HIV continuum;
- Provide targeted funding for TA for health departments to enhance collection, analysis and presentation, and dissemination of HIV surveillance data among AANHPI ethnicities to respond quickly to address clusters of new infections; and
- CBOs and health departments should work together regularly to support targeted efforts on data collection and analysis.

**San Juan, Puerto Rico Communities**

*Daniel Ramos, MPHE, Strategic Alliances Specialist, Puerto Rico Primary Care Association*

Mr. Ramos provided an overview of activities that the Puerto Rico Primary Care Association (PRPCA) is implementing with regard to the *EHE Initiative*. The PRPCA is composed of 20 grantees/members operating at nonprofit organizations and serves more than 392,000 patients. In Puerto Rico, these Federally Qualified Health Centers (FQHC) operate 95 clinics in 59 municipalities, mobile units, and school-based programs. Mr. Ramos described numerous and varied activities of the FQHCs toward achieving the National HIV/AIDS Strategy goals.

Cumulative data on HIV/AIDS Surveillance Program, Division of Epidemiology, Department of Health of Puerto Rico (PR), 1980–2019, include:

- HIV data are refreshed every three months;
- 49,675 HIV reported- cases between 1980 and 2019;
- 29,205 deaths from HIV;
- 18,473 people with HIV diagnosis at the end of May 2019; and
- 678 children (0–12 years old) diagnosed with HIV.

Mr. Ramos provided data from a 2018–2019 survey that was conducted with directors of 15 health centers in Puerto Rico that offer services for HIV and are also recipients of Ryan White funding Parts C and B, serving 1,824 patients in 2018. One-hundred percent responded having

knowledge about PrEP, but almost 42 percent responded that the current level of knowledge was moderate. Based on the survey responses, directors should work more to improve knowledge about PrEP in the following areas: eligible people; effectiveness of strategy; PrEP side effects; public policy strategy; and inacting a billing strategy for PrEP.

Additional survey questions/responses include how PrEP compares with other prevention methods, biggest concerns, current barriers to use among high-risk group, ways to publicize PrEP to health service providers.

Mr. Ramos offered the following suggestions to the Committee as it considers community engagement activities:

- Be friendly with the population, and have the workforce mirror them;
- Create dynamic activities that promote communication, such as games that relate to the topic;
- Provide precise information, transportation, monthly educational activities, and nutritional supplements;
- Create alliances with other organizations with similar goals; and
- Conduct separate male and female support groups.

### **III. Reducing Stigma and Discrimination**

#### ***Workforce Development Strategies for Reducing HIV Stigma and Discrimination***

*June Gipson, PhD, EdS, President and CEO, My Brother's Keeper*

To demonstrate the HIV disparities in the South, Dr. Gipson provided a historical perspective on the role of healthcare organizations and CBOs as care providers for people with HIV, and the need for diversity and development of an effective workforce to end the HIV epidemic.

HIV rates are higher in Southern States, which are home to around 45 percent of all people living with HIV and account for around half of new diagnoses annually, despite making up roughly one-third (37 percent) of the population (CDC, 2018).

- Blacks are severely affected by HIV in the South, accounting for 54 percent of new HIV diagnoses in 2014. Black gay, bisexual, and other MSM, accounted for 59 percent of all HIV diagnosed among black individuals in the South (CDC, 2016).
- In fact, of all black MSM diagnosed with HIV nationally in 2014, more than 60 percent were living in the South. Black women face an equally disproportionate burden of the disease, accounting for 69 percent of all HIV diagnoses among women in the South.

The impact of SDOH is significant in the South and the most important is health insurance. To tackle HIV prevention and care, you have to have a good health infrastructure. When Medicaid expansion occurred, 9 of the 14 States without Medicaid expansion were in the South. When it comes time to ending the HIV epidemic, it will be difficult when States decide health insurance is not an important factor.

In the early days of HIV, patients were treated in hospitals; clinics and CBOs were not equipped to care for them. HIV is now a chronic and often comorbid condition, and HIV care has been

shifted to primary care. Particularly in the South, primary care clinics avoid responsibility for the populations affected with HIV.

Stigma and discrimination result. Moreover, CBOs have challenges to effective delivery of prevention services, specifically, biomedical interventions such as PrEP and post-exposure prophylaxis and phlebotomy services. HIV prevention has moved to a medical model; although clinics and hospitals may have the skills, they may lack the workforce or the supportive services and behaviors needed to engage the affected communities into care.

Dr. Gipson offered the following suggestions to the Committee as it considers reducing stigma and discrimination, such as creating new funding streams that include:

- Funding directed toward models that create, improve, and sustain current community-based programming;
- Funding that incentivizes community-based and clinical partnerships;
- Providing access to a variety of training programs, promoting instructional best practices; and
- Supporting experts in the field as mentors to novice professionals.

Dr. Gipson also recommended greater emphasis on funding support services for at-risk and HIV-positive individuals, such as mental health, case management, peer navigation, emergency food assistance, housing, transportation, insurance and financial assistance, culturally competent staff and service location, and providers' unconscious bias.

***Leading with Resiliency: Tools for combating stigma in the healthcare system & promoting resiliency within vulnerable communities***

*Gabriel Maldonado, MBA, Founder & Chief Executive Officer, TruEvolution*

TruEvolution is a CBO serving Riverside and San Bernardino Counties in California focusing on mental health and emergency supportive housing program. It encompasses HIV prevention programs, including a newly established PrEP clinic. It is mostly a social services organization with mental health as its flagship clinical program. Mr. Maldonado provided a brief framework about stigma and types of stigma. He also described resiliency and ways to promote resiliency beyond the clinical setting.

Mr. Maldonado outlined seven recommendations for defying fatalism, the type of stigma that is internalized as a result of stereotypes, prejudices, and discrimination:

1. Create monolingual materials—"if I can read it, then I can engage with it;"
2. Promote health literacy—"if I know what it's called, then I can tell you;"
3. Engage peer support/navigators—staff members who know the culture, including the language spoken with that subculture;
4. Use multi-channel communication tools—"if I can reach you, then I feel connected and supported;"
5. Integrate behavioral health services;
6. Provide comprehensive prevention and care services—the more you can provide in a single setting increases clients' ability to navigate the health system; and

7. Use non–shame-based, empathy-driven language, engagement, and policies throughout case management services, protocol, and response plans.

He also summarized four ways of looking at resiliency and how it can be enacted:

- Begin by reflecting on myself and engaging in health-promoting actions, i.e., cognitive processing. If you think well about yourself, you can conceptualize who you are, your frame, and your identity in a positive way;
- Evaluate my choices and my healthy behavioral practices. Am I acting in a way that is going to promote my resiliency and be engaged in responsiveness that is going to address some of the issues in my life;
- Consider my circle and enlist social support from others. How we summon our “magic” is where we reveal and learn more about ourselves and each other; and
- Reflect on my perspective and responsibility to empower other young gay/bisexual men. The tools for combating stigma are being able to witness resiliency around you as a demonstration of what is possible. The perspective that there is a possibility of seeing a leader who is a black man living with HIV/AIDs that the at-risk community can identify with is a part of resiliency and a tool for summoning your “magic.”

#### **IV. Small Group Discussion**

Committee members discussed issues that emerged from the presentations and the most productive way to proceed. Based on the discussion, Committee members agreed to develop recommendations to address two topics: (1) Community Engagement and (2) Stigma Reduction.

ACMH members divided into two subgroups to discuss the overarching themes and principles surrounding their topic and to frame their recommendations on how best to achieve health equity through the *EHE Initiative*.

#### **V. Public Comment**

Taryn Couture, Associate Director of Government Relations at the National Coalition of STD Directors, Washington D.C., submitted comments regarding the rising Sexually Transmitted Diseases (STD) epidemic having reached the highest levels ever in the nation, and that black, Latino, and Native American people are bearing the overwhelming burden of these diseases. Given the connection between STDs and HIV, including that STDs increase the risk of HIV transmission and the disparities in STD cases, STDs among ethnic and minority populations must also be addressed to help end the HIV epidemic. Ms. Couture urges the Committee to consider making STDs a part of future convenings and discussions, as well as strategies for improving disparities in infectious disease. Dr. Wong encouraged the Committee to consider Ms. Couture’s recommendation, noting that she made several good points,

The meeting was adjourned for the day at 5:04 p.m. ET.

#### **Day Two—Friday, August 23, 2019**

##### **Call to Order and Agenda**

*Winston Wong, MD, Chair*

Dr. Wong called the meeting to order, reviewed the agenda for the day, conducted a round of introductions, and reviewed key issues from Day 1 of the meeting. The Committee is developing recommendations that will be shared with the Deputy Assistant Secretary for Minority Health to help develop strategies to end the HIV epidemic by focusing on racial and ethnic communities.

Dr. Wong presented a summary of the ACMH's morning discussion on issues presented on Day 1:

- Who are most impacted by inequities and disparities in HIV in any given community? Recognize these groups at both the national and local levels and implement strategies that go to the heart of connecting with those who have the highest risk;
- Recognize the highest priorities nationally are black, gay men, black MSM men, and gay Latino men. National intervention and prevention efforts need to be translated and relevant to these groups in local communities;
- Aspirations for certain data elements need to be better defined; and
- Recognizing that the ACMH is not a content expert in the latest breakthroughs in HIV and AIDS and that the science behind involving PrEP, screening, treatment, and viral suppression continues to be developed by the scientific community.

The Committee then divided into the two working subgroups to develop recommendations for Community Engagement and Stigma Reduction. Following the breakout sessions, the two subgroups presented their recommendations for the full Committee to review, discuss, and make clarifications/modifications where necessary.

## **I. Community Engagement**

Drs. Frizzell, Maddox, Parker, Panapasa, Vital, Wisdom and Wong

***Task: Broaden community engagement to better identify unmet needs and drive community plan development.***

The working subgroup developed the following recommendations:

### **Recommendation 1: Think global, act local**

- Tailor and customize education and community awareness and identify core elements to be customized based on community values, priorities, and culture.

### **Recommendation 2: Insist on engaging with nontraditional partners**

- Engage stakeholders in hair salon workers, barbershops, community health workers, community health representative (Tribal communities), CBOs, Federal Business Opportunities<sup>1</sup>, fraternities, sororities, laundromats, community centers for the elderly and other nontraditional partners. Solicit criteria or identify and partner/collaborate with non-mainstream organizations. Investing in trusted CBOs and nontraditional partners ensures community engagement that is driven by the community, for the community.

**Recommendation 3: Invest in racial, ethnic, and tribal and urban A/AN populations engagement, education, awareness**

- Enhance and strengthen capacity building, traditional spirituality and healing, and asset mapping to determine community readiness, identify gaps, and empower effective leadership. Provide space for organic solutions and champions to lead support and create stakeholder groups within the community.

**Recommendation 4: Develop a tailored communication plan/strategy with racial, ethnic, and tribal and urban AI/AN populations**

- Promote and motivate action related to PrEP and immunofluorescent assay screening. Capitalize on technology (e.g., CDC dashboard, social networking, ethnic media, toolkits) and provide 24/7 access with use of technology.

**Recommendation 5: Improve incidence and prevalence data collection, reporting, and dissemination of results on racial, ethnic, and tribal and urban AI/AN populations**

- Advance to granular-level data collection and reporting and census tracking to improve data-supported justification of under-represented populations in needs assessments.

**II. Reduce Stigma and Discrimination**

Drs. Daniels, Garcia, Patchell, and Yancy

***Task: Identify ways to reduce stigma and discrimination for individuals among racial ethnic minority populations to maximize prevention, diagnosis, and treatment.***

What's the Problem?

- Targeting Stigmatization/Discrimination/Absence of Self-Efficacy;
- Understanding how stigma and discrimination serve as impediments for prevention, screening, PrEP therapy and treatment (achieving non-detectable viral loads);
- Expanding services to targeted communities, identified by geography, geocoding (zip codes), and local incidence of HIV;
- Meeting the needs, that includes creating safe spaces (physical space that facilitates empowerment, engagement, safety, trust (community activation)); and
- Overcoming the challenges that include deep cultural barriers, adverse economics, privacy concerns, social influencers and social factors of health and improving access to useful data to monitor progress.

The working subgroup developed the following recommendations:

**Recommendation 1: Develop a renewed and recalibrated awareness campaign**

- Track with and collaborate with the network of USPHS officers, championed by the U.S. Surgeon General in PACE to tailor successful campaigns.

**Recommendation 2: Promote increased diversity of the community and public health workforce**

- Leverage the diversity and expertise of health professionals, such as physicians, nurses, social workers, dentists, mental health experts, counselors, and nutritionists, including the diverse and resilient community individuals, such as LGBTQ, Latinx, two-spirited people and varied Asian populations (including Native Hawaiians and Pacific Islanders) to decrease the silos and barriers.

**Recommendation 3: Create Grant-Making Initiatives**

- Develop and solicit grants aimed at reducing HIV in communities to curate exemplars of best practices in regions at highest risk. Solicit local solutions, enabling sufficient resources to test success.

**Recommendation 4: Develop a Quality Improvement Initiative**

- Enact a constant monitoring program within community engagement and stigma reduction efforts to ensure quality outcomes in communities. This can be achieved through a “least burdensome effort” that captures number of lives impacted, methods deployed, outcome measures, and evidence of success to decrease the burden of HIV at the community level. Such a quality assurance program achieves an accountability process in the use of public funds for local solutions.

**III. Public Comment:** None

**IV. Wrap up and Next Steps:**

The draft meeting notes and recommendations report will be circulated to ACMH members for comment and revisions in September.

The meeting was adjourned at 1:40 p.m. ET.