Julie Hook:

Good afternoon or good morning, depending on where you are, and welcome to this webinar on Fostering Equity in HIV Planning. My name is Julie Hook from the Integrated HIV/AIDS Planning Technical Assistance Center or the IHAP TAC. And I want to thank everyone for making time to participate in today's webinar. Inclusive and equitable HIV prevention and care planning is an essential part of promoting health equity and responding to the changing demographics of the HIV epidemic. The recently released Integrated HIV Prevention and Care Plan Guidance for 2022 to 2026 speaks to the need for equitable HIV planning, highlighting how the achievement of national goals in the epidemic is intrinsically linked to the elimination of existing health inequities.

Julie Hook:

During today's webinar, our colleagues from HealthHIV will present the ways in which power imbalances can manifest in HIV planning bodies. And we're also extremely privileged to have presenters representing the Colorado Health Network and Los Angeles County on how their planning bodies sought to promote equity and strategies that can be implemented to foster equity and mitigate power imbalances based on race, education, age and SES status. Next slide, please.

Julie Hook:

We'll be answering questions at the end of the call. We'll answer as many as time permits. And I'm sure you're all very familiar with Zoom at this point, but if you have any questions during the call, you can submit them through the Q&A feature. And I also wanted to mention that after our webinar ends an evaluation will pop up and we thank you in advance for filling this out as it helps to inform future webinars and trainings. Next slide, please.

Julie Hook:

So we hope that you're familiar with the IHAP TAC, but just in case where HRSA HAB TA center funded to support Ryan White HIV/AIDS Program Parts A and B recipients and their respective planning bodies with overall integrated planning efforts as well as implementation and monitoring, and now, development of their integrated HIV prevention and care plans. We provide both national and one-on-one TA and training activities. And we're led by JSI with our partner HealthHIV. Next slide. As I'm sure many of you have seen on June 30, HRSA and CDC jointly released the Integrated HIV Prevention and Care Plan Guidance for calendar year 2022 through 2026, which outlines the planning requirements for all Ryan White Parts A and B recipients in D sharp funded state local health departments. Next slide, please.

Julie Hook:

So the expectations that CDC and HRSA have that Part A and Part B recipients in D sharp funded state and local health departments will continue to use existing integrated HIV prevention and care plans as well as other jurisdictional plans, such as Ending the HIV Epidemic or Fast-Track Cities as their jurisdictional HIV roadmap until the submission of the new integrative plan, which will be due in December 2022. Many jurisdictions have already developed EHE plans or other plans and CDC and HRSA encouraged jurisdictions to use the appendices and checklists included in the guidance for instructions on how to leverage existing EHE documents to satisfy submission requirements. Next slide, please.

Julie Hook:

We are compiling and FAQ on the updated guidance. And so if you have any questions on these updated guidance, we encourage you to submit them to us. Next slide please. So we are available to provide TA and training on integrated planning and the development of plans, and we'll be launching some new TA opportunities and training materials soon to help you develop your integrated plan. So please stay tuned. Next slide please. So following the webinar, so getting back to the webinar, we hope that after the webinar we'll be able to discuss ways in which power imbalances can manifest in HIV planning bodies, understand how other planning bodies have sought to address implicit bias and promote equity, and identify strategies that can be applied to their own planning body to foster equity and mitigate power imbalances.

Julie Hook:

Now, I would like to hand over the presentation to our HealthHIV colleague, Marissa Tonelli, who is the Director of Health Systems Capacity Building for HealthHIV. And you'll introduce herself and the rest of the colleagues, Marissa.

Marissa Tonelli:

Good afternoon, everyone, and good morning for the West Coast folks. Just wanted to quickly introduce my team from HealthHIV that supports the Integrated HIV/AIDS Planning TA Center. And we'll be kicking off and facilitating the conversation with the two HIV planning bodies we have invited here today. As Julie mentioned, I'm the Director of Health Systems Capacity Building at HealthHIV, and also HealthHIV's lead on our IHAP TAC collaboration.

Eve Kelly:

Good afternoon or good morning everyone. My name is Eve Kelly and I'm the Senior Capacity Building Assistance Project Coordinator at HealthHIV. And I've had the opportunity to work with Marissa pretty closely on the IHAP project for the last couple of years.

Grace Hazlett:

Hi, everyone. Thanks so much for joining us. My name is Grace Hazlett and I'm the Capacity Building Fellow with HealthHIV. And I've spent the last year working with Marissa and Eve on some IHAP TAC activities. So really happy that you all are able to join us today.

Marissa Tonelli:

So today on our agenda, a few things that we wanted to discuss is really to first and foremost, characterize some of the power imbalances that happen in HIV planning and their impact on the effectiveness of HIV planning. We'll review some findings from a 2021 planning body assessment that HealthHIV conducted, findings that were related specifically to equity. And then we'll also discuss some equity and inequity related challenges experienced by two unique HIV planning bodies and the strategies they've implemented to address those in equities. So as we mentioned, we're joined by two planning bodies today, and very excited to hear from them. And we'll finish with a live Q&A. As Julie mentioned at the very beginning, the HealthHIV facilitators and also our presenters from Colorado and Los Angeles County will be available for Q&A. We ask that you submit them to the Q&A section in this during the session. And then when we'll do the live Q&A, we'll be able to answer a majority of those questions time permitting.

Marissa Tonelli:

Just so everybody knows, this slide deck and the recording of the webinar will be archived by the IHAP TAC, I should say, on that target HIV website. So you will have access to this and we can provide more information following the webinar. So I'm going to turn it over to Grace.

Grace Hazlett:

Thank you, Marissa. So for the purposes of this webinar, we thought it was important to define power imbalances within the context of HIV planning. And throughout this presentation, the term power imbalances will refer to disproportionate influence of some members over others due to race, gender identity, sexual orientation, education, age, geographic location, socioeconomic status, et cetera. And it may also refer to the inaccessibility and technicality of policies, procedures, terms, and structures that can create barriers to understanding and can foster elitism as well. Next slide, please.

Grace Hazlett:

So when having these conversations, it's also critical that we distinguish between efforts to foster equality and efforts to foster equity. Equality exists when each individual or group of people is given the same resources or opportunities. Equity on the other hand, recognizes that each individual has different circumstances and it allocates the exact resources and opportunities that are needed to reach an equal outcome. Next slide please.

Grace Hazlett:

So before transitioning into the rest of our presentation, we'd like to get a sense of your experiences with power imbalances in HIV planning. Please use the polling function to answer the following question. How significantly do power imbalances affect your ability to conduct effective HIV planning? And so the poll function should have popped up on your screen. If you could fill it out, that would be wonderful. Maybe in a few moments, we can end the polling function and review the results. Great. Thank you. Thank you to everyone who participated in that.

Grace Hazlett:

So it looks like on 42% of you all that indicated that power imbalances strongly impact your ability to conduct effective HIV planning, with 22% saying slightly impact, and then 18% saying very strongly impact. So I think that just goes to show that this is a really important conversation to be having.

Marissa Tonelli:

Great. Thank you, Grace. Certainly interesting, especially that only 2% said that it does not impact or only slightly impacts. So that's great to see. One of the things that we just wanted to put forth as some background and a stage setting for this conversation is the fact that there are many policy data and landscape factors that are impacting HIV planning equity. Of course, there's the need for more effective, more efficient planning with the Ending the HIV Epidemic in the US. Some jurisdictions received additional resources per planning. They also have additional deliverables and that can create some inequity within jurisdictions or within states. The HIV epidemic also has changed a lot in terms of the demographics over the past two decades. HIV infections are, of course, disproportionately impacting people of color, primarily blacks and African-Americans, and even new HIV diagnoses are highest among people ages 25 to 29.

Marissa Tonelli:

So, of course, considering those demographics within your planning body and, of course, highlighting and elevating those voices is more important than ever. Also since March 2020, with the COVID-19 pandemic, most planning bodies have transitioned to an all virtual engagement. This of course, impacts participation among people without access to technology, individuals who are simply not tech savvy and also there's ADA accessibility concerns as well. So what individuals with disabilities are able to access or how they're able to access on a virtual platform. And then the social justice movements, like the Black Lives Matter Movement, protesting against police brutality, racially motivated violence against black people, extremely important and how they change that dynamic or certainly changed some of the emotions that individuals in planning bring to the table and concerns that individuals bring to the table around the HIV epidemic and these social justice movements, again, more important than ever in impacting planning equity.

Marissa Tonelli:

And I'll talk just a little bit about the integration of planning bodies as well. So with integrated planning, we know this began quite a number of years ago in the first iteration of the Integrated HIV Prevention and Care Planning Guidance. But another factor on power imbalances and equity is language and the ability of different planning body members to communicate effectively. Certainly, when you're integrating prevention, HIV prevention and HIV care, whether it is Part A planning or Part B planning, they are accustomed to different terminology, different acronyms, and again, can create a power imbalance with individuals that might have more understanding of certain terms, acronyms or even policies.

Marissa Tonelli:

Funding as well is a factor as the planning body may be driven primarily by the HRSA Part A policies, which is legislatively mandated. And of course, time and responsibilities is another factor. Some bodies maybe did not increase meeting timer or occurrences as responsibilities expanded for EHE or for integration among planning the two different planning structures or three different planning structures depending on how a jurisdiction may have integrated. So we know ultimately and most importantly, that engagement of planning body members impacts the effectiveness and the outcomes of HIV planning. And so ultimately this is our goal to engage in this discussion today and talk about how we can improve that engagement by addressing the power imbalances and inequity.

Eve Kelly:

Awesome. So I'll take it from here. Thank you, Marissa and Grace. So this slide we built after working with planning bodies for the last couple of years and having a chance to go through an assessment process with them to hear about how different structures and things like equity play into their ability to operate effectively as planning bodies. And so this provides some context around word from the field, and that was directly shared with us from planning body members about different challenges that they're facing when it comes to equity.

Eve Kelly:

So just to give a brief overview of some of the themes that we noticed coming up pretty consistently with, of course, very varied depending on the planning body we were talking to, but it was something that we saw across the board as impacting planning bodies in different ways. So the first one that we noticed, which really speaks to what Marissa was just touching on is just in general, the inaccessibility and the dense language that's used in policies and procedures. And so just the over intellectualization of

processes that makes it much harder for folks who don't have planning experience to come into these bodies and participate in a meaningful way. And so we heard from a number of sites that new member orientation had really limited engagement, especially moving into the virtual world was just a dump of really dense information coming very quickly. And I was very jargon heavy and complex. And so there wasn't any moving forward, there weren't meaningful check-ins with new members to help alleviate some of that barrier of entry in terms of accessibility.

Eve Kelly:

Likewise, we saw an overemphasis on some formal processes and procedures, so things like parliamentary procedure was just this whole new language that folks had to learn coming in. And people who didn't have exposure to that in other settings were at a disadvantage in that regard of not feeling like they were allowed to or knew how to begin engaging in discussion without those formal systems of language that others were using to communicate. Likewise, we saw that in some planning groups, members noted that they felt that speaking time is really dominated by certain members as well as those members also promoting condescending behavior or even structural barriers like misogyny and racism that, of course, strained inter member relationships, and also just made it much harder for folks to be able to participate meaningfully when they felt that their participation wasn't valued or even weren't welcomed in a space.

Eve Kelly:

And so paired with all of that was some groups really struggled to engage consumers in their planning. So even those who were on planning bodies, if they didn't feel welcome or they didn't feel that they knew how to even communicate or speak up in meetings that their voices were being left out. So that's something that we've heard from different planning bodies across the country as well as... And this was not the case in all of them. And it was really interesting to hear how different groups were approaching it. But some folks reported back that there was an avoidance or a tendency to shy away from having really direct discussions about things like racism and how it's impacting planning work that made it much harder to address those issues if they weren't being talked about.

Eve Kelly:

So we won't spend too much time on this question at the bottom, but I do just want to throw it out there for you all to think about. And you're welcome to put any thoughts into the chat box as we continue on with the presentations. But what power imbalances or inequities in planning are you experiencing? We saw that the most frequently answered response in our poll question was that this is having an impact at least to some extent for most of you. So we'd be very interested to hear if you have any experiences that you want to share in the chat box. Feel free to do so or you can just continue to reflect on this as we carry on. But I think I'll transition over to our presentation. So if you go to the next slide, Marissa.

Eve Kelly:

Awesome. So as Marissa and others have said, we have members from two different groups with us today to speak a little bit more about their experience with inequity and planning as well as what they're all doing to address these structural issues going forward. So first we're going to hear from Deja and Chris from the 5280 Fast Track Cities Taskforce in Denver, Colorado. After them, we'll hear from Dawn, Cheryl and April from the Los Angeles County Commission on HIV, but I'll go ahead and pass it over to Deja and Chris to properly introduce themselves.

Deja Moore:

Yeah. Thank you, Eve, so much. My name is Deja Moore. I'm the Colorado Department of Public Health and Environment, Comprehensive Human Sexuality Education Program Coordinator. So it's CHSE for short. But I'm also the community activation work group lead for Fast Track Cities in Denver.

Christopher Zivalich:

And my name is Christopher Zivalich. He, him, his pronouns. I'm the Director of Public Health Interventions at the Colorado Health Network. And I'm one of co-chairs, the nonclinical community co-chair of the 5280 Fast Track Cities Taskforce. So while Deja works at the State Health Department, and I work for a large ASO, we are specifically representing our roles on this task force and HIV planning body in this particular conversation. So thank you. And next slide, please.

Christopher Zivalich:

Just wanted to do a quick little overview of what Fast Track Cities Denver is all about. Some of you may be very familiar with the Fast Track Cities global initiative that came out in response to the Paris declaration and in pursuit of achieving and exceeding the 90/90/90 goals, that 90% of people living with HIV are diagnosed, 90% of them are linked to treatment, and 90% of them have a viral suppression rates or have been virally suppressed. So here is a little quick overview of how the Fast Track Cities, Denver, when we signed on to this initiative, what our strategic framework looked like and how we plan that out over the last couple of years. So we cover five different geographic focus areas. Four out of the five are in the Denver Metro, counties within the Denver Metropolitan Area.

Christopher Zivalich:

I think according to the most recent census, it's just under three million people who are in the Denver Metro Area. So that's about half of the entire population of Colorado. So that is understandably, so why that's a large focus for our Fast Track Cities initiative, but we do also cover the non-Metro Denver area as well to account for, especially a lot of the rural communities in our state. Colorado is a huge state with a lot of rural communities that are also included in our strategic framework. We ultimately have two goals that are combining care and prevention, sustainable, equitable, and comprehensive care and prevention and making sure that are widely available. In our strategic framework, we came up with eight indicators to be able to assess whether or not we are achieving those two goals. So we have those listed here: Late diagnosis, linkage to care, engagement in care, viral suppression, disparities, access to PrEP and PEP, comorbidities and communication. And also in alignment with the Fast Track Cities global initiative, we aim to eliminate stigma in our communities.

Christopher Zivalich:

That is obviously a very challenging, complex and overarching goal, but we thought it made sense to have that a part of our strategic framework so that an anti stigma lens is always incorporated in the work that we do. And to explain a little bit about this HIV planning body, we have over 100 members who have at some point touched the Denver Fast Track Cities Taskforce. They've participated in some way. That doesn't necessarily mean that they've participated in some of our work groups or some of our more day-to-day work that demands some more time and attention, but it really has been a coalition of ASOs and HIV service providers, a lot of physicians and medical providers, as well as some community members. Although, we're going to be talking a lot about today, the way that we have failed in some ways to meaningfully engage a lot of community members who are not paid professionals in the HIV field, which I think is a huge issue that speaks to what has already been talked a lot about today so far.

Christopher Zivalich:

And then we have 10 individuals who serve on the steering committee that includes Deja and myself. I'm the nonclinical co-chair. And then we do have another clinical co-chair or had a clinical co-chair, who is a pharmacist here in Denver. So I went through this part really fast, but I just want everyone to have a little bit of an outline of what the Denver Fast Track Cities Taskforce is. And we do work in partnership with a lot of the other HIV planning bodies throughout the State of Colorado. And we're going to talk a little bit about what that's looked like when it comes to issues in inequities which leads us to our next slide.

Deja Moore:

Yeah. So I think it's important, with one of our goals being for folks living with HIV to really have access to quality care and services as we have to address the root causes of inequities and disparities right within our community. And specifically in Denver, what we see, and also Colorado, I should say, is there's a large disproportionate rate for Black and Brown folks, particularly the Latinx and Black communities. And we also know our trans population and gender diverse folks as well in Denver are disproportionately affected. And why is really because of social determinants of health. We know that our communities don't have the access that they need when it comes to housing, education, workforce development and so forth. And I think too, we can also address the matter that there's systemic racism often involved within government and also within some of the planning bodies. And so that structural racism and white supremacy really prevents our folks of color from speaking out and really addressing those health disparities and really trying to articulate a plan that's helpful and insightful to really get at the root cause.

Deja Moore:

And so what we see too is that there's new diagnosis that are higher in the Latinx population across the state. I already touched on there's a lack of engaged community members in the planning body. So our planning bodies, we have about five in Colorado. There's the Colorado HIV Alliance, there's the Colorado HIV and Aids Prevention Program, there's the Colorado State Drug Advisory Program, and then there's also Fast Track Cities and the Denver HIV Resources Planning Council. And so these five main bodies really help address a lot of the disparities and inequities, but there's still that lack of engagement, which is a problem.

Deja Moore:

What we see too is that there's a high number of Latinx MSM enrolled in our Rapid-Start ART program, but there's a low number that participated in the feedback follow-up. And why is that is because there's challenges in recruiting and retaining leadership from our people of the global majority communities. And then, for instance, too one of our planning bodies witnessed an exodus of black female leadership. So when black females don't feel empowered to share their voice, they're leaving and it's really not showing an environment that's inclusive and equitable.

Deja Moore:

And some more about our communities and just our committees that I touched on is that there is a strong desire to bring community to the table, but again they're not adequate, really preparing to agree and seat them and make sure that their needs are being met. So meeting times, traditionally have not been in the evening times. That's why folks can't come, they're working. How do you expect people to show up to the table if they have jobs and they have to provide for themselves on the table? There's

also a lack of planning bodies, really devoting time and resources to recruitment. And that's also been a huge problem. I'm in the STF committee as well and we have a membership group. And I've been really adamant about trying to shift our times and resources and our marketing as far as what that looks like. If our marketing efforts are not inclusive to our communities of color that we're trying to attract, our gender diverse folks, how do we expect them to be at the table?

Deja Moore:

And to my last point too, there's this cyclical conversation emphasizing inequity, but there's not a lot of action. And so with the community action work group, that's what I'm really being intentional with Chris on is why are we not getting folks to the table? How do we eliminate some of those barriers and really provide the opportunities for these folks to be able to advocate for themselves to really get at the root causes?

Christopher Zivalich:

Oh yeah. Next slide, please. And this will be both of us chatting about this slide. So per the point that Deja just made and in response to what was discussed earlier in this webinar, we've talked a lot about community members who comes to the table and these planning bodies and are going to be experiencing a number of oppressions and come with that to the table. And that already makes it complicated to authentically engage them if that's not being recognized and written into the processes. But what we've noticed is in Colorado, we have a large issue with those individuals showing up in the first place. So it's not even that they're just showing up and experiencing racism and misogyny and certain power imbalances, those power imbalances are preventing those individuals from even coming in the first place to a planning body meeting. And then never mind when they show up, they may not want to stay.

Christopher Zivalich:

So this is the part where we talk about some potential solutions. Obviously, we all know that equity work is complicated and that no solution is going to be necessarily universal, but we have been working on some really interesting ideas and trying to get buy in from a variety of folks to make sure that these ideas work well in an attempt to chip away at these power imbalances in our planning bodies. So through Fast Track Cities at the beginning of this year, we actually offered an anti racism training and we specifically recruited and marketed the training to people who are a part of the Fast Track Cities Taskforce, but also people who don't show up to the Fast Track Cities Taskforce, people in the community or people who had a relationship to the planning bodies, but weren't always actively engaged. We wanted those people to come to this training so that we could build more relationships with a lot of different community members.

Christopher Zivalich:

And that two part anti-racism series training with creative strategies for change was really empowering and effective. And that actually is what inspired us to create the community activation work group. We did use that language from our trainers community activation as a part of their four point framework. And so we had two overarching goals with the creation of this group. One was to meet community members where they are at rather than trying to convince them to come to our table, because we have not created very welcoming spaces yet. And that is going to take some time to do that properly, but we don't want to lose out on prospective community engagement in the meantime. So we're going to go to where they are at.

Christopher Zivalich:

And by creating a specific group that focuses just on equity and anti-racism and anti-sexism and all the work that comes within that field, we're really allowing ourselves to devote some time and resources to that specific work. Obviously, folks in other HIV planning bodies should be focusing on equity work, but understandably so that's where it gets complicated, because I think as it was mentioned earlier, there's only so much time in certain meetings when you're also making decisions on Medicaid or on medication access or whatever the HIV planning body is pursuing. So we said, "You need a group that is literally, this is their job, this is what this group does." But to make sure that it doesn't stay in a silo and stay only within that group, the secondary goal of the community activation work group is that through that we come up with best practices and we actually go around and share those with all the other HIV planning bodies and come up with guidelines and practices and tool kits. So that way those other HIV planning bodies can implement more equitable practices, but there's a separate body that's really devoting the time and effort and resources to figure out what those best practices look like.

Christopher Zivalich:

And this is brand new. We started this at the beginning of 2021. I'm really excited about where it's been going and we've been meeting regularly to start this process. Honestly, one of our first goals is to potentially get funding for a paid position to have somebody really help us not only market events, but have somebody also to really devote that time and partnership with this group to engage the community authentically. We've talked about how the person hire for this, if we can find funding for it, should not probably be a person who's been regularly attending all these HIV planning bodies, it should be somebody from the community who has that authentic leadership, who's a real represent, who people listen to. And so that's where we're going right now. I'm going to pass it off to Deja to talk about what some of our other ideas are on this right column here.

Deja Moore:

Yeah. And so what we've seen with our five planning bodies is that there's oftentimes a lot of siloing. So there's not a lot of communication between each of the planning bodies and really trying to foster change. And that's really problematic because these planning bodies can't be individualistic to really address those disparities and inequities like we want them to. So what we're hoping to do with Fast Track Cities in our work group is I'm part of four to five groups, and so I'm hoping to work with this group and the other groups to really foster this cross agency, I guess, support program, or I guess have conversations really to help drive some of the engagement strategies that we're going to have towards this initiative.

Deja Moore:

And I think too, trying to make sure that we're putting money where it should be. I think money oftentimes, has been missed or put in places where it's not had the most impact like it should be. And so really trying to understand our funding and where it's going and why, and what's the impact of it within the community.

Deja Moore:

And then too, with this group, if we really want community folks to be there, I'm all about paying people for the emotional labor and their time. And I've talked with Chris about this is we keep having folks show up to the table that are people of the global majority, and we're not paying them. We expect people to give our time and our effort and our strength and just our mentality as far as how we address these

systemic issues and especially racism, but we're just not paying for it. So I think it's time that we pay our folks. And that's what we're trying to do is if we can get the funding for the, I guess, like the manager lead to help us apply for grant funding, to help pay for folks to get to the table. That's one way. And then two, I think just making sure people are paid when they're going to these meetings, because eventually we want to empower and train these folks to be able to use their voices with within each of these planning bodies and really have a good impact.

Deja Moore:

And then to my last point is we have to bridge the gap between providers and patients. And oftentimes, providers have always been in the conversation when it comes to reducing HIV, but patients are not, our communities are not, and we have to really prioritize this collaboration aspect and making sure folks get on. And there was a last point I needed to touch on is there's a lot of age-ism sometimes within our boards and that prevents our youth and our young folks from being at the table. So me as someone that's a young adult being there, I think it's so important that we get more youth voices there to really advocate for youth needs, even adult needs and everyone that needs to be at the table.

Christopher Zivalich:

Thank you for listening to me and Deja chat about this. I think that's the end of our presentation and we're happy to be on for the Q&A later.

Deja Moore:

Yeah. Thank you all.

Marissa Tonelli:

Excellent. So we will turn it over to the team from the Los Angeles County Commission on HIV.

Cheryl Barrit:

Okay, great. Thank you everyone for the opportunity to share what we're doing here in Los Angeles County. And I'm really blessed to conduct this sharing with Dawn McLendon and April Johnson and also our colleagues from Colorado. So I'll start off with the next slide, just to give very briefly some contextual information in terms of our demographic and key HIV metrics to give you an idea of Los Angeles County and how that impacts our conversations around equity and social justice. Next slide, please.

Cheryl Barrit:

Okay. So here's the map of California and the spot on the bottom there highlights the County of Los Angeles. LA County is vast and diverse in terms of its geographic scope and span, but then our county, we have almost 10 million residents and it's also very, very ethically diverse within one of the most ethically diverse in the country. I do want to point out that oftentimes when we see depictions of Los Angeles County in Hollywood or popular media, it's always shown as a very urban area when, in fact, we have a very large combination of urban, suburban and rural areas, where you have issues of transportation as well as dearth of services when it comes to different communities. So those are key areas that I just want to highlight in terms of where we are geographically, but the nature of the characteristic that brings on board and how that might impact where people might identify themselves coming from geographically. Next slide, please.

Cheryl Barrit:

These are some key HIV metrics in Los Angeles. Y'all might have seen this one. This is from our most recent 2019 surveillance data from our public health colleagues. We have still quite a ways to go in terms of ending the epidemic and joining our colleagues across the country and making sure that we have a bold response towards ending the epidemic. I do want to highlight the last bullet point there in terms of geographic hotspots. There are top three hotspots for HIV in Los Angeles County, Hollywood Wilshire area, Central and the Long Beach health districts. But what's important to also note is that when we take a look at those specific hotspots and we overlay other public health issues, other chronic disease issues and other social determinants of health, we tend to see the same areas of disparities and we tend to see the same areas of communities that are deeply impacted by multiple issues across various parts of LA County, not just within the key centers, but also in the more rural areas of the county. Next slide, please.

Cheryl Barrit:

And then this is just very briefly a graphical representation of the demographics of the county versus the demographics of people living with HIV. So you'll see, on the left hand side, the Latinx population represents the largest group of individuals in the county followed by the white community, black men and women, which represents 8% of the total county population. However, when you take a look at the demographics of individuals living with HIV, we have some clear markers of inequities, as you can see, where the sizes of the box changed significantly. So for people living with HIV, Latinos represent 40% of people living and diagnosed with HIV, followed by white and black males, 16%. So there's a significant mismatch in terms of population representation versus the burden of disease. Together, those three groups represent more than 80% of people diagnosed with HIV in LA County.

Cheryl Barrit:

So I just wanted to set the stage in terms of how those particular data points come into play when we enter spaces as human beings within the planning framework, what we do within the HIV movement. So I'll turn it over with the next slide to Dawn McLendon, who will speak a little bit more about the commission.

Dawn McLendon:

Thanks, Cheryl. Hello, everyone. Thank you for joining us. Yes, LA County is unique in all of the best ways and unfortunately, not so much in all of the worst ways, especially when it comes to inequities. And so let me give you just a little brief history on the commission. We are the Los Angeles County Commission on HIV. We were formed in the late 1990s, early 2000s. I was in high school. So this is what I was told, but the commission was formed under the LA County Department of Public Health. At the time, they were known as the Office of Aids Programs and Policy. They are now the Division of HIV and STD Programs. And the commission is the Ryan White Part A planning body.

Dawn McLendon:

And just a little fun fact to throw out there, we have one commission member who was a member at the inception of the commission back in the late 90s to early 2000s. And that's Al Ballesteros. I just want to give him a shout out. And that is an incredible demonstration of what commitment looks like. He is still a very active and engaged commissioner today. And so as the commission was formed a couple of years later under the Department of Public Health, there were concerns with conflict of interest, whether it

was perceived or where there were actual conflicts of interest, especially being under the Department of Public Health who holds purse strings.

Dawn McLendon:

There were concerns around the priority setting and resource allocation process. And as a result, the county established the commission as its own autonomous entity under the board of supervisor. And so to this day, we are autonomous, we are under the board of supervisors. And of course, we work closely with our grantee, the Department of Public Health division of HIV and STD programs. Fast forward a few years, especially, amid the conversation around care as prevention and understanding that integrating prevention and care is the only way that we can in good faith really address HIV. The commission got married in 2013. After we recorded the CDC funded prevention planning committee for LA County for about a year and a half, the commission and the prevention planning committee merged. And we then became an Integrated Prevention and Care Planning Council in 2013. Next slide.

Dawn McLendon:

So going back to that, LA County is unique in all of the best and sometimes worst ways. The commission planning body is reflective of that in that we have 51 members that does not include our alternates, which are around six to eight alternates we currently have. So we're talking about almost 60 members all representing their respective jurisdictions, their communities. And so we have a pretty reflective voice at our planning table. Each member is assigned to one of our five standing committees which include our executive committee. They are our leadership group. We have our operations committee who's oversees and manages membership and training. We have our standards and best practices committee that develop standards of care and best practices, assess the service effectiveness. We have our planning priorities and allocations committee, which manages the priority setting and resource allocation process. And then we have our public policy committee that champions our legislation and policy initiatives for our communities.

Dawn McLendon:

If that's not enough, we have three caucuses that are really designed to create a safe space for our more vulnerable populations, which are our consumer caucus, our transgender caucus and our women's caucus. In addition to that, we have two task forces, the aging task force, and we have the black African-American community task force. And then we'll round it all up with one work group. We have a prevention planning work group. So as you can imagine, this is an enormous amount of work. And each of these groups meet at least once a month. So that totals may be around 12 meetings per month and over 144 meetings per year. And I lead with that to say that all of that, the work, the meetings, the members are supported by an incredible small, but mighty staff. And that's our five staff and one academic intern. So let me just give them a shout out. That's Cheryl and that's myself, Carolyn Jose, Sonya and Catherine.

Dawn McLendon:

And so that gives you a brief background of who we are. And so in the spirit of the Olympics, I will pass the baton to April Johnson. Just real quickly, in response to the George Floyd murder, the racial injustices, we are consulted and collaborated with our LA County Human Relations Commission and providing a training series on how to have difficult conversations around race. We figured that we need to establish the fundamentals and learning how to have these conversations before we can really get into the substantive stuff. And so April is with us today to share a little bit more about that. So take on.

April Johnson:

Hello, everyone. My name is April Johnson and I am with the Human Relations Commission from Los Angeles County. If we can have the next slide. And so we came together to work with the HIV commission to be able to foster equity. And so how we did it was the human relations commission, we put together a strategy to foster equity within the COH is by implementing facilitated trainings during monthly commission meetings that focuses on presenting a principle or technique followed up with teaching and application using content from "So You Want to Talk About Race." We collaborated on that, of course, before and it was the decision of their commission to use the content from that book. And so far it's been extremely helpful in guiding them in having candid conversations.

April Johnson:

The goal is for the commissioners to feel very confident to apply these principles and techniques that we teach for engaging in constructively candid conversations with peers. This is being accomplished through engaging individuals and facilitating dialogue, we have interactive activities and we're teaching six important skills to apply in their interactions with each other. They're acquiring these six skills through workshops and trainings are empathy, self-management, managing implicit biases, what it is and how it works, inquiry, stages of relationships and definitely valuing diversity cultivates the effective practice of equitable inclusiveness and mitigates power imbalances based on race, education, age, and socioeconomic status.

April Johnson:

And as a result of implementing these facilitated trainings within the HIV commission monthly meetings, it further promotes equity and provides commissioners with solutions to respond positively to inter-group conflict. It supports resilience and encourage inter-group solidarity. So that is our role in helping to foster equity within a large planning body. Thank you. I'll turn it back over to Dawn.

Dawn McLendon:

And I'll turn it to Marissa.

Marissa Tonelli:

Great. Thank you guys. Well, that was very, very informative. I just want to thank all of our speakers, Chris, Deja, Cheryl, April, Dawn. I want to ask if anyone has any questions to please use the Q&A function and we'll facilitate a brief Q&A session right now. I saw a couple of questions that I think the Colorado team answered in the Q&A already, but I thought it might be helpful just to share with the full audience members. And that was Deja's excellent comment about compensating community members, planning body members for their participation, their time, their energy. And I think, Chris, you may have responded, but just wanted to see if there's any other things you wanted to add about how a planning body might be able to do that or how you were thinking you might be able to fund that type of compensation, because I think others might be interested in that.

Christopher Zivalich:

Yeah. I don't mind adding to that. That's been one of the main focuses, I should say, of our community activation group right now. Part of the solution is maybe looking for funding that is traditionally outside of the HIV realm. So much of the funding that I think a lot of us are used to is primarily earmarked for funding specific services or something in that realm. So, for example, here in Colorado, we looked at

certain foundations that do community driven work, and they don't necessarily have a history, all of them, at least, of funding HIV or sexual health related work. But a lot of the other work they do is in line with our community activation goals. And they prioritize paying community members to do work.

Christopher Zivalich:

So that's part of our strategy has been, let's apply for something that maybe hasn't had as much of a role in the past in our specific field, but what they fund are the things like community stipends that we're looking for to compensate people for their time. And that might add to more sustainable funding if we can then demonstrate to the more traditional HIV funders, look at what this does, assuming we're successful. Deja, I don't know if want to add anything, but that's my...

Deja Moore:

Yeah, I think for payment of services, it's just that's like the main priority, but also I think we're missing the point on funding community folks to share their experiences and what they're going through and maybe develop their own strategies that will be helpful for their selves and for their own community as well. So I think we're trying to shift the model in the way funders think of funding and how they fund communities. And to Chris's point, there's a foundation here in Colorado that really wants to help the resiliency of Black and Brown folks within the community. And so, because that's a priority for them, we're trying to show these are the systemic issues because of racism and white supremacy, now, this is why you can dedicate funding to help address this in this one area.

Marissa Tonelli:

That's great. Thank you so much for elaborating on that. One other question, I guess, this is both for Colorado and for the Los Angeles County Commission on HIV, is you mentioned a number of trainings or sessions that were held with the planning bodies. And I'm curious if maybe you could share with some of the other attendees here, how you identify those speakers, maybe if there was resources that you access that might be nationally available or even a local resource that someone may be able to mirror in their jurisdiction. I think that would be great to just share briefly.

Cheryl Barrit:

I'll take a stab for Los Angeles. I think we're blessed. The Human Relations Commission, they have been providing support to address communications and humans relations issues in the community for many, many years. And so with us, we just felt that it was important to lean on more within existing county resources who are experts in the field. And also, the Human Relations Commission had, had the opportunity to be a part of the county's efforts around the anti-racism initiative supported by the board. So it was just staff reaching out to their executive director. And the conversation started from there and had grown into this wonderful partnership with April and the Human Relations Commission.

Cheryl Barrit:

And we're going to lean on them for additional resources. We're learning what we need to work on further in terms of building positive relationships and confronting difficult conversation. We also get feedback from the commissioners themselves or community members about potential speakers or resource and thought partners that we can bring to the table.

Deja Moore:

Yeah, I think as far as Denver, and Chris, you can expand upon this too, a lot of the trainings have been once people are voted in as members for the planning bodies, then they get trained on how the planning body works and how they can use their voice effectively for that planning body. And as far as Fast Track Cities, we know that we did a racial equity training, but it has to go beyond that. And so what we're trying to do with this new model is train community folks, not necessarily just beyond how they can use their voice, but what resources are available that they can share within their networks. So if we're trying to tackle social determinants of health, maybe provide trainings on housing opportunities, education opportunities, transportation opportunities, and so forth, and really make sure folks have that foundational knowledge to bring that into the planning body so that they can be insightful and helpful when they're advocating for themselves.

Marissa Tonelli:

Excellent. I just have one last question that I think maybe we could answer quickly, which is around comment that those who are generally in control of funding, whether it's agencies, government entities or large agencies and community, often have the most say... I'm sorry, I'm reading from a chat, but also are least informed about social determinants of health and lack understanding of Black-Brown communities, client experience, et cetera. So this individual asks, do you have any suggestions for how one might go about voicing or conveying the challenges that they see to those key stakeholders or maybe the power holders in a room?

Christopher Zivalich:

I think that's a really good question and it points to a very structural problem. I guess, my personal response to that and what I've seen happen here in Colorado and just what I have tried to invest in myself strategically is, well, there are channels for those funders to be able to get that feedback to definitely take advantage of those. But, and I'm not sure this is the best answer, going to our other point, we're trying to find other funding sources or other bodies that can take those other funding sources to do that work.

Christopher Zivalich:

So I bring up Fast Track, again, and that's why I think we're an interesting example. We're not regulated since we're not a government body, we're not regulated by the same laws or funding restrictions as some of our other planning bodies are, but that doesn't mean that we can't find funding, do some of this work and then share that information and make sure that it's co-implemented as best as possible with the HIV planning bodies that are going to have more restrictions from their funders and regulators. Yeah. I'm not sure if that's getting at what you're asking, but it's like finding different funding that will listen to us, or if there are any particular feedback channels for those funders to change the way they limit and control the funding itself and taking advantage of as many of those communication channels as possible, I guess.

Deja Moore:

Yeah. And I'll chime in too as a trans woman of color as well is I'm tired of seeing the data continually show the HIV disparities amongst my communities. And I'm showing up to the table, I'm going to each of those meetings and I'm really advocating, why are we not changing the data? The data continues to happen over and over and over, and we're not seeing change. So I've been really adamant about just being present and vocal and trying to empower other black and brown folks to be present and show their voices, because the people that have control are not going to move until there's people that show

up to the table to really show and advocate for themselves. So I say, just push back, get those people to rally and get there, and they'll listen. They have to.

Marissa Tonelli:

Great. I think that's an excellent note to end on and great call to action to Deja. And I just want to, again, think as really incredible and thoughtful panel of individuals from both Colorado and LA, there will be some additional resources that we can share in the archived presentation. But since we are at time, I just want to thank everyone so much for attending. Please join me, IHAP TAC mailing list. You can request TA at the email address on the screen. And just another reminder that there will be an evaluation pop up that we would like everyone to complete. I'll see if anyone else from JSI wants to add anything. But I want to thank everyone so much for your time and your participation on today's webinar.

Christopher Zivalich:

Thank you.

Julie Hook:

Yeah. Thank you, everyone, so much for joining us. Have a great afternoon.

April Johnson:

Thank you, guys.

Deja Moore:

Yeah. Thank you all too.

Marissa Tonelli:

Thank you so much, April. Thank you all.

Grace Hazlett:

Thanks everyone. Have a great day.

Christopher Zivalich:

I was reminded how massive LA is.

Deja Moore:

Yeah.

Christopher Zivalich:

That's always a good moment for me to be like, "Yeah, that is a huge county with a lot of stuff."

Dawn McLendon:

Yes. It is an undertaking.

Christopher Zivalich:

Yes.

Marissa Tonelli:

She feels 144 meetings a year, that's what catches that...