MINUTES: PLANNING COUNCIL

April 21, 2020 / 5:30 – 7:30 pm / War Memorial, 101 N. Gay Street, Baltimore, MD 21202

Facilitator (Chair)	J. Keruly/M. Cole	**PCSO Lead**	Vanessa Graves
Time started:	5:39 p.m.	**Quorum:**	There was quorum at the start of the meeting
Members present:	Markton Cole, Jeanne Keruly, Fernando Mena-Carrasco, Dennis Rivera, Jonathan Wright, Charles Culver, Christopher Stuckey, Wendy Merrick, Shakima Richardson, Peter DeMartino, Abbey Plusen, Sara Zisow-McClean, Pam Kurowski, Sean Thames, Kim Whittaker, Brande Ward, Shalyta Campbell, Akil Patterson, Dr. Victoria Cargill, Evelyn Nicholson,		
Members absent:	Kemahn Jones, Monique Thomas, Reginald Douglas, Carlton Gross,		
Visitors:	Dale Brewer, P.J. Gouldman, Carlton Smith, Dr. Valli Meeks, Adam Huebner, Jocelyn Stenhouse, Judith Shaw, Krista Hein, Roshaundra Ingram-Harvey, V. Woolums, Mike Valentin, Gabrielle Newton, Elizabeth Leibow, Danielle German, Emily Leonard		
Ryan White Part A:	Sonney Pelham, Lin Ferrari, Nargis Hussaini, Joan Carey, Lauren Wagner, Stephon Effinger		
Handouts:	Agenda, Part A & B reports, Maryland Gonorrhea & Chlamydia Heat Table, Maryland Gonorrhea, Chlamydia Youth, Protecting Adolescent Sexual Health Key Facts, February Meeting Minutes,		

AGENDA

1: Introductions **Presenter:** M. Cole, Vice-Chair

Discussion:

- The meeting was called to order and a moment of silence was observed.
- Introductions were made.

2: Review and Approval of Minutes **Presenter:** Committee

- Tabled until the end of the meeting.

3: Ryan White Part A **Presenter:** Sonney Pelham

Sonney Pelham

- We just received the final full Part A/MAI award.
- We received notification on Thursday/Friday.
- We have about $300K less than what we had last year to work with.
- There are some categories that will have unexpended funds and there are some that can absorb some additional funding.
- Not sure if we have enough time tonight to go through this or if there is another mechanism by which the council would prefer to use so that adjustments can be made and funding can get distributed as soon as possible.

Jeanne Keruly

- Opened discussion up to the committee.

Dale Brewer

- If doctors' offices aren't taking appointments how can services expend the dollars?

Christopher Stuckey

- Some providers have moved to telemedicine.

Sonney Pelham

- Initially this is based off strictly applications and what funding is necessary based off these applications as well as prior activity.
- We will also have a five month reprogramming coming up soon.
- Believes that when budgets are received that we will see other funding adjustments that may need to be done.
- Currently we cannot quantify those particular changes.
- This is based off what we know through applications and activity of FY19.

Markton Cole

- Asked S. Pelham if he is confirming that based on information we received those service categories that would be able to expend those dollars currently?

Sonney Pelham

- Stated yes, but we might see at 5th & 7th month reprogramming additional things that might need to be done.
- There are certain categories that have not asked for as much funding that is within those categories.
- We have some based off what we did at PSRA last year that some of the service categories might be underfunded to keep some program whole.

Jeanne Keruly

- Recommends the fiscal committee convene a meeting to make recommendations for moving money.

Sonney Pelham

- This is simply a matter of sub recipients already received partial awards and if we don't make adjustments within this full award then there would have to be another adjustment. Basically, I am just trying to eliminate how many times they would have to make adjustments.
- Regarding a time line, this would need to be done as soon as possible.

Lin Ferrari

- Spoke with their fiscal agent today, they are requesting that the sub recipients provide partial budgets in order to reimburse them.
- Either way they will have to prepare a partial and full award budget.

Fiscal committee co-chairs agreed with the recommendation.

- Meeting information will be sent to the committee.

Fernando Mena-Carrasco

- Would it be possible to extend this invitation to anyone that wanted to attend this meeting?

Jeanne Keruly

- All committee meeting are open, so yes.
- Asked all interested to show this in the chat and meeting notification will be sent to them.

4: Part B **Presenter:** Peter De Martino

Peter De Martino

- The report has been linked to the states website which covers Corona virus and which has ongoing updates on everything happening and all the governors executive orders.
- We are under a state health emergency.
- The vast majority of our staff is teleworking or on administrative leave. Most of our facilities are closed to the public.
- The governor did leave a very specific order around MADAP eligibility. We are still collecting it but no one will be cut off the program due to eligibility issues until 30 days after the state emergency is lifted.
- We have been working with our agencies to figure out what their needs are during this period.
- We have also been working on guidance for our programs to ensure that there are as much continuity of services as possible and to ensure that everything that happens during this state of emergency will be reimbursable for our programs.
- Ryan White and HOPWA were included in the coronavirus aid relief and economic security act. All the RW parts including the AETC and the dental programs were provided with CARES additional funding.
- MDH is working to figure out the best way to operationalize this for people affected and living with HIV/AIDS.
- We have a new Center Chief for HIV Prevention and Health Services, Bruno Benavidas.
    - Tomorrow is the Bureau's deputy's last day. As of May 1st, this position will become vacant.
    - The state is currently in a hiring freeze but there are still positions available.

- The Department of Labor is hiring 100 additional employment specialist for the employment program in the state.

Markton Cole

- Have we gotten any information about the direction the state will take with the additional test received for COVID-19?

Peter De Martino

- We don't have all the plans yet but the point is to get those test out into the community as soon as possible.

5: Data Presentations **Presenter:**

Barrett La Russa

- Has put together slides that will be shared and will serve as a background for the presenters to give a brief overview and answer questions.

Presenters:
Elisabeth Liebow, MPH
Policy and Program Associate
Center for STI Prevention
Infectious Disease Prevention and Health Services Bureau
Maryland Department of Health

- Stated that the slide set that went out with her recording on Sunday actually has two slides that have the wrong graphs on them.
- If you have already heard the recorded presentation the slide that had to do with the portion of students responding to if they used condoms during last sexual intercourse and the slide with the percentage of students who drank alcohol or used drugs before last sexual intercourse these two were switched.
    - The epidemiologist who prepared the data notified her of this.
    - Believes the corrected data was sent out.
- Several key points mentioned in the presentation
    - Adolescents and young adults 15 & 24 comprise of about half of all new STI infections that are reported annually to health departments and to Centers for Disease Control and Prevention (CDC).
    - One of the groups with the greatest disparity in terms of STI is adolescents, especially the 15-19 year old age group.
    - There are a number of factors that contribute to the disparity and vulnerability of adolescents nationwide and in Maryland.
    - What we see here in Maryland mirrors exactly what's happening at the national level whether its risk groups or populations disproportionately affected by STI's, barriers to care and the amount of significant increases in chlamydia, gonorrhea and syphilis that have gone on for five years in a row across the country.
    - The factors that place adolescents at risk for STI's are biological.

- Young females have immature cells in the cervical area so when they are having vaginal sex as opposed to oral or anal sex they are at significantly higher risk for acquiring an STI.
- In terms of their reproductive tracts they are at a much higher risk for serious and long term consequences, including infertility and pelvic inflammatory disease and ectopic pregnancy which could be fatal.
- Many youth with HIV prevention, testing programs and HIV care, many adolescents are really concerned about confidentiality. If they are on a policyholder's private insurance the explanation of benefits that goes to the policyholder which is most often a parent is going to disclose this sensitive health information services they received.
- This is a gigantic barrier, standing in the way of adolescents wanting to their own pediatric providers to talk about STI testing or treatment and of course reproductive health care.
- We know across the board nationwide that providers are uncomfortable taking sexual histories.
    - They are uncomfortable bringing up the conversation about sexual health behaviors and sexual health services with adolescent patients.
    - We also know that they are not all screening according to national recommended guidelines.
- There are other factors that contribute to a lack of access to health care especially for adolescents in terms of not having services available after school hours or on the weekends.
    - Transportation
    - And some health departments where there is literally one waiting room and one clinic in the entire county.
    - Teenagers in small communities are absolutely not willing to go to a health department where they are going to walk in and be seen a neighbor sitting in the waiting room.
- A lot of adolescents have disclosed having multiple sex partners which is another very significant risk for acquiring an STI and also HIV.
- Untreated STI's cause lifelong health problems.
- Males can also become sterile if they untreated STI's.
- One of the key messages is STI prevention is HIV prevention.
- Untreated STI's can increase some ones risk of getting HIV.
- It also increases the risk of transmitting HIV and un-infected sex partner.
- If you have an STI and HIV the viral load is increased. So it make one more likely to transmit HIV to someone else.
- The impact of these sexual behaviors are first to teen females across the state
- A very large cases of chlamydia, cases of gonorrhea, cases of primary and secondary syphilis which are the most infectious stages. Specific cases are listed on the one page key facts sheet.
- So what do you do with all this? You try to advocate and implement best practices where you have at the national level a number of known evidence based best practices, these include:

        - Access to medical comprehensive sexual health education.
        - The decisions about sexual health education are made at the local level.
- Those of us at the state health department, local health departments and state and local health agencies have actually no power to influence which schools use which comprehensive sexual health for absence only curriculum.
    - This is something that we would like your partnership on, to try and address this.
    - If we were teaching kids about safer sex practices and disease transmission and other things that go along with a comprehensive evidenced based sexual health curricula we are lost.
- The other thing that is a best practice is the access to sexual health services and that includes condoms.
    - Trojans are partnering with our national organizations and are offering free condoms to any school district across the county.
    - Three school districts in Maryland distribute condoms in the high schools;
        - Howard County, Prince Georges and Montgomery County. Baltimore city does as well.
- All were encouraged to reach out to Ms. Liebow if they were interested in participating at any level/somehow on condom distribution in schools.
- The two final best practices are
    - Access to STI testing and treatment – whether through school based wellness centers, school nurses specifically implemented STI testing in schools that are not affiliated with the whole comprehensive wellness centers
    - Finally, vaccination is really important for adolescents for human papilloma virus (HPV) vaccine that can prevent high risk viral strengths that can lead to cancer. Then hepatitis B and A, vaccines as well.
- They have prepared youth risk behavior survey slide decks for each of our jurisdictions. It's similar to the slides she showed.

Questions/Discussion

- Hepatitis B vaccines are actually administered to every new born in the U.S.
- It's really important for pediatricians to bring up these conversations with their adolescent patients.
- These children are not comfortable with bringing these things up themselves.
- Vaccination is the best practice.
- With respect to Hepatitis A & B vaccine they are on a national schedule of recommended vaccines. They are offered to every child.
- There is still a lot of opposition in this country on the part of parents against the HPV vaccine.
- Because HPV is transmitted sexually a lot of parents think that their children due to age are not having sex and that the vaccine will promote them being sexually active.
- We need to do better about getting the word out that it is safe and effective and that in terms of the studies that have been done, does not promote early sexual debut.
- We have to do a better job of reaching parents.

- If the parents could see the data, x percent of 13 year olds that were surveyed across Maryland said they have 4 or more partners by the time they reach 12th grade.
    - X percent say they don't use condoms but they do have sex
    - X percent say they have sex by age 13
    - Parents might change their minds about the kinds of information out there that help keep their kids safe.
    - Part of the responsibility to provide the education is the schools but they have so much opposition from a small group of conservative and frightened parents.
    - We have to work with pediatricians and parents more.

Barrett La Russa

- In the entrance of time, we can take questions via email.

Presenter:
Dr. Daniel German
BESURE

- Provided an overview of what they have seen over time.
- BESURE is the Baltimore site of national HIV behavioral surveillance and their purpose is to do annual surveys among one of three populations in any given year to be able to monitor and see if there are changes in prevalence in HIV risk behaviors and service utilization.
- Generally they work with either MSM, people who inject drugs or people who are at increased heterosexual risk.
- Some of you are aware that we are in the process of except for COVID would have been launching a parallel project among Trans populations in Baltimore.
- In the slides is what we have seen since over the last 3-4 waves of data in these three populations with a primary focus on the indicators we have embedded in the survey and that speak to HIV prevalence and indicators along the care cascade.
- I can talk a bit about what we have seen in social determinants over time and some of the characteristics we've seen in terms of disparities in HIV.
- What's on the slide highlights the data from our most recent two waves which were among MSM and people who inject drugs?
- We just in December finished data collection among the people who are at increased heterosexual risk.
- We are preparing a presentation for that. We will have this ready to disseminate virtually probably over the next month or so.
- The short version, is that all the indicators were able to say that Baltimore is doing very well.
- We have seen on all the indicators really positive favorable increases in where we would hope that there would be.
- What's here is the most recent findings about differences in HIV prevalence and what we have seen in terms of the high proportion of people who if they have been previously diagnosed they are in touch with a care provider and the vast majority are taking their ARV's.
    - Quite a substantial proportion are reporting viral load suppression.
- We also looked at characters of people who had reached these indicators.

Questions/Discussion

- Slides say individuals "had" viral load suppression. Do they have or had viral load suppression?
    - The way the question is asked "has your provider told you that have at essentially some point and time have been suppressed" this is not necessarily a current indicator and it's a new question that we have not asked in the past.
    - I am hopeful that we will have better data going forward. It is a relatively limited question right now.
- Regarding MSM prevalence data, we are looking at almost 40%, have you seen this number go up or down?
    - Yes, within the slides you will see that actual proportion. This is our 5th wave of data for MSM and actually this year we are slated to do an MSM 6th data collection.
    - For MSM the prevalence really has been within the 35% to 40% proportion all the way going back to round one.
    - All the way back to 2005 it has been at this proportion.
    - Where we have seen some change is in the racial differences. There is an extreme racial disparity and what we have seen is that in the earlier waves we had about twice as much prevalence of HIV among people who identified as non-Hispanic Blacks than non-Hispanic whites.
    - More recently we are starting to see a slight shift in this where it's still a disproportionate prevalence among people who identify as non-Hispanic Black but somewhat an increase and mildly so that it is sort of shifting that ratio a little bit.

Vanessa Lathan

- In the essence of time if we could just ask one question.

Barrett La Russa

- If anyone has any additional questions, please put them in the chat box.

Presenter:
Dr. Andrea Wirtz

- This is an ongoing cohort.
- We have folks enrolled from just starting their survey all the way up to those who have completed a 24 month visit.
- We are actually starting to extend this.
- We have a cohort that extends six cities and Baltimore city is one of them.
- The cohort was originally funded by NIH with the goal of understanding specific HIV incidence and risk among the population of Transgendered woman.
- Transgendered woman for a long time have contributed to HIV research but they actually haven't been a study that focused on their unique risk for HIV.
- We partnered with a number of researchers and institutions across the Eastern and Southern US
- Our study focused on HIV incidence so enrolled a cohort that focused on Transgendered woman who are not living with HIV and the baseline we are able to include those that living with HIV and those that are not.

- We have a lot of HIV care for that population.
- From the previous slide we had 131 Transgendered woman enrolled in a baseline survey from Baltimore city.
- The data shared in the presentation, I include Baltimore city data and also data from the wider cohort because the wider cohort gives us a much more substantial number of participants, more robust measures.
- Overwhelmingly there are a number of social issues that are important as we are thinking of program planning.
- The one that is really a priority that we hear resoundingly from the community of transgendered woman is the issue of violence.
    - Basically 85% have reported some form of violence and victimization whether physical, psychological or sexual.
    - Many people who experience violence might experience multiple forms of violence.
    - What we found as well is a culture of the cohort specifically is that even if among people who experience no violence over 60% report violence at a later date.
    - This is important because it shows a high incidence of violence.
    - This is also a sustained experience as well.
    - This is a really important area for intervention and programming.
- In terms of trying to mitigate the violence in and of itself and trying to mitigate the long term health effect of violence for this particular group.
- We also see other issues around low levels of literacy and employment.
    - This is really important as we think about having enough income to engage in other issues or to engage in services, HIV and prevention services etc.
    - We are thinking about what are the more urgent needs that need to be addressed.
- Related to this we see high levels of engagement in sex work and history of arrest.
    - This also serves as a barrier to employment as well.
- About half report food insecurity, unstable housing and high levels of mental health problems and disorders.
- We looked at barriers to care among transgendered woman.
- There are some unique differences based on HIV statuses but overwhelmingly for those living with HIV, transportation is a barrier to any sort of healthcare.
- There is also this item that talks about worried about safety getting to and from healthcare.
    - This is another transportation barrier that speaks to the concerns that participants report.
    - In terms of waiting for public transportation and issues that can arise when trying to get to health services.
- Some of the other issues scene are related to cost.
- There are other items that are related to experiences and perceptions of experiences that might have at health facilities. Prior experiences of providers not being comfortable caring for transgendered patients.
    - Also reporting some form of mistreatment from staff or others.
    - These are major issues just in terms of having decent experiences when one is seeking healthcare.

- Being transgendered and having someone's name before they transitioned these have major impacts in terms of whether or not they will engage in health services.
- These are basic issues that need to be addressed just for people to really and fully engage in HIV services.

Questions/Discussion

- Based on the violence that's going on. Is this being brought on due to steroids that the transgendered person is taking?
    - Are they reporting this violence to you or just the criminal violence?
- We have a pretty comprehensive violence measure, we measure physical, sexual psychological violence.
    - We also measure the perpetrator and then we have separate measures of psychological violence that particularly encompasses the transgendered related experiences.
    - We have measures of whether their partners are controlling their hormones or their disclosure of their gender identities.
    - In some cases it might be related to their transition or their partners are controlling their transition disclosure.
    - In other cases violence could be perpetrated on the street by a stranger or family member.
    - We have a very comprehensive measure and I can give more detailed analysis on this at a later date.
- Generally when we look at the perpetrators of violence it really encompasses the number of different people, partners, family members and strangers.
    - The motivations are wide and varied.
- They have never heard anything that would suggest side effects of medications would cause this.
- How directly does this information relate to transgendered people living with the virus? How this data then used by this body to reflect funding mechanisms and recommendations in moving forward?
    - There is not a specific service category under HRSA specifically directed toward transgendered individuals but the way we go through our process of reviewing the data and using those data decisions to determine priorities and also to allocate.
        - My example would be the way we do for other populations, MSM etc. of risk categories that impact.
    - Although it may not directly link to a specific category there are things that one as a provider, clinician and human do understand that the impact of care.
        - When you talk about 80% of lifetime violence exposure with 40% having experienced violence in the last three months with 35% having distress within the last 30 days, 20% having significant distress within the last 30 days and 24% alcohol disorders, 29% drug use disorder we know that those are extreme deterrents for HIV outcomes.
        - We know that the more they happen the more they stigmatize HIV health care.
        - From the presentation, transportation is a huge problem precisely more for individuals who are HIV positive and those transgendered individuals more than those who are HIV negative among trans women.

        - These are key considerations that are very fundable problems reported by these individuals.
        - We also know that having a bad experience with a provider will impact your engagement with the care system.
        - These are considerations that we have as we look at models of care and how we address the standards of care.
        - Something that really resonated with me is that individuals when they are told to choose between HIV Care, they will choose aspects of their lives that are far more important than HIV care at that time.
            - Mainly homelessness, income and inability to jobs and those are things that we need to be aware of as HIV planners.
        - These are all things that can be intervened upon. If you can't prevent violence in and of itself our ways to mitigate mental health problems impacts on HIV intervention and care.
        - There are emerging studies that say that perpetrators can also control ARV therapy/PreP use.
            - They may control someone's ability to access health services or their ability to even just leave the house.
            - Those are all areas to try and address providing integrated harm reduction programs or support and psycho social services to people engaged in HIV prevention and care.
    - How do we directly link this back to the areas in which we will use this data to move services to where they need to be?
            - If there is a lack of trust in providers then what/who are the providers that they do most trust? This is how we will get them to trust providers.
                - There are cultural competency trainings for just better improvement/collaboration with the transgendered community that are important.
                - There are certainly some places that the community does trust i.e Chase Brexton is probably one of the leading ones in providing these services.

Presenter:
Dr. Victoria Cargill
BCHD

- Thinks that part of her presentation will help answer, address or shed some light on things.
- I have been concerned about this area of the gap between the biomedical research community and transgender populations.
- I tried to bring this all together based upon that paper which is coming out tomorrow as well as some of the work being done in RW.
- Biologic sex is really confer that sterilization and that every felt body derives from that fertilization experience and so therefore it is not surprising.

- NIH mandated back in January that sex would be considered in every act of the biological research. In fact, if it was not considered it had to be a good reason such as studying pregnancy or some other waiver of the research was rejected.
- The institute of medicine before NIH took this step in a very stinging report indicated that transgendered adults were very much an understudied population and were both in dire need of both biomedical and population health research.
- It is interesting that while we have sex as a biological variable mandate its exploding literature on sex differences in virtually every single organ system.
- In looking at sex differences in immunizations we know that females have a much more robust immune response than males.
- Even in COVID-19 we see sex differences with males tending to do more poorly.
- We know that our knowledge base for chronic conditions for transgendered persons is really insufficient.
- We took a look at the Medicare beneficiary data and there is a number of disparities not just by race but also by health conditions of transgender individuals whether you are looking at asthma, different hepatitis's, HIV, substance abuse disorders, depression, anxiety and really some of the things you have heard from Dr. Wirtz is not surprising given the long standing history.
- Even more disconcerting is that if you go back and take a look at the actual literature review done from January 2001 – June 2015 that's 15 years of primary transgender healthcare research and attempts to identify gaps and needs and the majority of the studies address HIV and sexual health.
- But there are absolutely no studies about mammography, colon cancer screening and what would be the recommendations surrounding some vaccines for transgender individuals.
- There are primary care guidelines that have emerged but again, having a primary care guideline is really driven by the evidence and the evidence is limited.
    - Especially if you want to take a look at what the Trans needs are.
- We need to take a look across the entire life course.
- There is some good news in however that family physicians for example, primary care physicians that listed family medicine is their primary affiliation.
    - Over 80% said they were going to provide care for individuals who are transgendered but that they wanted to learn more about gender affirming care.
- A particularly sensitive issue is if the insurance card doesn't match.
    - One way around this is at registration take forms that collect both.
    - It requires being psychologically awareness, medical accessibility everything from understanding the use of homotherapies, drug interactions etc.
- Ultimately the best outcome is if there is a multidisciplinary team to provide the most integrated important aspects of gender affirming service.
- When we took a look at our Baltimore –Towson EMA data for FY2018, we looked at the different populations and sub populations and viral load suppression was not as robust in trans populations.
- If you look at care retention, while it is a little bit more uneven, you will see those two populations in particular were not as well retained.
- We decided to take a look at sex differences and gender differences in individuals who were retained in care. We compared six woman of color to transgender consumers. In five service

categories and found that they had pretty similar rates of services in terms of uptake for all categories.
    - About over 80% but the outcomes were very different.
    - For transgender both emergency financial assistance and medical transportation really increased viral suppression rates to above 90%.
    - Women of color for retention rates were consistently above 85% except for early intervention services, this was only 74%.
    - In looking at transgendered clients, early intervention services increased care retention for better than anything else. It was about 91%. All the other services had a retention rate of between 64 and 79%.
- Quantitative numbers and data can't tell you the how but it can tell you that there is smoke.
- One of the take homes from this as we start to digest and continue to look further is that it implies how the services are delivered, affect the outcome for our clients and particularly our vulnerable clients in particularly our vulnerable clients, our transgendered consumers.
    - This would suggest that this is where a qualitative study in conjunction with these quantitative findings i.e numbers which is really a mixed message.
    - It's very helpful for us in defining critical service delivery methods and this would include the way people are treated, how gender affirming practices, how sensitive and cultural appropriate they are for these vulnerable populations which will lead to improved care delivery but outcomes.

Questions/Discussion:
None

Presenter:
Dr. Kathleen Page

- There's been some good news in the field of HIV over the last decade.
- With declining incidence rates in most groups including overall in African Americans, and Whites.
- The HIV rates among Latinos has remained stable.
- When you look at specific groups particularly MSM you see a different more concerning trend.
    - HIV diagnosis have been going down among white MSM, they went up but have been stable among African Americans.
    - Among Latino MSM's it seems to have accelerated over the last few years.
- Among MSM especially high minority men, there's projections that 1 and 2 African American MSM could be diagnosed with HIV in their lifetime and 1 and 4 Hispanic MSM could be diagnosed within their lifetime. This is in comparison to a much lower risk in white MSM's.
- HIV trends from 2011 – 2015, good news for women it has reduced HIV diagnosis there are stabilizing rates among Black MSM's but unfortunately we are seeing diagnosis among Latino MSM young adults.
- 2018 data from Maryland, the continuum of care among people who are infected with HIV by race and ethnicity that there are lower rates of diagnosis among Hispanics and lower virologic suppression than in other groups in particular compared to whites.
- For all Hispanics linkage to care is not bad.

- We see consistently in clinical practice that Latino's overall may have some risk factors.
- There are many social structures that can impact this. Such as language.
- There is a direct link to this unfavorable or discriminatory policies and rhetoric on mental health directly and this can affect both the risk of other mental health conditions.
- This is a small study but a very telling study of almost 300 documented and undocumented Latinos migrants.
- They were asked about what they thought about immigration policies and HIV.
    - That investigators found were that people with misconceptions about immigration policy were 2/10th likely to ever be tested for HIV.
    - For example, the types of things people believed were that immigration officers keep record of immigrants that take HIV test.
    - That immigrants must prove their legal residence to receive testing.
    - That if someone from immigration finds out they have HIV that they will be deported.
    - Immigrants will receive HIV cards and can be arrested for using public health including HIV testing.
    - That all HIV providers are required to report people when they see them.
- The fact that people believe these things can have an impact on HIV care.
- Another important thing to remember for this population is that they are often not eligible for many of the benefits that we make take for granted in other populations.
- Immigrants often don't have benefits and transportation could be an issue.
- Regarding the real ID requirements, immigrants can still get an id that can be used.
- We see regarding stigma that manifested in many ways in this community there is a lot of stigma.
- One of the things we see a lot of is too many people presenting with late HIV care often with AIDS.
    - This is most common in men.
    - Barriers to HIV screening
- Launched a campaign last year that speak to why people don't get their HIV results.
- The campaign is designed to dispel those misconceptions.
- The Latinx Access program which is a collaboration between the health department and Johns Hopkins which includes advocacy and a Latino support group.
- We have a program that has been wonderful support group in helping newly diagnosed people.
- They are grateful to be able to address the issue of language and cultural barriers.

Motion:	**Who made the motion? Second?**	**Motion passed?**
Motion to extend meeting for an additional ten minutes.	D.Brewer/J. Wright	Passed

Jeanne Keruly

- Asked all to send any questions to Vanessa and these will be sent to Dr. Page for response.
- There was a question about how we were allocating resources and what sub recipients were doing to support our consumers during the COVID 19 pandemic.

    - Jeanne stated she would move this forward to have a more formal response from our Part A leadership before our next meeting.
- How is the testing situation working?
    - There was a call out from the Part A leadership to find out from sub recipients what has been put in place in order to;
        1. Conduct visits remotely
- Most agencies have moved to providing telemedicine visits which is the safest way to do it.
    - To go to the care centers you have to have a doctor's note and an appointment.
    - Telehealth is approved because the state took immediate actions to ensure that people had access to some level of care.
    - When it comes to blood work and labs you have to work this out with your individual provider.
    - Every facility that is able to do some form of testing in terms of HIV testing are still doing those.
    - We only have a half a million COVID 19 test kits that were just delivered as of today.
    - We don't know what the full plan is for those but they are working out those measures to ensure that first responders, health care providers, patients and those most at risk are given those test.

Motion:	**Who made the motion? Second?**	**Motion passed?**
Motion to approve the minutes from the February meeting.	J. Wright/K. Whittaker	Passed
		Abstain: 2

Motion:	**Who made the motion? Second?**	**Motion passed?**
Motion to adjourn meeting	J. Wright/A. Patterson	Passed

Meeting Adjourned 7:45 pm