

**Philadelphia Prevention Planning Group (PPG)**  
**Meeting Minutes**  
**Wednesday, September 28, 2011**  
**2:30 – 4:30 p.m.**  
**Office of HIV Planning, 340 N. 12<sup>th</sup> St., Suite 203, Philadelphia, PA 19107**

**Present:** David Acosta (Co-Chair), Jennifer Chapman (Co-Chair Elect), Terri Clark, Tony Daniel (Co-Chair), Annet Davis-Vogel, Katie Dunphy, Alison Lin, Alex Shirreffs, Erica Smith

**Excused:** Wesley Anderson, Christopher Collins, Lawrence Frazier, Jeffrey Jenne

**Absent:** Dawn Marie Acero, Antonio Davis, Andrew de los Reyes, Lomkhosi Denson, Emily Gible, Kareema Graham, D’Ontace Keyes, Loretta Matus, Ken McGarvey

**Guests:** Gus Grannan, Patricia Jones (AACO), Noel Ramirez, Melvin White

**Staff:** Nicole Johns, Debbie Law, Briana Morgan, Mari Ross-Russell, Nishika Vidanage

**Call to Order/Introductions:**

J. Chapman called the meeting to order at 2:48 pm. Those present then introduced themselves.

**Approval of Agenda:**

J. Chapman presented the agenda for approval. **Motion:** T. Clark moved, A. Davis-Vogel seconded to approve the agenda. **Motion passed:** All in favor.

**Approval of Minutes:**

J. Chapman presented the August 24, 2011 minutes for approval. **Motion:** T. Clark moved, A. Davis-Vogel seconded to approve the minutes from the August 24, 2011 meeting. **Motion passed:** All in favor.

**Report of Co-Chairs:**

J. Chapman reported that she had participated in her first UCHAPS community phone call, and that all of the jurisdictions were eagerly waiting for the community planning guidance to be released. She went on to say that each jurisdiction had been discussing ways to engage the community more, as well as strategies for recruitment.

D. Acosta stated that the grantee had submitted its application to the CDC, noting that all PPG members had received a copy of the CDC Funding Opportunity Announcement (FOA). He went on to say that the PPG would be asked to submit a letter of concurrence in approximately six months, and noted that they were still working without the new community planning guidance. He further explained that the direction of PPGs would be changing, and that there would be less of an emphasis on the prioritization of interventions and populations. He noted that Philadelphia was expecting a reduction in funding, while the state would see an increase.

D. Acosta next stated that the FOA placed a heavy emphasis on testing and prevention with positives with less of an emphasis on EBIs. He explained that he had repeatedly reviewed notes from the prevention provider panels organized by the Literature & Education Committee and taken other measures to seek out information on the experiences of the providers in delivering interventions. He went on to say that CLEAR was not currently listed in their plan, but that the CDC was recommending this as one of the top interventions for PLWHA. He explained that CLEAR would meet the needs of clients and included six modules. He then stated that Philadelphia would need to be smarter in choosing its interventions, and that interventions would be carefully selected for the RFP process. He noted that a smaller menu of interventions would allow for faster training as well.

T. Clark asked if CLEAR would be a separate program, or under the umbrella of CRCS. D. Acosta replied that he would learn more at a meeting the following day, but that the CDC's FOA indicated that the two would be funded together. He went on to say that this would be a harm-reduction based intervention that was very client-centered, and would be ideal for clients in difficult situations and environments.

#### **Discussion Items:**

- **Prevention System Changes**

D. Acosta asked those present to review the AACO provider meeting slides (*see – attached handout*). He then stated that the CDC had seen a severe increase in infections amongst young African-American MSM, so AACO had called a meeting for providers on this topic. He went on to say that the health commissioner had attended this meeting, and that while the focus was on MSM, all prevention providers had been invited. He further explained that the health commissioner had asked the group to think about how they would configure the MSM HIV prevention system if they were able to build it from the ground up.

M. White stated that he had attended a panel discussion the previous night, and that he would have liked to see the panelists engage more with young African-American MSM. He explained that providers would need to seize opportunities to speak to youth in order to determine their needs. A. Davis-Vogel explained that the event had included free admission to a ball for anyone that got tested, but that she thought that it would be better to have free admission for those that attended the presentation. She further explained that, while it was important to know one's status, there were many other balls that included HIV testing. D. Acosta replied that these comments highlighted the challenge of reaching the young African-American MSM population, and that these would be important issues to discuss at the provider meeting. A. Davis-Vogel agreed, and went on to say that testing was very important, but that some of the young men that had attended the presentation had had excellent questions, and that they had missed an opportunity to reach more young men. T. Clark stated that the PPG would need to think about conducting more education on the state of the city rather than "HIV 101," suggesting additional presentations on the epidemic in certain zip codes. M. White then noted that youth would need to be tested more often than other populations since they were more likely to change partners frequently, and suggested providing incentives for youth to bring friends to get tested.

D. Acosta then resumed his presentation, noting that less than half of MSM had been tested in the past year even though there was a recommendation for MSM to be tested every six months. He went on to say that a study of MSM in twenty-one cities showed that only 10%

of MSM had ever been through an EBI. He next stated that the CDC had approached Philadelphia with a special project modeling the cost of averting new HIV infections, and that a presentation on this data would be forthcoming. He continued on to discuss the positivity rate in Philadelphia, explaining that the rate was lower than they would like given the scope of the epidemic. P. Jones noted that the linkage to care rate was also fairly low. J. Chapman asked if this rate only referred to linkage to a first visit, and P. Jones agreed.

D. Acosta stated that they could do a much better job of reaching MSM, and that they would need to develop a new paradigm for prevention. He went on to say that they would need to address the high seroprevalence in certain communities, and that they would have to increase emphasis on retention and linkage to care.

D. Acosta next stated that the health department would be looking to create environments where men can meet and socialize. He went on to say that syringe exchange had already been a huge success and they hoped that condom distribution would make the same impact. He then stated that they would also be looking at new ways to reach younger populations, such as social media, as well as biologic interventions.

M. Ross-Russell asked for additional information on a new expectation that a person be linked to care within ninety days of testing positive. P. Jones replied that this would become the standard for all testing units on January 1, 2012. T. Clark asked for more information on PEMS. P. Jones replied that PEMS would be replaced by another system.

- **Team Building Exercise**

N. Johns stated that the group would be conducting a brief exercise and indicated six signs placed around the conference room, which read, “sexual orientation,” “religion,” “age,” “race,” “gender,” and “socio-economic status.” She then explained that she would read several statements, and that members would walk to the most applicable sign for each statement. The statements included the following: the part of my identity that I’m most aware of on a daily basis; the part of my identity that I am least aware of on a daily basis; the part of my identity that was most emphasized by my family growing up; the part of my identity that I would like to explore further is; the part of my identity that garners me the most privilege; the part of my identity I believe is most misunderstood by others; and finally the part of my identity I feel is difficult to discuss with others that identify differently.

Following the exercise, N. Johns explained that the group should think about what they had in common with others, and to keep these things in mind as they moved forward. T. Clark stated that she did not think about these categories every day in her relationships with others, but that these would all come into play with deeper thought. N. Ramirez stated that he had recently attended the National HIV Prevention Conference, and that the conference had included exciting and intense discussions of identity politics. He went on to say that he had been thinking more about his identity and its implications in his work since the conference. He concluded that this exercise was very timely given the conversations occurring across the country. A. Lin stated that identities would be important as they tried to mobilize entire communities. She explained that they were focusing their efforts on young MSM of color, but that they would need buy-in from everyone in the community, even if they were not a young black MSM or an HIV service provider.

N. Johns then asked the group if they would like to participate in similar exercises in the future and welcomed other suggestions. She noted that this could provide an opportunity for members to get to know each other. E. Smith added that it was good to move around.

**Action Item:**

- **Bylaws Change**

*Tabled.*

A. Shirreffs asked for more information about the Nominations Committee. A. Davis-Vogel explained that the PPG had originally wanted to remove the Nominations Committee from its bylaws, but that the committee had since met twice without issue. She went on to say that they would have new PPG members that they would be asking to vote on the dissolution of the committee, but that they would not have a historical perspective on the committee. She concluded that they may want to keep the committee as it stood. T. Clark stated that they would need a chair if they did not dissolve the committee, so they would need a member to step into a leadership role. M. Ross-Russell stated that T. Daniel had introduced the bylaws change, and that he would be able to retract the change if he would like. T. Daniel replied that it was time to move forward, and that he would do whatever the majority wished. He went on to say that they would need to address burnout of members, and that they would need to speak with members and past guests about where they were, what they wanted as a body, and what they were not receiving. He explained that some members felt that there had been not change and that the process was unfair, and that they had also identified a lack of communication, leadership, dedication, and motivation. He then stated that the body would be more likely to reach quorum for bylaws changes if they were to reduce the number of members on the PPG.

A. Davis-Vogel stated that the last Nominations Committee meeting had included a very rich discussion and that they had developed a list of suggestions to stimulate more energy, enthusiasm and participation. She went on to suggest that the Nominations Committee continue to do this type of work as needed. D. Law noted that the Nominations Committee typically met for two sets of three meetings each year. J. Chapman suggested having the Nominations Committee use the months that that were not reviewing applications to discuss engagement and possibly a different a seating arrangement. She went on to say to say that many of the themes from the September committee meeting had also been discussed in March, so the committee could possibly present its suggestions to the entire PPG.

T. Daniel stated that he had not participated in scoring the last round of applications, but that they would need to bear in mind that they tried to ensure that membership matched the epidemic. He went on to say that he was concerned about how many members they could approve for the PPG, and that they would need to discuss the possibility of targeted recruitment. A. Davis-Vogel replied that it had been difficult to make decisions on membership with the limited information included in the applications, and suggested brainstorming a more in-depth application for the future. D. Acosta stated that membership requirements would be colored by the new community planning guidance, and explained that they would likely be required to have individuals that represented various systems. He explained that the National HIV/AIDS Strategy required increased coordination, which would likely affect the composition of PPGs. He went on to say that they would also need more representation from stakeholders in the community. T. Clark replied that this would

require having community organizers bring new people to the table. A. Davis-Vogel stated that they would need to identify gatekeepers in various communities in order to establish programs there. She then noted that the Nominations Committee planned to review its gaps after the community planning guidance was released.

K. Dunphy then asked if other local systems were incorporating HIV into their processes. D. Acosta explained that this was a part of PCSI, which included the substance use, mental health, tuberculosis, STD, HIV, and hepatitis systems. A. Shirreffs replied that it would be important to incorporate other systems, such as the prison system, in the future.

T. Daniel stated that Philadelphia had some of the highest unemployment rates in the country, and that they had five times the national average of HIV infections. He suggested hosting a public health open house or forum in each community as well as with city council. He explained that they needed to make sure that communities were aware that they could get free medical care, and suggested having a team of doctors as well as HIV tests available at the events. He went on to suggest partnering with liver disease and kidney organizations since they were trying to reach many of the same people. A. Shirreffs replied that she was working to organize the Hepatitis C community for an event the next year. D. Acosta stated that T. Daniel had made a valid point on the economic conditions in Philadelphia, and went on to say that it would be important to bundle a service that seems less important to the community with other services. A. Davis-Vogel stated that they might need to have members attend small neighborhood community meetings, such as block captain meetings, in order to ask for their ideas and any feedback they would like to give to the PPG. She went on to say that this was the nature of community organizing in the 1960s, and that it would still work. She then stated that they would need to think outside of the box since many people were unemployed with no discretionary funds, so they would probably not attend meetings at this location. P. Jones suggested conducting a community needs assessment rather than assuming what people needed.

N. Ramirez stated that framing was very important. He went on to say that he had begun work with Q-Spot, which was a community collaboration, with the spirit of health equity. He explained that they wanted to make a positive impact on the community. He then stated that he had attended neighborhood meetings in Center City, and learned that residents were annoyed by loitering and the presence of sex workers. He explained that this demonstrated opportunities for improvement, and that they could provide safe spaces for people to come to. T. Daniel stated that they were many organizations that were certified to test, and that they were beginning to create cliques. He went on to say that Germantown was successfully organizing, and that they had been hearing that community members were tired of having to move out of their communities in order to seek a service.

J. Chapman stated that she wanted to make sure that this topic was revisited for a few minutes at each meeting. She went on to say that this had been the most in-depth discussion in a PPG meeting for some time, and that it was an issue that they were all excited about. She noted that they would have much more to talk about once they received the community planning guidance. T. Daniel stated that he would like to see more exercises at each meeting. He suggested conducting the exercises as their first discussion item so the effect would trickle down into the PPG's conversations. A. Davis-Vogel then suggested designing the exercises to stimulate the discussion, rather than to serve as basic warm-ups.

**Report of Staff:**

M. Ross-Russell stated that the Office had asked Sam Cutler from the Office of Addiction Services to present at the October PPG meeting, since the PPG was moving toward incorporating other systems into its conversations. She went on to say that PPG members could email B. Morgan with ideas for future discussions or presentations. She noted that the October presentation would include current behavioral health data, and added that PPG members could submit any specific questions. D. Acosta replied that it would be helpful to hear how the HIV system and OAS interacted, as this could help the group to identify any disconnects. A. Davis-Vogel suggested having a presentation on strategies for engaging substance users in services, particularly youth without insurance. D. Acosta stated that it would also be helpful to have an overview of the substance abuse and mental health systems. T. Clark suggested asking S. Cutler to speak on the strengths of the Office of Addiction Services, as well as any potential challenges in moving toward a more integrated system. D. Acosta noted that there was also a great deal of testing happening in drug and alcohol programs. T. Clark replied that it would be helpful to know the positivity rate for this testing, as well as any particular challenges. M. Ross-Russell then clarified that S. Cutler would be presenting data, including who was being served and their drugs of choice. She noted that she could pass any specific questions on to S. Cutler. A. Shirreffs asked if it would be possible to include Lorna Best in the presentation, explaining that she worked on testing at various services. M. Ross-Russell replied that she would look into this. D. Acosta then stated that they would like to know what the substance abuse system was like, and how it interacted with the HIV system.

N. Ramirez stated that there was a great deal of programs that integrated HIV services with mental health services, and that he would be interested in identifying any gaps. A. Davis-Vogel added that she would also be interested in information on age gaps and identifying LGBTQ-friendly services in different neighborhoods.

M. Ross-Russell stated that she was not sure how many of these questions that S. Cutler would be able to integrate into his presentation, but that the group would be free to ask them again during the October meeting.

**Old Business:**

None.

**New Business:**

None.

**Research Update:**

None.

**Announcements:**

A. Davis-Vogel announced that there would be an event the coming Friday that would include a brief presentation, and that the first twenty-five men to attend with college IDs would get \$10 to spend at Shampoo. She noted that this event was geared toward young MSM although it was open to men of every age, and that separate events had been held for Trans women.

D. Law stated that the Nominations Committee had met. She went on to say that, as of September 30, the terms of three members would expire, three resignations would take effect, one member would reach his term limit, and two members would be removed for attendance. She noted that five new members had been approved, so the PPG would have a total of 22 members.

N. Ramirez announced that Q-Spot would be hosting a poetry slam on the coming Saturday.

**Adjournment:**

The meeting was adjourned by general consensus at 4:41 p.m.

Respectfully submitted,

Briana L. Morgan, Staff

**Handouts Distributed at the Meeting:**

- Meeting Agenda
- Meeting Minutes from August 24, 2011
- AACO Provider Meeting: HIV Prevention for MSM
- OHP Calendar

# Philadelphia Prevention Planning Group (PPG)

Wednesday, September 28, 2011

2:30 p.m. – 4:30 p.m.

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**Call to Order**

**Welcome/Introductions**

**Approval of Agenda**

**Approval of Minutes** (*August 24, 2011*)

**Timekeeper**

**Report of Co-Chairs** (5 minutes)

**Discussion Items:** (60 minutes)

- **Prevention System Changes**
- **Team Building Exercise**

**Action Items:** (15 minutes)

- **Bylaws Changes**

**Report of Staff** (5 minutes)

**Old Business**

**New Business**

**Research Update**

**Announcements**

**Adjournment**

**Please contact the office at least 5 days in advance if you require special assistance**

*The next meeting date of the PPG is scheduled for Wednesday, October 26, 2011 from 2:30 – 4:30 p.m.  
at the Office of HIV Planning, 340 N. 12<sup>TH</sup> Street, Suite 203, Philadelphia, PA 19107  
(215) 574-6760 • FAX (215) 574-6761 • [www.hivphilly.org](http://www.hivphilly.org)*

**Philadelphia Prevention Planning Group (PPG)**

**Meeting Minutes**

**Wednesday, August 24, 2011**

**2:30 – 4:30 p.m.**

**Office of HIV Planning, 340 N. 12<sup>th</sup> St., Suite 203, Philadelphia, PA 19107**

**Present:** David Acosta (Co-Chair), Wesley Anderson, Marne Castillo, Jennifer Chapman (Co-Chair Elect), Terri Clark, Christopher Collins, Tony Daniel (Co-Chair), Annet Davis-Vogel, Katie Dunphy, Alison Lin, Alex Shirreffs

**Excused:** Lawrence Frazier, Kareema Graham, Jeffrey Jenne, D'Ontace Keyes, Erica Smith

**Absent:** Dawn Marie Acero, Antonio Davis, Andrew de los Reyes, Lomkhosi Denson, Nicholas Deroose, Lisa Espinosa, Emily Gible, Dennis Hill, Loretta Matus, Ken McGarvey, Renee Seaford

**Guests:** Jason Bell, Lenny Bell, Mark Govens Jr., Gus Grannan, Patricia Jones (AACO), Najia Lugman, Eleanor Lundy-Wade, Gary Pinkney, Desmond Thomas, Leroy A. Way, Ann Williams, Robert A. Woodhouse III

**Staff:** Aneeza Agha, Nicole Johns, Debbie Law, Michael Milsop, Briana Morgan, Nishika Vidanage

**Call to Order/Introductions:**

D. Acosta called the meeting to order at 2:41 pm. Those present then introduced themselves.

**Approval of Agenda:**

J. Chapman presented the agenda for approval. **Motion:** T. Clark moved, M. Castillo seconded to approve the agenda. **Motion passed:** All in favor.

**Approval of Minutes:**

J. Chapman presented the July 27, 2011 minutes for approval. **Motion:** M. Castillo moved, K. Dunphy seconded to approve the minutes from the July 27, 2011 meeting. **Motion passed:** All in favor.

**Timekeeper:**

K. Dunphy volunteered to keep time during the meeting.

**Report of Co-Chairs:**

J. Chapman reported that she had attended her first state CPG meeting, and noted that the state CPG had finalized its Prevention Plan. She went on to say that the state CPG had originally been scheduled to review the community planning guidance as well, but that the guidance had not yet been released. She further explained that they had instead

discussed possible future changes, including the integration of care and prevention at the state level.

D. Acosta reported that AACO's response to the Funding Opportunity Announcement (FOA) was aligned with both the National HIV/AIDS Strategy (NHAS) and Enhanced Community HIV Prevention Planning (ECHPP). He went on to say that there would be shifting priorities over the next few years as the HIV prevention system changed. He then explained that AACO would first respond to the FOA, then RFP the system, and finally ask the PPG to approve a letter of concurrence. He went on to say that the emphasis on behavioral interventions was decreasing, and that they would need to do much more with less funding. He further explained that he had carefully read the minutes from the prevention provider panels, as they would need to carefully consider which interventions were funded in the future. He then noted that AACO would respond to Part A (for prevention services), Part B (for expanded testing), and Part C (a competitive project). He concluded that AACO would keep the PPG informed as they moved forward.

D. Acosta next reported that P. Jones and T. Daniel had attended the UCHAPS conference. P. Jones reported that UCHAPS was now a 501(c)3 with a board of seven, and that they were considering expanding the board to thirteen members. She went on to say that all decisions would go before the Steering Committee, and that they would be hiring for two positions. She then stated that UCHAPS wanted each jurisdiction to know that peer-to-peer technical assistance was available. She also noted that UCHAPS would be creating an ad hoc committee that would develop messages for the Super Congress that would be making decisions on budget cuts. She added that the next UCHAPS meeting would focus on using surveillance data in evaluating prevention programs. D. Acosta replied that the use of surveillance data to demonstrate the effectiveness of prevention would be dominating the federal conversation in the future.

#### **Discussion Items:**

- **PPG Recruitment**

D. Law stated that the fall open nominations process was beginning. She went on to say that the terms of seven current members were ending, and that the PPG would need to brainstorm ideas on reaching out to new members. T. Clark suggested using social media to advertise the importance of becoming a member, as well as provide information on the PPG and the OHP. She also suggested developing a flier or other promotional message to be used in an email blast for providers, universities, ASOs, and public health programs. N. Johns replied that the PPG had been using a flier designed by a former PPG member for the past five years, and asked if any current members would like to work on updating this flier.

J. Chapman next asked how many members were currently on the PPG, and how many were in danger of removal. D. Law replied that the PPG needed to have a total of twenty to thirty-five members. She went on to say that they currently had 28 members, and that approximately ten of those members were not fully participating. She explained that they needed certain affiliations (such as a government education agency, faith-based

community organization, or other government agencies) as well as certain areas of expertise (such as an epidemiological background or an education community background) and certain at-risk communities (such as mothers with or at risk for HIV and MSM/IDUs). M. Castillo suggested distributing this list to PPG members so they could each do personal targeted recruitment. She went on to say that it was difficult to describe the PPG, and suggested having a day for members to bring friends to the PPG meeting.

D. Acosta stated that expectations of community planning were changing, and that community planning bodies were now being seen as bodies that aid system coordination. He went on to say that there had been less of an emphasis on the nature of prevention, and instead more of an emphasis on assisting in coordinating access to the various systems. He explained that they would need more input from mental health, substance use, housing, and other services. J. Chapman asked if the PPG would need an authority to require these representatives to join the PPG. D. Acosta replied that he was not sure, and that the PPG would need to think of ways to bring these people to the PPG. He went on to ask if the PPG should make a formal request that these representatives attend the meetings. He then added that J. Chapman had suggested that they convene the Nominations Committee to remove members that had not attended meetings for a very long time since the PPG was having difficulty reaching quorum.

T. Clark stated that she liked the idea of asking PPG members to bring a friend to a particular meeting. She explained that many of those in the community did not understand what the PPG does, how the PPG performs this work, and why the work of the PPG was important. She went on to say that it could be important to hold this type of event as members reached out to their own social networks. M. Castillo explained that they had previously tried to host open houses, but that they had been unsuccessful. She went on to suggest that the PPG designate certain meetings for members to bring friends. She then stated that members would need to think about whom they know in their professional circles, and then bring them to a meeting.

T. Clark then asked if there would be any changes to the roles of PPG members as the structure of prevention shifted. A. Agha replied that they were not sure, since the new community planning guidance had not yet been released. G. Grannan then asked if the PPG would consider moving its meetings to other parts of the city if they were looking to have increased community participation. M. White next asked what percentage of consumers they would like to see on the PPG. D. Law replied that they did not have a requirement for a percentage of consumers on the PPG, and that they did not ask applicants for their HIV status. M. White replied that he would pass this information on to the Positive Committee. K. Dunphy suggested that the PPG consider recruiting public health field instructors. T. Clark agreed, and stated it would be great to have members that were conducting HIV research. N. Lugman stated that Temple's undergraduate public health program required students to complete thirty hours of community service, and suggested asking one of these students to help the PPG to recruit new members.

T. Daniel suggested that the PPG take advantage of the UCHAPS peer technical assistance program in order to find out how partner jurisdictions recruited. He explained

that this would be an opportunity to learn how other areas, such as Houston and San Francisco, were able to find new members. He went on to say that they should share information, as well as look at recruitment tools from other jurisdictions. T. Clark asked if they would be able to choose which city provided the technical assistance. T. Daniel replied that that this was partly based on areas of expertise, and that jurisdictions would be paired based on needs.

D. Law stated that they would have a deadline of September 12 for fall applications to the PPG, and noted that they would be able to reach out using social media before that time. She went on to say that the PPG could discuss additional ideas moving forward. She then noted that she currently had five new applicants, and that she had also distributed applications to current members with expiring terms. D. Acosta noted that T. Daniel had previously suggested that the current duties of the Nominations Committee be reassigned to the Monitoring Committee. The group then agreed that the PPG Nominations Committee would meet on August 21.

J. Chapman stated that members could also email recruitment suggestions to OHP staff. D. Acosta stated that they should also look into recruiting representatives from other agencies. He explained that A. Shirreffs, for example, represented Hepatitis on the PPG. He further explained that they were seeking members like her from other city agencies. A. Shirreffs stated that she would speak with Marcelo Fernández-Viña about having representation from each agency that was a part of PCSI. D. Acosta replied that they would need to have representatives from each agency on the PPG as they began to coordinate the systems.

B. Morgan then asked PPG members to “like” the Office on Facebook and follow the Office on Twitter. She explained that any PPG recruitment messaging would be most effective if shared by current PPG members. She went on to say that the OHP currently had approximately 750 followers on Twitter, but that they were not all located in the Philadelphia area. She further explained that it would be very helpful for current members to re-tweet and share the messages so they would reach more of those located in Philadelphia.

- **Debriefing on the Last Planning Cycle**

M. Milsop distributed an outline of the planning cycle (*see – attached handout*). He also asked those present to review the key points from the 2011 Prevention Plan (*see – attached handout*). A. Agha noted that the Executive Summary of the Prevention Plan was available on the OHP website. M. Milsop then stated that the planning cycle had been shortened from five years to three years, so the PPG would need to work more quickly and spend less time evaluating their process. He also thanked members of the Planning Priorities Committee, and particularly M. Castillo, for the work they did to prioritize populations. M. Castillo replied that the process was always better when more members participated. She went on to say that the PPC did very concrete work, and that its committee meetings were very different from the PPG meetings. M. Milsop agreed and stated that he hoped that more members would attend the next month’s PPC meeting.

He added that they would continue operating under the current community planning guidance until the new guidance was released.

**Action Item:**

- **Bylaws Change**

*Tabled.*

**Review Committee and Workgroup Reports:**

B. Morgan reported that none of the PPG's committees had met in the month of August.

**Report of Staff:**

A. Agha reported that the CDC had released an HIV Prevention Strategic Plan. She went on to say that the PPG may want to discuss how their goals and objectives aligned with the Strategic Plan in the future.

**Old Business:**

W. Anderson asked if allocations meetings had been held. B. Morgan replied that the Ryan White Part A allocations meetings had not yet occurred, and that OHP staff would notify the community when the meetings were scheduled.

**New Business:**

K. Dunphy stated that that Bar AIDS, a fundraiser for Philadelphia ASOs, would be held the following night.

T. Daniel stated that five representatives from Philadelphia had attended Hip Hop 4 HIV Awareness in Houston in July, and that Houston had appreciated their presence. He went on to say that Philadelphia would need to begin thinking about how this hip hop and R&B concert could align with the prevention plan. He then explained that they would like to plan this as an annual event, and that they knew that distribution of condoms, testing, and linkage to care would be a part of the event. C. Collins stated that they were working on a presentation to help the community and the health department to get on board with the event. T. Daniel pointed out that the committee that was working on the event was separate from the PPG, and involved PPG members as well as the health department and members of the community. He added that they already had support from local radio stations and personalities, including Tiffany Bacon. P. Jones noted that Houston had been able to test 15,000 people in one month through this event. A. Shirreffs asked how many of these people had tested positive. P. Jones replied that 1% had tested positive for HIV, while 12% had tested positive for chlamydia and gonorrhea.

A. Davis-Vogel stated that the PPG ought to be able to say that they were co-sponsors of this event in Philadelphia, particularly as they discussed visibility for recruitment purposes. She went on to say that the PPG ought to send letters to Mayor Nutter and Don Schwarz to ask for their support for the event. C. Collins replied that someone from Mayor Nutter's staff was updating him on the event, but that he would appreciate the PPG sending a letter. He went on to say that Philadelphia youth needed something to do, particularly in the summertime. T. Daniel stated that he and J. Chapman would draft a

letter and bring it to the PPG for approval. He added that anyone with questions on the event should speak with P. Jones or C. Collins.

T. Clark asked if ASOs should sit on the group that was planning the event. P. Jones replied that they were currently creating a structure for involvement, and that they would send out a letter with that information.

**Research Update:**

None.

**Announcements:**

T. Daniel announced that his email address had changed.

T. Clark announced that Action AIDS had an open position for a full-time counselor and tester.

D. Acosta announced that an artist would soon be visiting Philadelphia, and that he had fliers available.

**Adjournment:**

The meeting was adjourned by general consensus at 3:50 p.m.

Respectfully submitted,

Briana L. Morgan, Staff

**Handouts Distributed at the Meeting:**

- Meeting Agenda
- Meeting Minutes from July 27, 2011
- Key Points: 2011 HIV Prevention Plan
- CPG Activities: Proposed 3-Year Plan (2011 – 2014)
- OHP Calendar

## AACO Provider Meeting: HIV Prevention for MSM

September 16, 2011

### Agenda

- Health Commissioner Charge and Activities
- Local Surveillance Data, Syphilis Data and NHBS description
- CDC Modeling Data
- Local Prevention Performance
- National Call to Reconfigure MSM HIV Prevention
- Health Department Strategies
- Messages
- Call to Action
- Questions/Comments

## Health Commissioner's charge to AACO

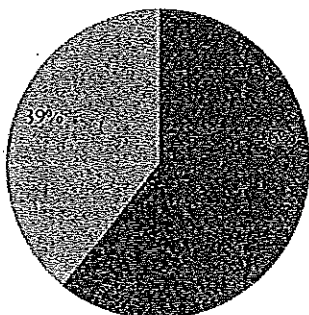
- Concern about Youth and STDs including HIV
  - Philadelphia Condom Campaign
- Concern about MSM HIV prevention – is it working - especially with young MSM
- Charge: how would you configure the MSM HIV prevention system if you were building it up from the ground
- HC Activities: meetings with Bar owners ...

## Epidemiology

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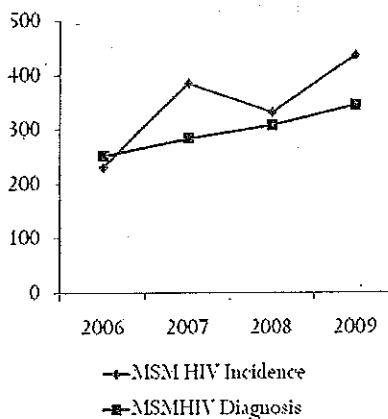
## Philadelphia Incidence Estimates

2009 Incidence Estimate  
Estimated 941 infections



■ MSM ■ IDU ■ HET

MSM HIV Trends



## HIV in MSM in Philadelphia

### HIV Incidence Estimates

- Estimated that 1.6% of MSM in Philadelphia became infected with HIV in 2009.
- 88.8% estimated increase in HIV incidence in MSM between 2006 and 2009 (driven by new infections in 13-24 AA MSM).
- 28% increase in the number of MSM newly diagnosed with HIV between 2006 and 2009.
- Suggests an increasing number of MSM are unaware they are infected.

### HIV Prevalence (aware) among MSM, 12/31/2009

	Pop size	MSM	MSM	% HIV
	Age 13+	estimate	with HIV	infected
Black	235,259	11,763	3,200	27.2%
White	268,904	13,445	2,080	15.5%
Latino	69,252	3,463	530	15.3%

## National HIV Behavioral Surveillance

- Objectives
  - Risk Behaviors
  - HIV Testing Behaviors
  - Prevention
- Populations – MSM, IDU, HET
- MSM
  - Venue-based, time-space sampling methodology (participants from randomly selected venues are systematically recruited and interviewed)

## National HIV Behavioral Surveillance

- Venue-based sampling
  - A venue is an area, location, or building where men can be approached and recruited
  - Attended by men for purposes *other* than receiving medical or mental healthcare, social services, or HIV/STD diagnostic testing or prevention services
  - venues that yield > 50% ineligible men should be excluded from the sampling frame.
- Types of Venues – NHBS-MSM3
  - 53 venues, 158 day time periods
  - List includes 16 bars, 2 cafes/restaurants, 6 dance clubs, 1 gym, 6 large community celebrations, 5 social organizations, 3 parks, 1 retail business, 5 street locations, 7 sex environments and 1 ballroom event

## National HIV Behavioral Surveillance

- We are not currently meeting the PHS guidelines for HIV testing
  - 76.8% of MSM ever tested
  - Less than half (46.9%) of MSM had tested in the last year
- Large number of HIV+ MSM are unaware of their status
  - 10.6% of participants HIV+
  - 70.8% of positives were unaware

## Early syphilis cases among MSM January through June 2011

- Overall decrease in the number of early syphilis cases identified among MSM
- Proportion of cases identified among Black MSM has declined while proportion of cases among White MSM has increased
- Proportion of cases identified among 20-24 year old MSM has declined while that of 41 – 59 year old MSM has increased
- Distribution of HIV status among MSM cases remains stable with HIV positive cases representing approximately 50%

## CDC modeling of HIV prevention in Philadelphia

- Scope
  - Limited interventions considered: does not include condom, groups all HE/RR together
  - Planning horizon
- Inputs
  - Size of at risk populations
  - Cost and efficacy of interventions
  - Transmission rates
- Outputs
  - Cost of new infection averted
  - Optimized allocations
- Limitations
  - Mathematical model with limited scope: but can show directions we should take

## Local Performance Data

## Local Prevention Performance

2010 HIV Testing Data:	All Tests	All MSM Tests	*MSM Tests by AAGO funded non-clinical CTR Programs
Tests	81,850	8,761	3,018
New Positives	502	202	73
Sero-Positivity Rate	0.61%	2.31%	2.42%
Linked to Care	212	89	43
Linkage Rate	42%	44%	59%

\*Other programs include: Expanded and Integrated Routine Testing in Clinical sites, Expanded and Integrated Non-clinical MSM Social Networks Testing, CDC Directly-funded CBO CTR Programs, Ryan White Early Intervention Programs, Health Department Testing Programs (City Health Centers, Office of Addiction Services, Cooperative Agreement Sites), and Perinatal Testing Programs

## Local Prevention Performance

2006 - 2010 Health Education Risk Reduction Client Level Data*	
Total Number of Clients in PEMS	9,015
Number of Clients in PEMS with a completed Risk Profile	3,190
Percent of those with a completed Risk Profile	35%
Number of MSM Clients in PEMS	487
Percent of MSM Clients in PEMS	5.4%

\* Does not include aggregate level data entered into PEMS

## Local Prevention Performance

### What is our current reach into the MSM population in Philadelphia?

	Number	Percent
Total Estimated HIV Negative/Unknown MSM Population	21,815	100%
Number of MSM tested in 2010	8,781	40%
MSM tested by funded non-clinical CTR programs in 2010	3,018	14%
MSM tested by other HIV testing programs in 2010	5,743	26%
MSM receiving an HE/RR intervention between 2006 and 2010	487	2%

## MSM HIV Prevention Strategies

New Paradigm for MSM in USA

## National HIV/AIDS Strategy

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related disparities
  
- Quantified targets set to reach each of the three broad goals –see handout

## New paradigm for MSM: Why?

- Continued incidence of new HIV infections among MSM and young AA MSM in particular
- Recognition of structural factors impeding prevention efforts among MSM
- Recognition of the limits of traditional risk reduction strategies to address the epidemic among MSM in the USA

## Why? continued

- Recognition of the need to address social and structural factors
- Vulnerability to infection due to high incidence/prevalence
- Prevention funding for MSM is consistently under prioritized

## New strategies

- Reducing Viral load in community
- Addressing social and structural factors
- New strategies to reduce sexual risk behavior

## Handouts

- AMFAR MSM Issue Brief
- Testing paper on approaches for testing MSM
- Article on HIV transmission in primary relationships among MSM
- National Strategic Goals

## Health Department Approaches

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## Key points

- CDC modeling using Philadelphia data stresses that resources need to target MSMs
- Incidence data indicates new HIV infections are increasing in young African American MSMs
- Need to know where MSMs go
  - Live everywhere in the city
  - Tend to travel outside their geographical areas
  - Lots of traffic on cyber venues

## Refocusing on condom distribution

- Condom Distribution by prevention providers
- Freedom Condom Campaign
  - Geared toward youth in general
- Planning new efforts to target condom distribution to MSM

## HIV testing

- Healthcare settings remain important
  - Routine opt-out screening
- Targeted Testing in non-healthcare settings – 3 strategies
  - Venue-based targeted outreach and testing of MSM
  - Social network testing
  - Partner services
    - Referral of all preliminary positives
    - Use of surveillance data

## Linkage, retention, and re-engagement: HIV medical care

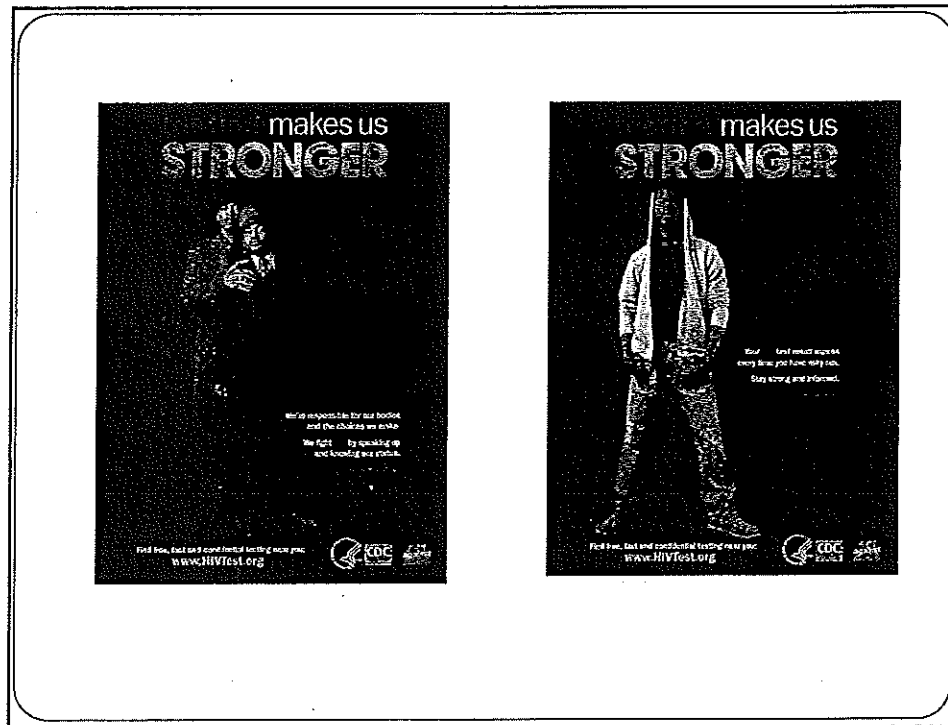
- Linkage to medical care within 90 days
- Ongoing retention in medical care
- Medication Adherence Programs
- Re-engagement for those lost to HIV medical care and “previously positive” persons retested

## Evidence-based HE/RR (EBIs)

- Limited number of scalable EBIs
- Focus on HIV-positive MSM
- Focus on HIV-negative African American MSM
- Leverage CDC directly funded programs

## MSM & Social Media

- Funding to target MSM through social media
  - Cyber sites
  - Twitter
  - Facebook
  - Media campaign



## Biologic Interventions

- nPEP
  - Workgroup finalizing protocols
  - Pilot project in planning stages
  - NOW: 1-800-985-2437 for referral to Health Centers
  - NOW – Off Hours – Go to Emergency Room
- PrEP
  - Workgroup of healthcare and community stakeholders to be convened

## Who are our targets?

- Young African American MSM
- MSM who hook-up on the internet
- MSM in primary relationships
- MSM who go to Center City Bars
- MSM who never go to Center City Bars
- Middle-age white MSM
- Latino MSM who stay in the neighborhood

This is not a complete or comprehensive list!

## Complicated communities: multiple messages

- Risk reduction
  - Use condoms
  - Harm reduction/disclosure/informed decisions
- Test and link to care

## A Call to Action

### Reassess your programs

- Has your program become complacent and too satisfied with the status quo? You and your team need to answer this as you assess your prevention efforts.
- Each program needs to rethink their prevention efforts from the ground up. All staff should be familiar with program goals as well as what the data says about your efforts.
- Programs need to reassess testing and outreach sites on a regular basis.
- Use data to help manage your program. If the data are incorrect, talk to AACO.

## Reassess your venues frequently

- It is not a question of the number of tests obtained, but the number of positives found.
- Outreach should help to identify locations as well as individuals.
- Rethink not only locations, but hours when testing or other prevention services are available.
- Explore testing in non-gay identified venues, are there nights when there are a high number of gay customers?
- How you offer testing should be appropriate with the venue.

## Establish a community presence

- Community partners should know who you are, what you do, and how to reach you.
- Community partners need to understand why HIV prevention efforts are important.
- Be consistent, be where you say you'll be when the you say you'll be there, no exceptions.

## Test and link to care

- Develop methods to ensure individuals receive confirmatory results
- Develop methods to ensure newly identified positives are effectively linked to care
- Develop strong collaboration with medical sites. This is not only important for referrals to them but also from them.
- Refer newly diagnosed positives to partner services
- Refer to prevention services based on risk assessment

## Try new strategies

- Develop new outreach/testing venues
- Try social network strategies to recruit persons for testing
  - Social network strategies are not an add-on to your CTR program, but are a intervention in themselves
- Promote partner services with your clients

## A call to action

Don't be afraid to change – if you're not finding positives, you need to rethink and relocate.

Questions and Comments