

Philadelphia Prevention Community Planning Group (CPG)
Meeting Minutes
Wednesday, March 24th, 2010
2:30 – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, David Acosta (Co-Chair), Wesley Anderson, Wade Briscoe, Marné Castillo, Jennifer Chapman, Terri Clark, Christopher Collins (Co-Chair), Tony Daniel (Co-Chair Elect), Andrew De Los Reyes, Tricia Dressel, Jeffrey Jenne, Andrea Johnson, Denette Lienau, Tyreef King, Alison Lin, Val Sowell, Roberta Waite

Excused: Antonio Davis, Annet Davis-Vogel, Nicholas Deroose, Rick Feely, Ken McGarvey, Michelle Teti

Guests: Craig Ashley, D'Angelo D'Ontace-Keyes, Kate Dunphy, Kevin Hackett, Duane Kaufman, Eleanor Lundy-Wade, Ronald Montgomery, Melvin White

Absent: Khadeja Barnes, Robin Brennan, Arti Chhabria, David Powell, Dionna Samuel

Staff: Aneeza Agha, Joseph Ellis, Nicole Johns, Debbie C. Law, Michael Milsop, Mari Ross-Russell

Call to Order/ Introductions

D. Acosta called the meeting to order at 2:34 pm. Afterwards, each member of the group took a moment to introduce his or herself. C. Collins asked whether anyone in the group would be willing to be a timekeeper for the meeting. T. Daniel volunteered for the task.

Approval of Agenda

Motion: After taking a moment to review the meeting agenda, M. Castillo moved and D. Lienau seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*February 24th, 2010*)

The group took a moment to review a draft of the minutes from their January meeting.

Motion: T. Clark moved and T. Daniel seconded to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor.

Report of Co-Chairs

D. Acosta reported that AACO had nearly completed the APR (Annual Progress Report) and would submit it to the CDC for prevention funding by March 29th. He said that, after the report had been submitted, a copy would be given to the CPG members.

Additionally, D. Acosta informed the group that the Health Department had been conducting a needs assessment for MSM populations over the past six months. He said that a report on the activity had just been completed and would be given to the CPG so that the data could be factored in with their ongoing planning. He told the members of

the CPG that, if a request was submitted to AACO, a presentation on the needs assessment could be given at one of their upcoming meeting.

C. Collins reported that he had just attended the most recent UCHAPS meeting, where the group had discussed needle exchange access, PCSI, and the National HIV/AIDS Strategy. He offered to send presentations from the meeting to anyone who was interested. He informed the CPG that UCHAPS would be coming to Philadelphia in June for their next meeting and that a community representative with the organization would be documenting the state of HIV prevention in Philadelphia, as the individual was doing in all jurisdictions affiliated with UCHAPS. D. Acosta clarified that UCHAPS was coming to Philadelphia to highlight the city's youth programs and to be a part of all of the prevention activities scheduled for June, in addition to the fact that the city was relatively inexpensive. He said that, although the UCHAPS calendar was already set, he was unsure of what the date for the Philadelphia meeting was.

C. Collins also informed the group that he had recently attended the State CPG meeting. He noted that, at the meetings, he contributed to the work of the Epidemiology Committee, which set priorities, made programming decisions, and charged other committees with work. He also reported that the State CPG had given recognition to the fact that TIP was becoming a separate organization.

D. Acosta also commented on the cuts in prevention funding at the state level in light of an analysis by the National Association of State and Territorial Directors on how the cuts were affecting various systems. He noted that California had lost approximately 95 million dollars in prevention funding and that the only reason some of the state's programs were still running was because a few cities had provided funding. He stressed that, since President Obama had said that prevention would receive flat funding for three years, there would be no increases for quite a while. However, he said that there were some advocacy efforts at the provider level to make sure that services were not cut too deeply. He reported that, in Pennsylvania, Philadelphia was most affected by the cuts while Pittsburg was the second most affected city.

Workgroup Session

- **Weight Factors for Prioritizing Populations –PPC**

While M. Milsop distributed copies of *Worksheet 2: Weighting Factors for Target Populations*, M. Castillo explained that the presentation would provide information on completing the handout (see presentation handout for more details). She then asked that everyone who was not a CPG member write the word "guest" at the top of his or her worksheet.

T. Clark asked why the scale for the weights was 1, 3, 5, & 8 instead of consecutive numbers. A. de los Reyes explained that, by using numbers that were spaced further apart, the range of the results would be broader, which would make the priorities clearer.

J. Jenne asked whether the fourth factor on the list, AIDS Incidence, should be "diagnosed with AIDS" since there was no real test to determine when an individual had progressed from

HIV to AIDS. M. Milsop agreed that the factor could be considered as “diagnosed with AIDS.”

For the fifth factor, Key indicators of risk behaviors: STDs, A. de los Reyes explained to the group that the committee could not obtain the rate of syphilis cases among each of the behavioral risk groups because there was no information on the total sizes of each of the populations. However, he said that there were data available on total cases of syphilis in Philadelphia, which were under 1000. Additionally, he reported that MSM, especially African Americans, bore the burden of syphilis cases in the city and that nearly 50% of MSM with syphilis were dually infected with HIV, about 100 – 200 cases.

D. Lienau asked how the committee would collect the data for Key indicators of risk behaviors: substance use (injection drugs). D. Acosta responded that the committee could not obtain solid data on substance abuse treatment from OAS (Office of Addiction Services). As a result, he said that the members of the CPG would have to use the knowledge they had gained through their personal and professional experiences to make a decision.

T. Clark asked for a clearer description of the difference between the last two factors on the worksheet – Difficulty of meeting population needs and Barriers to reaching the population. M. Castillo explained that Barriers to reaching the population were issues, structural or personal, that kept members of the target populations from accessing services. Furthermore, she said that Difficulty of meeting population needs sought to address whether existing programs were making an impact after they had been accessed by the target population.

Discussion Item:

• **June CPG Meeting – C. Collins**

C. Collins explained to the group that he wanted to discuss a possible rescheduling of the June CPG meeting in order to include Anna Ford from UCHAPS. J. Jenne noted that UCHAPS would be in Philadelphia from June 11th to the 14th and that all the CPG members were welcome to attend the meetings. He also said that A. Ford lived in Washington so, if the CPG meeting could not be rescheduled to include her, she could come up at another time.

D. Acosta suggested that the group try to meet with UCHAPS at a different occasion instead of rescheduling their June meeting. He said that it would likely be too difficult to find an alternative date for the meeting with all of the other prevention-related activities that would take place in June. The rest of the group agreed. C. Collins said that he had a presentation on UCHAPS that he would send to anyone who wanted more information on the coalition. Additionally, he told the group that, if any organizations were interested in having A. Ford review their prevention programs, they should contact him so that a meeting could be coordinated.

J. Jenne reported that, at the last UCHAPS meeting, representatives from each jurisdiction had had to list the members of their delegation. He said that C. Collins and T. Daniels had been listed as the community representatives for Philadelphia but UCHAPS only had funding to send one community representative to their meetings. As a result, he said that the group would have to make a decision about who would be their one community representative,

noting that some other jurisdictions had suggesting designating a single, standing representative who was not tied in with the Community Co-Chair position. He told the group that, following the Philadelphia meeting in June, the next UCHAPS meeting would be in Chicago in September.

Review Committee and Workgroup Reports

The Co-Chairs of each of the committees took a moment to read the *CPG Subcommittees Report* for the month of March (see handout for more information).

After J. Chapman had read the report for the Literature & Education Committee, T. Clark asked D. Acosta whether he had any information on structural interventions for the committee's upcoming review of the programs. D. Acosta responded that most current discussions on structural interventions were more focused on theory than practical applications. However, he listed perinatal prevention, HIV testing in care settings, needle exchange programs, and housing as examples of structural interventions. He said that structural interventions had still not been widely studied as most efforts were still focused on behavioral interventions. He told the group that he would coordinate a meeting with M. Ross-Russell to discuss the matter further with the committee.

In response to a question by T. Dressel, T. Clark said that the Lit & Ed committee had so far approved Healthy Relationships for inclusion in the next prevention system. C. Collins clarified that the committee still had to go through a second round of reviewing for all of the approved programs. He said that information culled from the prevention provider panel discussions would feed into the committee's second review.

Report of Staff

N. Johns noted that, near the sign in sheet, there were copies of two articles for anyone who was interested in reading them. The first article, she explained, was a discussion on the current state of AIDS in America from the New England Journal of Medicine. The second article, she continued, examined the role of theory in HIV prevention.

D. Law reported that orientation for new CPG members was scheduled for Wednesday, April 21st, from 1:00 – 4:00 pm.

Old Business

None

New Business

None

Research Update

None

Announcements

- A. de los Reyes announced that Health Center One would be putting up new posters and so he was going to send out an email asking for submissions that dealt with positive, health education related messages.
- A de los Reyes also announced that the Partner Services presentation he had given at the last CPG meeting could be delivered at other organizations as well.
- M. Milsop announced that TIP was becoming a separate organization with its own office.
- A guest announced that the HIV/AIDS ministry would be holding a workshop on June 5th to inform parents on the activities of youth.
- T. King announced that GALAEI's 20th anniversary celebration would take place on April 16th at the Gershman YMCA
- C. Collins announced that 3MV: Bridge the Generation Gap would take place on April 3rd and 4th at Washington West.
- T. Daniel announced that, on March 31st, there would be an LGBT town hall at Drexel University
- T. Daniel also announced that Black Gay Pride Week in Philadelphia was scheduled for April 18th – 25th.

Adjournment

The meeting was adjourned by general consensus at 3:52 pm.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*February 24th, 2010*)
- Handouts for Presentation on the Weighting Factors Process
- Worksheet 2: Weighting Factors for Target Populations
- CPG Subcommittee Report – March 2010
- OHP Meeting Calendar

Philadelphia Prevention Community Planning Group (CPG)

Wednesday, March 24th, 2010

2:30 – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes (*February 24th, 2010*)

Report of Co-Chairs (5 minutes)

Workgroup Session: (45 minutes)

- **Weight Factors for Prioritizing Populations - PPC**

Discussion Item: (15 minutes)

- **June CPG Meeting – C. Collins**

Review Committee and Workgroup Reports (5 minutes)

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 CPG is scheduled for **Wednesday, April 28th, from 2:30 – 4:30 p.m.***

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(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

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Excused: David Acosta (Co-Chair), Marné Castillo, Arti Chhabria, Nicholas Deroose, Denette Lienau, Alison Lin, David Powell, Val Sowell, Michelle Teti

Guests: Craig Ashley, Robert Lane, Eleanor Lundy-Wade, Ronald Montgomery, Amy Nuir, Jane Oprea, Darryl Rush, Coleman Terrell, Tye Underdue, Melvin White

Absent: Yexsy Alicia, Khadeja Barnes, Robin Brennan, Wade Briscoe

Staff: Aneeza Agha, Joseph Ellis, Nicole Johns, Debbie C. Law, Michael Milsop

Call to Order/ Introductions

C. Collins called the meeting to order at 2:34 pm. Afterwards, each member of the group took a moment to introduce his or herself. C. Collins asked whether anyone in the group was willing to be a timekeeper for the meeting. T. Daniel volunteered for the task.

Approval of Agenda

Motion: After taking a moment to review the meeting agenda, T. Daniel moved and A. Davis seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*January 27th, 2010*)

The group took a moment to review a draft of the minutes from their January meeting. E. Lundy-Wade noted that she had been in attendance at the last meeting but was not included in the list of guests. **Motion:** With the noted correction, D. Acero moved and T. Clark to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor.

Report of Co-Chairs

C. Collins informed the group that he would be attending the next UCHAPS meeting from February 27th through March 1st. He said that he would report any information he obtained at the meeting when the CPG convened in March.

J. Jenne reported that he was substituting as governmental Co-Chair because D. Acosta was currently unavailable. He then gave the floor to C. Terrell, who had an update on prevention funding from the state. C. Terrell informed the group that, in the previous fiscal year, the city had received 4.8 million dollars from the state for prevention services

through a combination of basic prevention funding, the testing initiative, and the State 656 funds. However, he continued, AACO had learned in January that, for the current fiscal year, state funding for prevention would be reduced by approximately 1.7 million dollars due to Pennsylvania's ongoing budget crisis. He said that the situation was especially serious because, as they were already halfway through the fiscal year, they had been operating under assumption that the city would receive level-funding of 4.8 million dollars. However, he told the group that AACO had been working with CDC project officers to locate overlap funding and shift some programs to different funding sources, such as using Part B funding for prevention with positives programs and including some counseling and testing programs with Ryan White early intervention services. As a result of their efforts, he continued, the city was able to make up all but \$380,000 of their lost funding for the fiscal year. He then told the group that, despite the significant amount of funding they had been able to recover, the loss was still substantial and would cause all State 656 programs to be terminated as of February 28th. He noted that losing the State 656 programs, which were mostly focused on HIV education, meant that a total of approximately 120 of the state's 78,000 HIV tests would not be administered for the year. In closing, he said that he was unsure whether AACO would again be able to make up the loss of funding in the next fiscal year if the situation was repeated.

- **Partner Services Update** – *A. de los Reyes (PPC)*

A. de los Reyes started his presentation by noting that, although some individuals referred to Partner Services (PS) as Partner Counseling Referral Services (PCRS) or partner notification, PS actually included many other activities. He then told the group that, after he finished with his presentation, he was interested in hearing about their thoughts and experiences with PS (see handouts for more information).

R. Feely asked for a description of the PS notification process. A de los Reyes replied that, contrary to some reports, PS did not travel to individuals' houses in highly identifiable vehicles. He said that, primarily, providers notified either AACO or STD Control whenever an individual tested positive for HIV or an STD. These entities, he continued, notified PS so that its counselors could be present when the confirmatory results were given to discuss transmission, risk reduction and the different ways that individuals who they have had contact with can be notified about their risk of infection. He said that, if the patients were willing and supplied them with contact information, PS first tried to make contact by phone and, if they did not get a response, would confidentially try to contact them at their houses if the information was provided. He clarified that all parties could refuse PS if they so desired.

A. Davis-Vogel asked what the protocol for PS was in the event that someone who had tested positive did not return for their confirmatory test. A. de los Reyes replied that PS was invited by providers to sit with patients when they returned for their confirmatory tests. He clarified that it was not their responsibility nor were they ever requested to track down individuals who did not return for their confirmatory tests, noting that such individuals were lost to care. However, he also stated that if a consumer was able to access care services without a confirmatory test, their providers were to notify PS.

A. Davis-Vogel asked how PS notified partners of teens who tested positive for HIV, noting that the population was at high risk for intimate partner violence. A. de los Reyes replied that PS counselors were trained to identify signs of intimate partner violence and to respond to the needs of individuals who showed signs of such violence. He said that individuals who were the victims of violence might not view HIV infection as a priority and, as a result, would need to be dealt with differently. He also noted that, although PS had never received reports of violence that resulted from their services, they were aware of the possibility.

C. Collins asked what the next step was for PS counselors if they were unable to make contact with someone either on the phone or at their house. A. de los Reyes replied that, while the guidelines did not specify how many attempts should be made, counselors would drop a case if the listed phone line was disconnected and the address was incorrect. C. Collins asked what happened when counselors made contact but the individuals made it clear that they did not wish to speak with PS. A. de los Reyes replied that counselors would try to use their counseling skills or knowledge of motivational interviewing, but only to a degree.

M. White felt that PS should try to use peers more heavily in the notification process. A. de los Reyes replied that, while there were benefits to using either counselors or peers, having providers enact the process had been proven to be far more beneficial. However, he noted that combinations of providers with peers or outside counselors were sometimes used for notification purposes. He then pointed out that using providers was more beneficial because, unlike peers, they were completely free of any biases and because the data they collected for the Health Department was much more thorough.

R. Feely asked for clarification on what was considered a refusal of PS by partners who they had notified. A. de los Reyes replied that refusals were assessed on a case by case basis. However, he said that blatant refusals, such as slamming a door on a provider attempting notification at someone's home, would always close cases. He told the group that the most important aspect of PS was letting someone know that they may have been exposed to the virus because the information might lead them to testing eventually, even if not immediately through PS. He added that, although the location of testing was not as important as notification of risk, there were benefits to being tested through PS.

T. King asked how the consumer protections of Act 148 affected PS. A. de los Reyes replied that PS always ensured total respect of confidentiality. He told the group that notification counselors were thoroughly trained so that partners were never made aware of who named them or when they were potentially exposed to the virus.

T. King asked how the partners of sex workers were identified and notified through PS. A. de los Reyes responded that PS could only work with whatever information sex workers were willing to give on either their clients or their regular partners. He noted that a PS counselor could not simply go to an area in which a sex worker solicited clients in an attempt to locate individuals. He also said that PS required more than just a name for notification and would work with sex workers to try and acquire more identifying information about individuals they had come into contact with, such as cell phone or license plate numbers. In response to another question by T. King, A de los Reyes stated that, if anyone knew of a positive

individual who had not talked with a PS counselor, the best method was to contact PS and tell the individual that a counselor would be in to talk with them.

T. Clark asked how PS followed up on individuals who preferred to be tested at other Community Based Organizations (CBOs). A de los Reyes replied that PS usually worked out arrangements with the individuals so that they could follow up with them and collect their data after they had been tested elsewhere.

A. Davis-Vogel felt that PS framed their notification process in a manner that placed blame for spreading the disease on the initial person who reported names. A. de los Reyes assured the group that the intention of PS was not to place blame on those who reported names. He then thanked A. Davis-Vogel for pointing out the perception and said that he would bring it to his peers for consideration.

D. Acero asked whether name-based reporting helped to ease the responsibilities of PS. A. de los Reyes responded that name-based reporting was more focused on data-sharing agreements and was not used by PS to locate partners of consumers.

D. Samuel asked whether PS could contact an individual whose name had been given to them if they were only able to locate the person through a social media web site, such as Facebook. A. de los Reyes replied that PS would require more identifying characteristics about a person, such as tattoos, before they would attempt making contact through social media sites.

D. Samuel asked whether the PS counselor who first was given names when an individual tested positive was also the same person who attempted to contact the partners. She noted that such a protocol could complicate the situation because counselors could not honestly say that they did not know who had reported the partners. A. de los Reyes responded that, while some jurisdictions did use such a procedure, Philadelphia never used the same individuals who had received names for notifying partners. He said that, although counselors had sometimes been accused of knowing who the initial reporter was, there had never been a reported breach of confidentiality in the city.

J. Chapman asked whether counselors could test partners at their homes since the ultimate goal of PS was testing and linkage to care. In response, A. de los Reyes informed the group that PS counselors could perform serum-based testing, which required drawing blood, on site. However, he noted that staff shortages were a problem as there were currently only four full-time PS workers in Philadelphia. As a result, he said that they preferred to have testing performed in clinics and would only test on site if partners were not willing to go elsewhere for it.

K. McGarvey informed the group that the state of Pennsylvania had made PS a priority in an effort to focus on programs that produced results following the recent budget crisis. He then supported the statement that PS produced its best results when it was delivered by trained counselors from the Health Department. As a result, he encouraged providers to notify those who received their first HIV tests about PS in order to have them return for their

confirmatory tests. A. de los Reyes closed his presentation by thanking the group for their time and questions.

Discussion Item:

• **Reinstating the Youth Roundtable (YRT) – C. Collins & T. Daniel**

C. Collins reminded the group that, at the last CPG meeting, they had held a discussion on reinstating the YRT. He said that he had not been able to contact those who had signed up for further discussion at the last meeting; however, he said that the current discussion item would be used to further develop the idea and to possibly vote on any plans they created. Pointing out that current funding shortages would complicate reinstatement of the YRT, he asked whether organizations that already had programs for youth would be willing to write grant proposals or couple the YRT with existing programs.

T. King said that the message of the YRT would have to be changed from what it had been before the group was dissolved. He said that current prevention messages for youth tended to include attractive individuals and he felt that the messages should instead give a more honest depiction of the effects of HIV/AIDS. Additionally, he suggested getting youths' opinions about what they wanted to see in prevention messages, noting that young adults were usually not interested in the opinions of adults. He suggested focusing on outreach and working to bring in underrepresented populations, such as those from the ballroom community. Lastly, he said the YRT would have to be restructured because youth had not been comfortable in the previous meeting environment, which caused poor attendance. C. Collins noted that, through outreach, he and T. Daniel had been able to get some youths to the last CPG meeting. He said that some other young adults – transients and those who were connected with Y-HEP programs – had said that 3:00 – 5:00 pm would be a good time for them for a meeting. A. Davis Vogel suggested trying to convene focus groups at Y-HEP or other youth-centered organizations in order to get the opinions of young adults on the matter.

A. Johnson informed the group that she had just come from an after-school meeting in which the school board had asked for help in dealing with the numerous epidemics facing youth, such as truancy, drugs, and STDs. She said that numerous experts on the matter simply did not know how to deal with the syndemic. She then gave her support to asking youths how they wanted to address the issues that faced them.

R. Feely suggested scaling back the conversation to focus on available resources and next steps. He said that, primarily, they needed to find out whether the YRT could be reinstated at the OHP or whether any other groups would be willing to convene a meeting. D. Samuel agreed, saying that the group could easily try to take on too much and prevent their efforts from being effective. She also felt that, if they tried to convene too many different types of youths into a single meeting, there could be trouble resulting from groups that did not like each other.

T. Daniel commended the group for holding a discussion that was focused on incorporating youth into prevention efforts. He then suggested that the group select a time to hold a drop-in at the OHP, to which they would invite organizations, the school district, and youths outside of the school district. D. Samuel proposed developing a survey primarily, because

she believed that a focus group would be difficult to convene and that a survey could be accessed by a larger sample of youths.

C. Collins suggested convening a committee to continue the current discussion and come to a decision on how to reinstate the YRT. A. Agha clarified that, as the YRT had been funded by the state, a new meeting on the group would have to be convened as an ad hoc committee of the CPG in order to take place at the OHP. **Motion: D. Samuel moved and A. Johnson seconded to convene an ad hoc committee of the CPG in order to continue discussion on reinstating the YRT. Motion Passed: 13 in favor, none opposed, no abstentions.**

Review Committee and Workgroup Reports

C. Collins took a moment to read the *CPG Subcommittees Report* for the month of January (see handout for more information). Afterwards, T. Daniel directed the group's attention to the handout entitled, *Factors Selected for CPG Target Populations*. He informed the CPG members that, at their next meeting, they would be weighting each of the factors on the handout, which would then be used to prioritize target populations for the next prevention plan. He suggested that the group take some time to familiarize themselves with each of the factors before the process took place at the next meeting. M. Milsop added that, as part of the regular process for prioritizing populations, the PPC had selected the factors in the worksheet based on whether the related data was available.

T. Dressel reiterated that applications for new CPG members would be accepted until March 9th. She then encouraged the group to recruit individuals who would fill gaps in the CPG membership, namely, African American males; representatives from governmental agencies involved with education, substance abuse, mental health, and corrections; epidemiologists, representatives from the education community, MSM/IDUs, MSM, mothers with or at-risk for HIV infection, and adolescents.

Report of Staff

D. Law reported that the Empowerment Workshop scheduled for March 9th would give information on the basics of HIV planning. She said that the event was primarily intended for consumers but that providers were encouraged to attend as well. She noted that, although the event was free, an RSVP was required.

M. Milsop reported that there would be two consumer town halls in Philadelphia, on March 16th and April 1st, to collect data on HIV/AIDS care services in the city.

Old Business

None

New Business

None

Research Update

None

Announcements

- T. King announced that GALAEI's 20th Anniversary Celebration would take place on April 16th at the Gershman YMCA.
- T. Daniel announced that, on March 18th at the National Constitution Center, there would be an event to mark the two-year anniversary of President Obama's speech on race.
- A. Johnson announced that there would be a kickoff event for Women's and Girl's HIV Awareness month at the Women's Coalition.

Adjournment

The meeting was adjourned by general consensus at 4:20 pm.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*January 27th, 2010*)
- Handouts for Presentation on Partner Services
- CPG Subcommittee Report – February 2010
- Factors Selected for CPG Target Populations
- OHP Meeting Calendar

Where we are now....

Planning Priorities Committee

March 2010

SEVEN KEY STEPS IN SETTING PRIORITIES FOR TARGET POPULATIONS

1. Identify target populations: Identify and define which populations to consider.
2. Determine factors: Decide which factors the CPG will use to set priorities for target populations.
3. Weight factors: Assign a weight (level of importance) to each factor.
4. Rate target populations using factors: Use the factors to rate each target population.
5. Score target populations using factors: Determine a score for each factor by multiplying the rating by the weight.
6. Rank target populations: For each target population, add the factor scores together. Compare the total scores to determine an overall rank.
7. Review rankings and prioritize target populations:
Review the results and agree upon the final list of target populations.

1. Identify target populations: Identify and define which populations to consider.

	Men	Women	Trans
	People Living With HIV/AIDS (PLWHA)		
	Uninfected High Risk Sex Partners or Needle Sharing Partners of PLWHA		
Injection Drug Users (IDU)- Sharing Injection Paraphernalia (SIP)	African Americans & Latinos 25+ years	African Americans & Latinos 25+ years	African American Trans who have Sex with Men (TSM) under the age of 40
Men who have Sex with Men (MSM)	African Americans & Latinos 14 – 64; Caucasians 25-64	N/A	
High Risk Heterosexuals (HRH)	African Americans ages 24-64 in North & West Philadelphia	African Americans ages 24-64 in North & West Philadelphia	

This list represents those at highest risk but isn't inclusive of all populations at risk of contracting HIV

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6. Rank target populations: For each target population, add the factor scores together. Compare the total scores to determine an overall rank.
7. Review rankings and prioritize target populations:
Review the results and agree upon the final list of target populations.

2. Determine factors: Decide which factors the CPG will use to set priorities for target populations.

- HIV Prevalence
- HIV Incidence
- AIDS Prevalence
- AIDS Incidence
- Key Indicators of risk behaviors: STD's (Syphilis)
- Key Indicators of risk behaviors: Substance Use (IDU)
- Riskiness of Population Behaviors
- Difficulty of meeting population needs
- Barriers to reaching the population

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6. Rank target populations: For each target population, add the factor scores together. Compare the total scores to determine an overall rank.
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Review the results and agree upon the final list of target populations.

Next Step is to weight the factors

- **Purpose:** *To assign weights to target population factors to indicate the relative importance of each factor for assessing the risk of each target population.*
- **Directions:** *For each of the following factors listed, consider how well the factor demonstrates the prevention needs of your target populations and to what extent the factor focuses on a greater risk for HIV infections among your target populations. Assign a 1, 3, 5 or 8 to each factor below.*
- **Please limit the weight of 8 (very high value) to only three of the factors below.**

HIV Prevalence

How many people in the target population are living with HIV?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

HIV Incidence

How many people in the target population tested positive for HIV in the past year?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

AIDS Prevalence

How many people in the target population are living with AIDS?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

AIDS Incidence

How many people in the target population tested positive for AIDS in the past year?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

Key indicators of risk behaviors: STDs

What were the reported STDs cases among the target population?(Syphilis)

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

Key indicators of risk behaviors substance use, injection drugs.

How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

Riskiness of population behaviors

What is the primary HIV risk behavior known to occur among the target population?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

Difficulty of meeting population needs

Has the target population's complex needs been reached by current programs?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

Barriers to reaching the population

Are there significant barriers to reaching the target population with HIV prevention interventions?

1-Low Value

3-Medium Value

5-High Value

8-Very High Value

Next Steps

- The factors on the sheets will be added then divided by the number of participants to determine the average weight of each factor.
4. Rate target populations using factors: Use the factors to rate each target population.

4. Rate target populations using factors: Use the factors to rate each target population.

	Men	Women	Trans
	People Living With HIV/AIDS (PLWHA)		
	Uninfected High Risk Sex Partners or Needle Sharing Partners of PLWHA		
Injection Drug Users- Sharing Injection Paraphernalia	African Americans & Latinos 25+ years	African Americans & Latinos 25+ years	African American TSM under the age of 40
Men who have Sex with Men	African Americans & Latinos 14 – 64; Caucasians 25-64	N/A	
High Risk Heterosexuals	African Americans ages 24-64 in North & West Philadelphia	African Americans ages 24-64 in North & West Philadelphia	

1. HIV Prevalence
2. HIV Incidence
3. AIDS Prevalence
4. AIDS Incidence
5. Key indicators of risk behaviors: Syphilis
6. Key indicators of risk behaviors: IDU
7. Riskiness of population behaviors
8. Difficulty of meeting population needs
9. Barriers to reaching the population

Questions?

Next Planning Priorities Committee meeting is Monday April 26th from 12-2

WORKSHEET 2

Weighting Factors for Target Populations

Purpose: *To assign weights to target population factors to indicate the relative importance of each factor for assessing the risk of the target population.*

Directions: *For each factor listed below, consider how well the factor demonstrates the prevention needs of your target populations and to what extent the factor focuses on a greater risk for HIV infections among your target populations. Assign a 1, 3, 5 or 8 to each factor below.*

Please limit the weight of 8 (very high value) to only three of the factors below.

Discuss and agree on how each factor will be weighted among the CPG.

Factor	Factor Information	Assign Weight
HIV Prevalence	How many people in the target population are living with HIV?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
HIV Incidence	How many people in the target population tested positive for HIV in the past year?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
AIDS Prevalence	How many people in the target population are living with AIDS?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
AIDS Incidence	How many people in the target population tested positive for AIDS in the past year?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value

Factor	Factor Information	Assign Weight
Key indicators of risk behaviors: STDs	What were the reported STDs cases among the target population? (Syphilis)	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
Key indicators of risk behaviors substance use injection drugs.	How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
Riskiness of population behaviors	What is the primary HIV risk behavior known to occur among the target population?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
Difficulty of meeting population needs	Has the target population's complex needs been reached by current programs?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
Barriers to reaching the population	Are there significant barriers to reaching the target population with HIV prevention interventions?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value

CPG Subcommittees Report – March 2010

Planning Priorities Committee

- At the March PPC meeting, the group continued planning the process by which the CPG would weight the factors for prioritizing populations.
- The next meeting of the PPC is scheduled for Monday, April 26th, from 1:00 – 3:00 pm.

The Literature & Education Committee

- At their March meeting, the Lit & Ed Committee continued with their review of interventions, making decisions on the following programs: 3MV, Brief Group Counseling, Healthy Relationships, Partnerships for Health, Nia, Real Men.
- The group also started planning for the upcoming prevention provider panel discussions and developed some preliminary questions
- Additionally, the group elected T. Clark as their new Co-Chair
- Their next meeting will be held on Wednesday, April 28th, from 12:00 – 2:00 pm.

CPG Nominations Committee

- In March, the Nominations Committee scored and reviewed thirteen applications for membership, seating eleven of the applicants.
- Additionally, the committee reviewed CPG members' attendance and recommended to remove one member of the group.
- The group decided to meet briefly after the April CPG meeting in order to select a new Co-Chair.

The Points of Integration Workgroup

- The Points of Integration Workgroup did not meet in March; its next meeting date and time are TBD.

The Positive Committee

- In March, the Positive Committee discussed Prevention with Positives and watched a video from the CDC called *Prevention is Care*.
- They also rescheduled their next planning meeting for 11am on April 12th (right before the positive Committee meeting) to discuss activities for the year.
- The March 9th Consumer Empowerment workshop was a success with about 50 people attending. Applications for both the CPG and Planning Council resulted from the workshop, as well as new participants in the planning process.
- In April, the committee will be discussing ways to make the committee more open and accessible to younger people, as well as those who work or have other commitments during the day. OHP staff will also review recent decisions by the Planning Council concerning FY2010 funding and upcoming Planning Council activities. The committee will also continue discussions about HIV prevention by talking about the experiences and needs of women.

Monitoring Committee

- The Monitoring Committee did not meet in March; its next meeting date and time are TBD.