

**Philadelphia Prevention Community Planning Group (CPG)
Meeting Minutes**

Wednesday, May 26, 2010

2:30 – 4:30 p.m.

Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: David Acosta (Co-Chair), Wesley Anderson, Wade Briscoe, Marné Castillo, Jennifer Chapman, Terri Clark, Christopher Collins (Co-Chair), Tony Daniel (Co-Chair Elect), Annet Davis-Vogel, Andrew De Los Reyes, Lomkhosi Denson, Tricia Dressel, Katie Dunphy, Lisa Espinosa, Jeffrey Jenne, Andrea Johnson, D’Ontace Keyes, Tyreef King, Denette Lienau, Alison Lin, Ken McGarvey, Renee Seaford

Excused: Dawn Acero, Antonio Davis, Nicholas Deroose, Rick Feely, Dionna Samuel, Val Sowell, Roberta Waite

Absent: Jolie Anderson, Khadeja Barnes, Arti Chhabria, Aida Green

Guests: Gail Bober, Kathleen Brady, Mike Canfield, Tahai Exum, Lawrence Frazier, Dennis Hill, John Izzo, Allison Kurtz, Juan Lanez, Eleanor Lundy-Wade

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

Call to Order/Introductions:

C. Collins called the meeting to order at 2:43 pm. Afterwards, the group took a moment to give their introductions.

Approval of Agenda:

The group took a moment to review the agenda. **Motion:** Afterwards, D. Lienau moved and J. Chapman seconded to approve the document. **Motion passed:** All in favor.

Approval of Minutes:

C. Collins directed the group’s attention to a draft of the minutes from their last meeting. A. de los Reyes stated that, contrary to what was in written in the third paragraph on page 4 of the minutes, STD Control conducted testing for gonorrhea and Chlamydia in all Philadelphia public high schools, not 80%. A. Davis-Vogel asked whether the use of the word “AIDS” instead of “HIV” was accurate in the last sentence of the fourth full paragraph on page three of the minutes. J. Ellis said that he would check the tape to ensure that the statement was accurate. **Motion:** T. Clark moved, W. Anderson seconded to approve the April 28, 2010 minutes as amended. **Motion Passed:** All in favor.

Report of Co-Chairs:

C. Collins reported that he had attended the most recent meeting of the State CPG. He said that the planning body had decided to write a letter in support of Philadelphia following the Auditor General’s recent allegations concerning the misappropriation of

HIV prevention money by the Department of Health. He also informed the group that the meeting had included five presentations from different organizations around the state, one of which focused on MSM and IDU rates of infection in Pennsylvania. He said that he could provide more information on the presentations to anyone who was interested.

D. Acosta reported that AACO's award decisions for responses to the last RFP (Request for Proposals) had been presented to the Health Commissioner on May 21st. He said that the grantee was now working on a FOA (Funding Opportunity Announcement), which was due the following day, that would extend HIV testing in Philadelphia ERs for the next three years. He also said that the Health Department had been working with STD Control and the Hepatitis coordinator to further advance the ongoing PCSI initiative. In closing, he reported that there had been an emergency meeting last week at the CDC with NASTAD and UCHAPS to discuss new directions in HIV prevention and the impacts of the state budget cuts.

Prioritization Activity:

- **Rating Factors for MSM and Heterosexuals – Planning Priorities Committee**

M. Castillo stated that the PPC was working in conjunction with the Lit & Ed Committee to coordinate the activities involved with prioritizing populations with the panel discussions. She then directed those present to review the three worksheets in the packet, titled *Large Scale Rating Model for Target Populations*. She said that the documents would be explained in the presentation and then collected after the panel discussions so that the group would have time to think about their responses. She clarified that, while individuals who were not CPG members were welcome to participate in the process, they were asked to write the word "guest" at the top of their worksheets.

Starting the presentation entitled *Working the Steps*, M. Castillo explained that the first three steps for prioritizing populations had already been completed and that the current activity was the fourth step. She then showed the group the results of the last step in the process, weighting factors, and explained the differences between subjective and objective factors. In closing, she explained the purpose and directions for the worksheet activity (*see attached handout*).

Prevention Provider Panel Discussions:

- **3MV, MPowerment, and Healthy Relationships**

J. Chapman informed the group that the Lit & Ed Committee had recently completed its initial review of the CDC's compendium of interventions to make decisions about which programs would be included in Philadelphia's next prevention plan. She reported that, out of the approximately sixty-five programs that the committee had reviewed, they had approved most, rejected a few, and approved a number of the programs with reservations. She then directed the group's attention to the handout which broke down a number of factors for 3MV, MPowerment, and Healthy Relationships. She explained that the factors listed on the sheet were what the committee had used to make its decisions about each of the programs in the compendium. She then directed the group's attention to the *Prevention Panel Discussion Points* handout and asked that the panelists write their responses to each of the points for future reference.

○ **Healthy Relationships**

Mike Canfield introduced himself as an HIV Prevention Education Provider from the Pennsylvania School for the Deaf (PSD). Responding to the questions in the *Prevention Panel Discussion Points*, he said that Healthy Relationships at PSD served HIV positive, deaf MSM, which he described as a very small community.

For adaptability, M. Canfield stated that Healthy Relationships utilized a video with captions, which made it easier for those running the program to communicate with participants. He also said that some of the program's core elements were difficult to achieve because many deaf individuals were not familiar with words in the curriculum due to differences between English and ASL (American Sign Language). Specifically, he said that achieving the fourth core element – provide participants with personal feedback – was complicated because many deaf individuals preferred signing to reading English, which required staff to explain the documents distributed.

M. Canfield stated that Healthy Relationships was a success with positive, deaf MSM because it was highly visual and used activities to keep groups interested. He said that the incentives offered by the program helped to attract participants because many individuals in the deaf community were unemployed. As a result, he felt that continued funding for staff, refreshments, and incentives was necessary to maintain the program's success.

For challenges, M. Canfield stated that some of the movie clips used in Healthy Relationships were old and needed to be updated. He said that some of the facilitators had expressed an interest in creating their own clips for the program so that it could be tailored more specifically for the deaf community and include ASL. Gail Bober explained that the facilitators had not been able to make their own film clips due to a lack of resources and funding. M. Canfield also listed inclement weather as a challenge for Healthy Living, saying that he would probably never again conduct the program during the winter. He said that there were not many other problems for the program except for low attendance; however, he noted that the group's usual size of 8 – 10 people was convenient for facilitators because it allowed them to give fuller explanations. G. Bober pointed out that the attendance was also a result of the target population's small size. She said that the program would like to expand to the counties to attract more participants.

M. Canfield informed the group that, occasionally, technical issues such as faulty projectors hampered the effectiveness of Healthy Relationships. Concerning training, he said that not all of the staff had received formal training and that the one or two staff members who had been trained in the curriculum relayed the information to the rest of the group. G. Bober explained that only some of the staff members had been formally trained because of the cost that would be involved in hiring interpreters for the deaf staff members. As a result, she clarified, the hearing staff members attended trainings and then relayed the information to the deaf staff members.

John Izzo introduced himself as a co-facilitator of Healthy Relationships at the Mazzoni Center. He said that his program targeted HIV positive men who were gay or bisexual and at least 25 years old. He told the group that his program focused on status disclosure but, with some heavy rewriting, it could also address sexual negotiation. Concerning adaptability, he said that, because the video clips were very specific to individual populations, new clips would be required to adapt the program to a new population. He felt that the program's successes were due to its highly interactive structure, saying that sessions included a great deal of discussion and engagement and very few awkward pauses. He reported that the use of film clips allowed individuals to talk about status disclosure and safer sex without having to relay personal information.

For challenges, J. Izzo noted that Healthy Relationships relied on a great deal of equipment, including worksheets, signs, a DVD player, and a television. He also said that the program's focus on disclosure made some individuals uncomfortable. He pointed out that, for some individuals, simply attending a group meeting was a form of disclosure or a method of identifying themselves as HIV-positive. Additionally, he told the group that some clients who were more familiar with support groups or had come from open forums found Healthy Relationships to be preachy or information-heavy. He then supported M. Canfield's statement about the program's video clips being outdated. He added that some participants had found the clips insensitive or offensive because they used footage that still portrayed HIV-positivity as a death sentence. Unlike the PSD, he said that training was accessible to all facilitators from Mazzoni and that they had no technical needs. Although the program was evaluated, he said that the process was handled by supervision staff. In closing, he said that, to other organizations that were considering implementing Healthy Relationships, he would point out that the program required significant time and money for recruitment since many people in the targeted population were not interested in participating.

G. Bober supported the statement that Healthy Relationships often had trouble with recruitment because of its focus on disclosure. As a result, she said that the PSD wanted to include HIV-negative participants as well in order to foster more realistic interaction between the participants. M. Canfield supported the statement, saying that communication was an issue in the deaf community, especially with hearing individuals.

o **MPowerment**

Jay Grant introduced himself as the Director of Intake for the Attic Youth Center. He told the group that MPowerment at the Attic served 13 to 23 year olds, particularly MSM. He said the program was fairly easy to adapt to any populations that wanted to build community, develop a community norm for safer sex, and increase consideration of safer sex. He felt that the program was successful because it provided young people with an opportunity to take on leadership roles and mentor others. He said that the Attic was lucky because it had been running the intervention for about five years and, while other programs tended to lose initiative, MPowerment continued to bring in new and energetic participants, who constantly changed and developed it.

J. Grant reported that attendance was a challenge for MPowerment. He clarified that, because participation in each session was voluntary, attendance fluctuated. He said that, due to the attendance issues, the administrators had considered making attendance mandatory but decided not to in order to maintain the spirit of the space. For technical issues, he said that training was complicated because one staff member who was formally-trained provided training for the rest of the facilitators. He told the group that MPowerment facilitators did not have to deal much with outdated video clips because they were used only occasionally for discussion guidelines. He clarified that participants usually brought in their own articles for discussion, a process which he felt worked well because it constantly used updated materials and participants could discuss what interested them.

o **3MV**

Tahai Exum introduced himself as a facilitator of Many Men Many Voices (3MV) at the Mazzone Center. He said that the program served YMSM of color, ages 16 – 23, and that it was currently targeting more youth from the ballroom community. He felt that, while it was possible to adapt the program to other populations, doing so would not be easy because each population had distinct issues.

He felt that the successes of 3MV resulted from the facilitators because they were knowledgeable and could relate to the program's participants. He said that all of the facilitators of 3MV believed in the program and respected the participants and each other. He also noted that 3MV was a good recruitment tool for CRCS because it made individuals more comfortable with the setting of group meetings.

T. Exum felt that facilitators' abilities to recognize their own strengths and work together effectively were the biggest challenges for 3MV. However, he added that scheduling meeting times was also difficult.

Dennis Hill introduced himself as a facilitator for 3MV at GALAEI, which served both adult and youth MSM of color and was developing an intergenerational form of the program. He added that MtF Transgender individuals were occasionally included in the program as well because of CDC designations for the population. He felt that one of the successes of 3MV was its ability to recruit sex workers and other individuals from transitional housing, halfway houses, and shelters due to the substance use that regularly occurred in the locations. He said that the positive changes the program often caused in its participants helped to recruit others.

For challenges, D. Hill stated that some individuals had difficulty segmenting the various sessions of 3MV and, therefore, had to complete the whole program at once. However, he said that it took time for any client to desire and enact personal change. In closing, he told the group that, contrary to popular belief, openly gay African American males were more difficult to recruit and maintain than those who were closeted.

C. Collins, who also facilitated 3MV at the Mazzone Center, felt that the program was very adaptable to other populations because it focused on discussions about stereotyping.

As an example, he noted that the program had already been adapted to younger generations of African American MSM even though it was developed for older groups. He said that one of the successes of the program was that it had been able to recruit many underserved populations, such as Transgender groups, sex workers, and ballroom youth.

C. Collins informed the group that one of the challenges of 3MV was getting youth who had already been through the program to leave so that new recruits could come in. He added that recruits who would attend the next 3MV retreat would train two other youths in the intervention who, in turn, would train their friends on the program. He told the group that training for 3MV was abundant because it was one of only two programs that had been designed specifically for African American MSM. He added that a book available from the CHBT (Centers for Healthy Behavioral Training) also provided training for the intervention. However, he said that finding space for the program could be challenging because the number of recruits tended to be high.

C. Collins stated that the Mazzoni Center used the CAB survey as an evaluation measure for 3MV and that facilitators were evaluated through a separate form. Additionally, he said that a check-in on participants, which was conducted a few months after the program ended, ensured their adherence to and understanding of their behavioral changes. In closing, he said that, for any intervention that considered implementing 3MV, he advised securing the necessary space and being knowledgeable about the targeted population.

A guest, who facilitated for Healthy Relationships, supported the statement that the videos were outdated and often inappropriate. She asked whether any of the panelists had discovered better materials for the program. J. Izzo stated that his group had shown only part of the video and supplemented the program with a demonstration on putting condoms on with one's mouth.

The guest also asked the panel for ideas for recruiting from the suburbs. M. Canfield replied that, because the deaf community used a lot of technology, he had recruited through Facebook with great success. A. Agha asked the panel about other online strategies that they had used. C. Collins replied that, in addition to social networking sites, he performed outreach on sexual websites. D. Hill supported the statement but added that he currently used Facebook more than any other sites.

A guest asked why the seven-week session of 3MV was less successful than the retreat. C. Collins felt that the retreat was more successful because of the shorter time commitment, saying that it was difficult to get youth to regularly attend sessions for seven weeks. T. Dressel supported the statement and said that, because of the successes of the retreat, the Mazzoni Center had applied for the adaptive model. D. Hill agreed with the statements but noted that some individuals found the weekly sessions more agreeable as they could not get away for a three-day retreat. Additionally, he pointed out that the goal of 3MV was changing behavior, which he felt could not realistically be accomplished in three days.

- **Comprehensive Risk Counseling and Services (CRCS)**

D. Hill informed the group that he facilitated CRCS at GALAEI for YMSM of color. He said that recruitment and retention as well as participants' unwillingness to discuss their personal lives despite an intimate setting were difficulties faced by facilitators. He noted that he usually countered these problems by engaging clients when they were not with friends or distracted by other outside influences.

T. Exum reported that he facilitated CRCS at the Mazzoni Center for MSM of color. He said that, when he started working with the program, he struggled with its delivery because he did not understand the Stages of Change and could not identify the stage at which clients were situated. He also noted that, although counselors were supposed to provide information, they were conducting the program improperly if they were dominating the conversation in a session. Additionally, he felt that it was important to conduct CRCS outside of the office as many people within the targeted populations would not attend sessions in such an environment.

J. Izzo noted that he facilitated CRCS at the Mazzoni Center for HIV-positive MSM who were eighteen or older. He said that the program was extremely adaptable because, as an ILI, counselors could focus on individual needs rather than those of the population. He said that the program had been working very well with recently-diagnosed individuals, who often asked for information and support. He told the group that CRCS had a good working relationship with other providers as 100% of new clients were referrals. However, he said that it had taken some time to earn the trust of other providers who had not understood what CRCS was since it was neither therapy nor case management. He also reported receiving a great deal of training for CRCS, some of which focused on topics other than the actual program, such as using CareWare and treatment adherence.

J. Grant reported that CRCS at the Attic Youth Center targeted high-risk, YMSM of color. He said that his organization had some difficulty advertising the services as CRCS because young people did not know what they were. He agreed with the earlier statement that, in order for CRCS to work, facilitators had to let their clients talk about their own needs and concerns. He also said that it was important for facilitators to be able to connect with the clients and relate to their friends and family who help them to make good decisions. He told the group that one of the challenges for CRCS at the Attic was that there were numerous lesbians accessing the services who were outside the targeted population and, therefore, were counted differently. Additionally, he said that, in general, sensitive and competent resources for LGBTQ youth were difficult to find.

T. Clark brought the discussion to a close by noting that, as this had been the first panel discussion, the Lit & Ed Committee would work to make the process run more smoothly and within the time limit at future meetings. She then stated that, despite the difficulties, the information gathered from the discussion would be very helpful for the committee's planning.

Prioritization Activity:

- **Rating Factors for MSM and Heterosexuals – PPC**

M. Castillo asked those present to complete the worksheets and return them before leaving the meeting (*see attached handout*).

Review Committee and Workgroup Reports:

T. Daniel directed those present to review the CPG subcommittee report (*see attached handout*).

Report of Staff/ Old Business/ New Business/ Research Update

None

Announcements:

- K. Dunphy announced that information for AIDS Education Month events was available at www.fight.org/aem.
- T. Dressel announced that the Trans Health Conference would be June 3rd through the 6th and that LGBT Pride was on June 13th.
- T. Daniel announced that June 5th was Latino Pride Day and that June 27th was National HIV Testing Day.
- A. Johnson announced an event called “Because I Care About You” on June 11th, at which would be discussed HIV/AIDS in the African American Community.
- J. Jenne announced that an HIV Testing Think Tank would be held on June 11th – 12th and that UCHAPS would meet in Philadelphia June 13th – 14th. He said that he would send an agenda for the UCHAPS meeting when it became available.

Adjournment:

The meeting was adjourned at 4:24 pm by general consensus.

Respectfully submitted,

Joseph Ellis & Briana L. Morgan, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*April 28, 2010*)
- “Working the Steps!” Slides
- Worksheet 2 Large Scale Rating Model for Target Populations (3)
- Prevention Panel Discussion Points
- Intervention Spreadsheet
- CPG Subcommittees Report – May 2010
- OHP Calendar

Philadelphia Prevention Community Planning Group (CPG)

Wednesday, May 26th, 2010

2:30 – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes (*April 28th, 2010*)

Report of Co-Chairs (5 minutes)

Prevention Provider Panel Discussions: (1 hour)

- **3MV, MPowerment, & Healthy Relationships**
- **CRCS**

Prioritization Activity: (30 minutes)

- **Rating Factors for MSM and Heterosexuals - PPC**

Review Committee and Workgroup Reports (15 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, June 23rd, from 2:30 – 4:30 p.m.***

Office of HIV Planning, 340 N. 12TH Street, Suite 203, Philadelphia, PA 19107

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

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Wednesday, April 28th, 2010

2:30 – 4:30 p.m.

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Present: David Acosta (Co-Chair), Wesley Anderson, Marné Castillo, Jennifer Chapman, Terri Clark, Christopher Collins (Co-Chair), Antonio Davis, Annet Davis-Vogel, Andrew De Los Reyes, Lomkhosi Denson, Katie Dunphy, Lisa Espinosa, Denette Lienau, Tyreef King, Alison Lin, Ken McGarvey, Renee Seaford, Val Sowell, Roberta Waite

Excused: Dawn Acero, Jolie Anderson, Nicholas Deroose, Tricia Dressel, Rick Feely, Jeffrey Jenne, Andrea Johnson, D'Ontace Keyes, David Powell, Dionna Samuel

Guests: Eleanor Lundy-Wade, Judith Peters, Melvin White

Absent: Khadeja Barnes, Wade Briscoe, Arti Chhabria, Tony Daniel (Co-Chair Elect), Aida Green,

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

Call to Order/ Introductions

C. Collins called the meeting to order at 2:38 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. Clark volunteered for the task.

Approval of Agenda

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

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

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

Motion: M. Castillo moved and D. Lienau seconded to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor

Report of Co-Chairs

D. Acosta began his report by welcoming the new CPG members and encouraging them to ask any questions that arose throughout the course of the meeting. He then told the group that AACO had submitted the APR (Annual Progress Report) and that a copy had been sent by email to all the CPG members. He said that he would respond to any questions about the report through email.

D. Acosta also reported that the MSM needs assessment activity had been completed and that a report on the activity had been released the previous week at the executive

directors' meeting. He said that the report had been sent to all the executive directors in the directory and would be part of a presentation given to the CPG in the near future. However, he said that if anyone wanted to see the report before the presentation, they could request a copy from the Office of HIV Planning.

D. Acosta informed the group that a new FOA (Funding Opportunity Announcement) would expand the current initiative for HIV testing in ERs and clinics for another three years. He said that the new RFP (Request for Proposals) was different from the last because it emphasized and focused on linkage to prevention and care services. He noted that the Health Department would develop a response to the request. He also reported that another FOA had been released as part of PCSI (Program Collaboration and Service Integration), which sought to integrate the CDC portfolio of disease systems. He said that Philadelphia, as an area with a large population of PLWHA, was eligible to respond to the announcement. He felt that the city had a good chance at receiving the funding because it had been very proactive in local integration efforts. He said that AACO was working on improving its response to the FOA.

Lastly, D. Acosta reported that the White House had sent out the first draft of its report of public recommendations for the National HIV/AIDS strategy. He said that he had attempted to send the CPG a copy of the document but it was too large to send by email. He informed the group that a meeting in May in Washington would gather input for a second draft of the report. J. Chapman noted that the public could comment on the report until May 3rd.

Special Presentation:

- **Youth Risk Behavior Survey (YRBS) – J. Peters**

J. Peters said that the YRBS was an opportunity for students to report on their own behaviors on a variety of topics, including sexual behavior. She informed the group that Temple University was subcontracted by the school district to conduct the survey. She then reported that the 2009 YRBS data had been analyzed and the school district was now waiting for the results of the national survey to be released so they could perform a comparison. She clarified that, in Philadelphia, randomly selected high school students took the survey using paper and pencil. She told the group that 2009 was the first year in a while that Pennsylvania had conducted a statewide YRBS (see handouts for more information). She noted that, as a result of Pennsylvania's participation, some Philadelphia schools had been required to participate in all three samples – local, state, and national – which was disruptive to classes.

In response to a question by D. Acosta, J. Peters clarified that the demographics information in the presentation was only for 2009. She then added that the city did not ask students LGBT questions, noting that there were only four jurisdictions in the country that did so. However, she said that the CDC was now pushing all jurisdictions to ask LGBT questions so the school district was discussing the matter. She then stated that the CDC chose the YRBS categories, not the school district.

During the discussion of major improvements since the 2008 YRBS, A. Davis-Vogel asked whether the improvements were hard to gauge since the students taking the survey changed

each year. J. Peters agreed, clarifying that the improvements were based on percentages, not individuals.

D. Acosta stated that some of the improvements recorded in the YRBS were the results of structural interventions, such as those that sought to decrease tobacco use and increase seatbelt use. J. Peters agreed, and reported that approximately ten cities and thirty-nine states participated in programs to increase seatbelt use.

J. Peters reported that the drastic dip in weapons carrying and fighting that had occurred between 1999 and 2004 was concurrent with the institution of the zero tolerance policy. However, she said that the policy had since become lax, which could explain why injury and violence was again on the rise. In response to a question by T. Clark, she said that, when students were expelled, they usually went to Glenn Mills, charter schools, or the Arch Diocese.

J. Peters informed the group that K-8 principles were now requesting sex education at their schools because many students were engaging in oral sex. She felt that young students were exhibiting the behavior because they had seen it in their homes.

T. Clark asked whether the schools were able to compare the data from schools coupled with HRCs (Health Resource Centers) with those that were not in order to determine whether the centers were having any effect. J. Peters said that the district would be able to perform such comparisons. However, she said that the district did not publish the results of the YRBS broken down by school in order to not promote any negative stereotypes associated with each of the schools. She clarified that some schools were already incorrectly known for having many students with AIDS while others were said to have high pregnancy rates.

J. Peters informed the group that a number of students who wanted to attend HRCs could not do so because they had been opted out of the program by their parents. A. Davis-Vogel said that she believed HRCs did not require parental consent due to their funding source. However, J. Peters explained that parents' ability to opt-out of HRC programs for their children had been a requirement since the beginning of such programs in the school district. The only exception, she continued, was for students who were eighteen or older.

J. Peters reported that the school district was currently conducting the School Health Profile, which was done every even-numbered year, when the YRBS was not conducted. She said that the profile was another CDC survey and that it was sent to the principles and lead health education teacher at every school to investigate curriculum and policy. She told the group that the profile investigated a number of topics, including HIV/AIDS. She then reported that, in Philadelphia, students required only one-quarter of a credit of health education in order to graduate. She said that she wished to have the requirement raised to two credits because students required better physical and mental health to perform well in school. She told the group that the school district looked forward to continued collaboration with outside agencies to improve overall student health.

C. Collins asked whether there were data available on other social issues among students, such as homelessness. J. Peters responded that a homelessness initiative collected such data. She then told the group that there were other ongoing efforts to improve the lives of students. As an example, she said that a new 5-million dollar grant would go to combating obesity and attempting to make students more physically active.

A. de los Reyes asked what the school district did with the data gathered by the YRBS. J. Peters responded that the information was used to guide professional development trainings, to buy materials for the school, and to determine what kinds of partnerships the district should make with outside agencies. As an example, she said that, on May 11th and 18th, the school district was holding a training session for counselors on LGBT issues.

In response to a question by T. Clark, J. Peters noted that the YRBS did not gather data from STI testing in schools. She then informed the group that the Health Department conducted STI testing in the schools every year and that, if a student tested positive, he or she would be sent to a provider where they could also be tested for HIV. However, she stressed that HIV testing would never be available in the schools. A. de los Reyes added that STI testing would take place in about 80% of schools. He said that, while condoms could not be distributed in schools, stations were being set up near schools so that the prophylactics could be delivered. He told the group that school students learned about HIV testing through videos, so they knew that the services were available. J. Peters added that an HIV unit knew of the sites where students could be tested.

- **Theories of Behavioral Interventions – N. Johns (OHP)**

N. Johns informed the CPG that she had developed the current presentation in order to give them some background information before they started discussing interventions for the next prevention plan. T. Clark reported that many of the interventions in the CDC's compendium were based on multiple theories. N. Johns noted that she had additional resources for anyone who was interested in them (see handout for more information).

V. Sowell noted that the Stages of Change Theory that she was familiar with also included 'relapse' as an additional stage. C. Collins replied that there were many different versions of the Stages of Change, one of which included ten different stages.

Discussion Item:

- **Follow up on Weighted Factors for Prioritizing Populations - PPC**

M. Castillo directed the group's attention to the handout entitled *Final List of Weights for Factors*. She explained that the numbers were the results of the exercise that had been completed at the last CPG meeting. She encouraged the group to ask any questions they had about the process or the results as, beginning in May, the CPG would begin applying the weights to targeted populations for the purpose of prioritization.

D. Acosta informed the group that the PPC had been surprised by some of the results because the three most subjective factors – barriers of reaching population, riskiness of population, and difficulty of meeting population needs – had risen to the top of the list. He said that the group would have to balance the subjective factors with those based on harder data. He told

the group that the PPC had discussed whether to even use ‘barriers’ and ‘difficulty’ because the data supporting the factors was so subjective.

M. Castillo brought the discussion to a close by noting that the PPC would explain the factors once again before the CPG started to apply them to populations. Additionally, she said that there would be opportunity for greater discussion on the factors as well since they would impact the way in which the prevention plan was written.

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 April (see handout for more information). T. Clark added that the Lit & Ed Committee had also discussed structural interventions at their April meeting and decided to use social networking sites to obtain more information about such programs operating in Philadelphia.

Report of Staff

D. Law reported that four new CPG members were in attendance at the current meeting. N. Johns reported that the OHP had developed some new business cards to advertise its new website and its presence on social networking sites. She pointed out that the new cards were available near the sign in sheet.

Old Business

D. Acosta asked if a decision had been made on whether or not to cancel the June meeting of the CPG. M. Ross-Russell responded that the meeting would likely be held due to the prevention provider panel discussions. She also noted that none of the conflicts taking place that month were scheduled for the date of the meeting. D. Acosta informed the group that the Co-director of UCHAPS might attend the meeting.

New Business

None

Research Update

A. Davis-Vogel informed the group that the University of Pennsylvania was currently enrolling for an HIV vaccine trial for MSM who did not have HIV.

Announcements

- A. Davis Vogel announced that on May 18th, HIV Vaccine Awareness Day, the community advisory board at the University of Pennsylvania was sponsoring an event. On May 19th, she continued, there would also be a poetry slam to mark the occasion.
- A. de los Reyes asked for more contributions for potential posters at Health Center 1. He said that, despite numerous emails, only two suggestions had been received.
- A. de los Reyes announced that STD Control was accepting applications for a disease intervention specialist.
- T. Clark announced that Dining Out for Life was the following day.

- C. Collins announced that T. Daniels would be the next youth leader for Black Gay Pride.

Adjournment

Motion: T. King moved and R. Waite seconded to adjourn the meeting at 4:03 pm.

Motion Passed: All in favor.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*March 24th, 2010*)
- Handouts for YRBS Presentation
- Handouts for Health Behavior Theories Presentation
- Final List of Weights for Factors
- CPG Subcommittee Report – April 2010
- OHP Meeting Calendar

DRAFT

Working the steps!

Planning Priorities Committee

May 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

3. Weight factors: Assign a weight (level of importance) to each factor.

	<u>Weights</u>
• Barriers to reaching the population	6.21
• Riskiness of population behaviors	6
• Difficulty of meeting population needs	5.48
• HIV Incidence	5.45
• HIV Prevalence	5.41
• AIDS Incidence	4.45
• AIDS Prevalence	4.03

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

Subjective Factors

- **Barriers to reaching the population**
- **Riskiness of population behaviors**
- **Difficulty of meeting population needs**

These 3 factors have rating information & examples that will help you make your decisions.

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

Objective Factors

- **HIV Incidence**
- **HIV Prevalence**
- **AIDS Incidence**
- **AIDS Prevalence**

These 4 factors have 2008 data and an associated scale.
These factors will have the ratings assigned based on
the available data.

Worksheet Activity

- **Purpose:** *To assign a rating to each factor based on the information available for each target population.*
- **Directions:** *Select a numeric value based on the scale provided for each factor.*
- **Please wait until after the panel discussions to complete the worksheets.**

CPG Meeting	Intervention	Agency	
05/26/10 3:00	3MV	GALAEI	Panel by Population: Men who have Sex with Men
	3MV	MAZZONI	
	MPOWERMENT	THE ATTIC	
	HEALTHY RELATIONSHIPS	MAZZONI	
	HEALTHY RELATIONSHIPS	PA School for the Deaf	
5/26/2010 3:30	CRCS	THE ATTIC	Panel by Intervention type: CRCS
	CRCS	GALAEI	
	CRCS	MAZZONI	
6/23/2010 3:00	CRCS	ACTIONAIDS	Panel by Intervention Type: CRCS
	CRCS	CHOP R	
	CRCS	CHOP V	
	CRCS	CONGRESO	
	CRCS	DREXEL ST. CHRIS	
6/23/2010 3:30	BE PROUD	ACTIONAIDS	Panel by Population: Youth
	Protocol Based Counseling	CHOP Adolescent	
	Teens Linked to Care	DREXEL ST. CHRIS	
7/28/2010 3:00	SAFETY COUNTS	BEBASHI	Panel by Population: Drug User
	SAFETY COUNTS	FIGHT	
	SAFETY COUNTS	ODAAT	
	SAFETY COUNTS	PREVENTION PT	
	SAFETY COUNTS TIP	PREVENTION PT	
7/28/2010 3:30	CRCS	BEBASHI	Panel by Intervention Type: CRCS
	CRCS	PREVENTION PT	
7/28/2010 3:30	TEACH	FIGHT	Local Intervention
	TEACH OUTSIDE	FIGHT	
8/25/2010 3:00	BART	URBAN SOLUTIONS	Panel/s by Population Type: Youth
	BART	YOACAP	
	BE PROUD	PA School for the Deaf	
	BE PROUD	VISION for Equality	
	PALMS	PHMC	
	SUPPORT GROUP	YOACAP	
	VOICES	CONGRESO	
VOICES	FIGHT YHEP		
9/22/2010 3:00	COMMUNITY PROMISE	COLOURS	Panel by Intervention Type: Community Level Intervention -
	COMMUNITY PROMISE	FPC SAFEGUARDS	
	COMMUNITY PROMISE	GALAEI	
	RAPP	Family Planning Council Circle of Care	
9/22/2010 3:30	PROJECT RESPECT	Family Planning Council Health Resource Centers	Panel by Intervention Type: Heterosexual
	PROJECT RESPECT	PA School for the Deaf	
	SISTA	Family Planning Council Circle of Care	
9/22/2010 3:30	PROTECT AND RESPECT	DREXEL Partnership Practice	Local Intervention
10/27/2010	HRC Palms Prison Case Management		Local Intervention

Name	Approval Status	CDC Designation	Type	Target Risk Group/ Age	Target Gender/ Race	Target Behavior	Efficacy	Theoretical Basis	Norms/ Values	Feasibility	Greatest Impact for less \$	Name	Approval Status	Local Relevance	Partner Linkage	Others
Many Men Many Voices (3MV)	Accepted	Best Evidence	GLI	MSM	AA, Male	Reduced unprotected anal intercourse with casual sex partners	73% retained at 3 months, 77% at 6 months	Social Cognitive Theory, Behavioral Skills Acquisition Model, Trans-theoretical Model of Behavior Change	Two trained black MSM peer co-facilitators	Cost 6, 2 to 3 hour session retreat (not always provided as retreat)		Many Men Many Voices (3MV)	Accepted		PCRS connection	Materials available
Mpowerment (new 2008)	Accepted	Promising	CLI	MSM 18 to 29	Male, AA, W, Hisp, API, Otr	sexual risk reduction		Diffusion of Innovation	peer lead, cultural and gender specific	fairly inexpensive		Mpowerment (new 2008)	Accepted		condom skills building	Materials available
Healthy Relationships	Accepted	Best Evidence	GLI	MSM	HIV+, Male, Trans, AA, W, Otr	Reduced unprotected anal (and or vaginal) casual sex partners	Sex risk reduction	Social Cognitive Theory	Positive facilitators	Cost- 5,2 hour sessions delivered weekly, gift cards	Delivered at CBO or ASO	Healthy Relationships	Accepted		PCRS connection	Materials available

Prevention Panel Discussion Points*

Population

What is the population that this intervention serves?

- Is this intervention population specific?

Adaptability

In your opinion is this an intervention that is easy/difficult to adapt for other populations?

- Would the core elements work with other populations?
- Would the cultural components work with other populations?

Successes

What in your opinion makes this a successful intervention?

- Why is this intervention successful with the target population?
- Is this intervention successful from an implementation perspective?
- Is it sustainable over time (e.g. funding to provide the service, staffing, is it a cost effective intervention)?
- Are the goals and objectives achievable?

Challenges

What in your opinion are some of the challenges you encountered with this intervention?

- Did the intervention pose a problem for the target population (e.g. too many sessions, not enough sessions, behavior was not sustainable over time, etc.)?
- Did you encounter difficulty during implementation of the intervention?
- Did you have challenges with achieving the intervention goals and objectives?

Technical

Were there any technical issues that arose with respect to this intervention?

- Training
- Technical Assistance
- Did this intervention have an evaluation process?
 - If yes, please provide a description of the process
 - If no, did your organization develop a mechanism to evaluate the service/s provided?
- Is there an intervention materials packet available?

What would you share with another organization contemplating implementing this intervention?

***Please answer the questions and send or bring your responses to the Office of HIV Planning, 340 North 12th Street, Suite 203, Philadelphia, Pa 19107 Attn: Lit & Education**

WORKSHEET 2

Large Scale Rating Model for Target Populations

Purpose: *To assign a rating to each factor based on the information available for each target population.*

Directions: *Select a numeric value based on the scale provided for each factor. (Please note: The staff applied rating for many of the factors based on available data which had been provided to the CPG. Some data was not available for the specified population. Where this occurred the population was assigned a mean value of 3.*

Target Population: Men who have sex with men

Factor	Rating Information	Scale	Rating
HIV Prevalence	How many people in the target population are living with HIV? (2,148 in 2008)	1: 0-650 3: 651-1,300 5: 1,301-1,950 8: >1,950	8
HIV Incidence	How many people in the target population are living with HIV? (361 in 2008)	1: 0-99 3: 100-199 5: 200-299 8: >299	8
AIDS Prevalence	How many people in the target population are living with AIDS? (3,398 in 2008)	1: 0-999 3: 1,000-1,999 5: 2,000-2,999 8: >2,999	8
AIDS Incidence	How many people in the target population tested positive for AIDS in the past year? (136 in 2008)	1: 0-45 3: 46-90 5: 91-135 8: >135	8

Factor	Rating Information	Scale	Rating
Riskiness of population behaviors	What is the primary HIV risk behavior known to occur among the target population?	Certain conditions, circumstances and behaviors can increase your risk of HIV infection. There are conditions and behaviors that make it easier for HIV to be transmitted from person to person.	1: Oral sex w/infected partner 3: Vaginal sex w/infected partner 5: Anal sex with infected partner 8: Sharing contaminated injection equipment
Difficulty of meeting population needs	Has the target population's complex needs been reached by current programs?	<ul style="list-style-type: none"> - Effective outreach - Cultural sensitivity - Interventions for target Populations - Trainings on engaging people in services 	1: Substantial programs exist to meet the target population's complex needs 3: Moderate programs exist to meet the target population's complex needs 5: Few or virtually no programs exist to meet the target population's complex needs 8: No programs exist to meet the target population's complex needs
Barriers to reaching the population	Are there significant barriers to reaching the target population with HIV prevention interventions?	<ul style="list-style-type: none"> -Don't think they need the service -Fear -Don't know or understand risk -Stigma associated with disease -Lack of transportation 	1: No barriers 3: Few barriers 5: Moderate barriers 8: Substantial barriers

WORKSHEET 2

Large Scale Rating Model for Target Populations

Purpose: *To assign a rating to each factor based on the information available for each target population.*

Directions: *Select a numeric value based on the scale provided for each factor. (Please note: The staff applied rating for many of the factors based on available data which had been provided to the CPG. Some data was not available for the specified population. Where this occurred the population was assigned a mean value of 3.*

Target Population: Heterosexual Males

Factor	Rating Information	Scale	Rating
HIV Prevalence	How many people in the target population are living with HIV? (1,490 in 2008)	1: 0-650 3: 651-1,300 5: 1,301-1,950 8: >1,950	5
HIV Incidence	How many people in the target population are living with HIV? (332 in 2008)	1: 0-99 3: 100-199 5: 200-299 8: >299	8
AIDS Prevalence	How many people in the target population are living with AIDS? (1,668 in 2008)	1: 0-999 3: 1,000-1,999 5: 2,000-2,999 8: >2,999	3
AIDS Incidence	How many people in the target population tested positive for AIDS in the past year? (139 in 2008)	1: 0-45 3: 46-90 5: 91-135 8: >135	8

Factor	Rating Information	Example	Rating
Riskiness of population behaviors	What is the primary HIV risk behavior known to occur among the target population?	Certain conditions, circumstances and behaviors can increase your risk of HIV infection. There are conditions and behaviors that make it easier for HIV to be transmitted from person to person.	1: Oral sex w/infected partner 3: Vaginal sex w/infected partner 5: Anal sex with infected partner 8: Sharing contaminated injection equipment
Difficulty of meeting population needs	Has the target population's complex needs been reached by current programs?	<ul style="list-style-type: none"> - Effective outreach - Cultural sensitivity - Interventions for target Populations - Trainings on engaging people in services 	1: Substantial programs exist to meet the target population's complex needs 3: Moderate programs exist to meet the target population's complex needs 5: Few programs exist to meet the target population's complex needs 8: No programs exist to meet the target population's complex needs
Barriers to reaching the population	Are there significant barriers to reaching the target population with HIV prevention interventions?	<ul style="list-style-type: none"> -Don't think they need the service -Fear -Don't know or understand risk -Stigma associated with disease -Lack of transportation 	1. No barriers 3: Few barriers 5: Moderate barriers 8: Substantial barriers

WORKSHEET 2

Large Scale Rating Model for Target Populations

Purpose: *To assign a rating to each factor based on the information available for each target population.*

Directions: *Select a numeric value based on the scale provided for each factor. (Please note: The staff applied rating for many of the factors based on available data which had been provided to the CPG. Some data was not available for the specified population. Where this occurred the population was assigned a mean value of 3.*

Target Population: Heterosexual Females

Factor	Rating Information	Scale	Rating
HIV Prevalence	How many people in the target population are living with HIV? (1,855 in 2008)	1: 0-650 3: 651-1,300 5: 1,301-1,950 8: >1,950	5
HIV Incidence	How many people in the target population are living with HIV? (298 in 2008)	1: 0-99 3: 100-199 5: 200-299 8: >299	5
AIDS Prevalence	How many people in the target population are living with AIDS? (1,815 in 2008)	1: 0-999 3: 1,000-1,999 5: 2,000-2,999 8: >2,999	3
AIDS Incidence	How many people in the target population tested positive for AIDS in the past year? (127 in 2008)	1: 0-45 3: 46-90 5: 91-135 8: >135	5

Factor	Rating Information	Example	Rating
Riskiness of population behaviors	What is the primary HIV risk behavior known to occur among the target population?	Certain conditions, circumstances and behaviors can increase your risk of HIV infection. There are conditions and behaviors that make it easier for HIV to be transmitted from person to person.	1: Oral sex w/infected partner 3: Vaginal sex w/infected partner 5: Anal sex with infected partner 8: Sharing contaminated injection equipment
Difficulty of meeting population needs	Has the target population's complex needs been reached by current programs?	<ul style="list-style-type: none"> - Effective outreach - Cultural sensitivity - Interventions for target Populations - Trainings on engaging people in services 	1: Substantial programs exist to meet the target population's complex needs 3: Moderate programs exist to meet the target population's complex needs 5: Few or no programs exist to meet the target population's complex needs 8: No programs exist to meet the target population's complex needs
Barriers to reaching the population	Are there significant barriers to reaching the target population with HIV prevention interventions?	<ul style="list-style-type: none"> -Don't think they need the service -Fear -Don't know or understand risk -Stigma associated with disease -Lack of transportation 	1: No barriers 3: Few barriers 5: Moderate barriers 8: Substantial barriers