

COMMUNITY PLANNING GROUP (CPG)  
**Monitoring Committee**

Meeting Agenda

Friday, March 11, 2011

12:00 p.m. – 2:00 p.m.

The Office of HIV Planning, 340 N. 12<sup>th</sup> Street, Suite 203, Philadelphia

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**Call to Order**

**Approval of Agenda**

**Approval of Minutes**

**Report of Staff**

**Report of Co-Chairs**

**Discussion Items:**

- **Extension and/or Addition of CPG Meeting**
- **Allocations**
- **CPG Nominations Committee**

**Old Business**

**New Business**

**Announcements**

**Adjournment**

*The next meeting date and time of the Monitoring Committee is TBA  
The Office of HIV Planning, 340 N. 12<sup>th</sup> Street, Suite 203, Philadelphia  
Please refer to the Office of HIV Planning's attached Calendar of Events or its website, [www.hivphilly.org](http://www.hivphilly.org), for  
updated committee meeting information.*

**Community Planning Group  
Monitoring Committee  
Meeting Minutes of  
Monday, August 23, 2010  
2:30 p.m. – 4:30 p.m.**

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

**Present:** David Acosta, Marne Castillo, Jennifer Chapman, Terri Clark, Christopher Collins, Tony Daniel

**Excused:** Tricia Dressel

**Staff:** Michael Milsop, Briana Morgan, Mari Ross-Russell

**Call to Order/Introductions:**

D. Acosta called the meeting to order at 2:42 p.m.

**Approval of Agenda:**

C. Collins presented the agenda for approval. Motion: M. Castillo moved, T. Daniel seconded to approve the agenda. Motion passed: All in favor.

**Approval of Minutes (13 May 2009):**

C. Collins presented the May 13, 2009 minutes for approval. T. Daniel stated that he would be interested in learning more about the open house. M. Castillo replied that they had had a presentation for AIDS Education Month and an open house in September. Motion: T. Daniel moved, J. Chapman seconded to approve the May 13, 2009 minutes. Motion passed: All in favor.

**Report of Staff:**

None.

**Report of Co-Chairs:**

C. Collins stated that he was trying to restart the Youth Roundtable, and that he was recruiting motivated youth to participate. M. Castillo asked how often the group would meet. C. Collins replied that he would like to have a meeting every other month. M. Castillo asked if there was a description of the Youth Roundtable available. C. Collins replied that he would ask Debbie Law for a description.

**Discussion Items:**

• **Committee Attendance**

M. Ross-Russell explained that they had been hearing concerns that only a few CPG members were doing the majority of the work, which mostly occurred in subcommittee meetings. She went on to say that the bylaws stated that committee membership was required, but there was no subcommittee attendance policy in place to hold members accountable. She noted that they would also have to consider which committee would enforce the committee attendance policy. She added that staff does track committee attendance. D. Acosta suggested having staff develop a paragraph on committee attendance to include in the bylaws. M. Ross-Russell clarified that he was asking to extend the same

attendance policy for the CPG to the subcommittees, and D. Acosta agreed. D. Acosta then added that they should have the Nominations Committee enforce the policy. He went on to say they should make it clear that no one could leave the next CPG meeting without having signed up for a subcommittee. C. Collins stated that they could ask the Nominations Committee to review committee sign-ups at their next meeting.

T. Daniel stated that they needed to make sure that the CPG members were going to do the needed work at subcommittee meetings. He suggested creating a list of members that are presently active on the committees, and asking everyone else to sign up for a committee. C. Collins then stated that they finally had members that attended the CPG meetings, but they were still not attending the subcommittee meetings.

D. Acosta suggested that they generate a list of the names of people that had signed up for a committee, and then ask the co-chairs of the committees to contact the members that had not been attending. He also suggested having the committee chairs actively recruit new committee members from the CPG.

M. Ross-Russell stated that the bulk of community planning happened in the committee meetings rather than the CPG meetings, and members were not representing the community if they did not attend committee meetings. She went on to say that there was another concern that they did not have allocation percentages, and the plan completed on January 1, 2012 would stand for five years.

M. Castillo asked if there was a maximum number of members allowed on each committee, and M. Ross-Russell replied that there were not. M. Castillo replied that they should encourage members to spread themselves amongst all of committees. She explained that her committee was very small, and that they would face problems if all CPG members gravitated toward one committee. D. Acosta suggested asking the committee co-chairs to think about who they would like on their committees. M. Castillo stated that A. Agha had previously done some committee recruiting, so staff could possibly help with this process. She also said that it would be helpful to have other members suggest possible committee members.

T. Clark asked what role the Nominations Committee had in recruiting committee members. M. Ross-Russell replied that the Nominations Committee was able to gather some information from the applications, but they would need to consider personal information as well. The group then discussed how they would need members with certain areas of expertise in certain committee meetings. T. Daniel then stated that they should consider current members' subcommittee attendance when they reapply for CPG membership.

D. Acosta stated that they had tasked the office with developing language on committee participation. He went on to say that the subcommittee co-chairs would call their members that were missing meetings, adding that they would have much better success recruiting members for committees with direct encouragement.

- **Annual Schedule/Time Line**

M. Ross-Russell stated that the CPG was in the last year of their planning cycle, and that their work needed to be complete by December 30, 2011. She explained that they would

need to review their timeline as shown on the conference room wall, which would also be emailed to the group. She went on to say that they would need to think about what they wanted to change before the next planning cycle started. D. Acosta stated that prevention had moved very rapidly since they began the process four years ago. He explained that they had been hearing a great deal about structural factors and social drivers in public health, in addition to biomedical interventions and structural interventions. He went on to say that they had only focused on behavioral interventions in the current cycle, and that they would need to consider changes for the next planning cycle. T. Clark agreed that they would not want to get locked into behavioral interventions.

M. Ross-Russell reviewed activities that needed to be included in the timeline for the plan, explaining that they would need to consider any activities they might like to see added. She noted that they would need to consider ongoing activities as well. She then explained that they needed to complete certain portions of the document within a certain time frame, and that they would need to consider what activities would be appropriate for the next plan due to the many changes in prevention. D. Acosta agreed that there was a new emphasis on structural factors, and that CDC language was encouraging the use of structural interventions. T. Clark stated that they could look at structural interventions more closely, and that they should conduct an assessment of providers in the area with the goal of gathering information about what is happening locally. M. Ross-Russell explained that there were other activities that enhance DEBIs and EBIs, which was where structural interventions were coming into play. She then suggested sending the timelines out to the group in Excel format in order to get feedback on what should be included in the planning cycle, or what would need to change. She then suggested reviewing these comments at the next meeting.

D. Acosta next stated that they were at the brink of new information being released, and that this would most likely come out after their plan was completed. He went on to say that those conducting EBIs and CRCS knew how time-consuming they could be, but their system was still very dependent on EBIs. M. Ross-Russell suggested that the group consider changing the five-year planning cycle, which would give them the ability to change as things change. She then explained that they currently had a five-year plan for more stability, but that this did not give them flexibility to change when new information or options became available. T. Clark asked if they were able to apply for anything that was not included in their plan. M. Ross-Russell replied that, the way the plan was written, they were required to keep the provider system bound to the design of the plan. She went on to say that the current plan allowed them to change as the field changed, but that they currently had a laundry list of interventions.

D. Acosta stated that there had been a great deal of talk about reducing viral loads in order to reduce the transmission of HIV. He explained that there was a possibility that positive MSM would not need to use condoms as long as they were on their medications. He went on to say that this was a very complicated issue, and that results of the study on this would come out in two to three years.

D. Acosta stated that they were currently in a different place than they were five years ago, in the face of reimbursement for tests, healthcare reform, and the National HIV/AIDS Strategy. He went on to say that they were now years behind the trends in prevention. C. Collins suggested developing a three-year planning cycle, which would allow them to

consider where they wanted to go in the future during the second year. M. Ross-Russell replied that they had the ability to change their planning cycle before the current plan was completed, which would give them 12-15 months to create a new timeline. T. Daniel agreed that a five-year cycle was too long, especially since many CPG members did not stay on the CPG long enough to see completion of a plan from beginning to end.

M. Castillo and C. Collins both agreed that a three-year process could help them to stay more current. M. Castillo then stated that they would need much better committee participation to be able to complete their work in three years rather than five. M. Ross-Russell noted that some sections in the plan would automatically be completed by Office staff, since this work needed to be done for both care and prevention. She went on to say that she had only seen one-, two-, and five-year plans, but she would discuss the possibility of a three-year plan with their project officer.

M. Ross-Russell then stated that she would develop a draft timeline to send to the committee for input. She also asked the co-chairs of the Planning Priorities and Literature & Education Committee to consider how much time they would need to complete their work. She explained that they would need to think about how much time they needed to review information, keeping in mind that CPG members were volunteers. She went on to say that any changes to their timeline would need to be approved by the CPG as a whole, and they would need to explain their reasoning for shifting to a three-year cycle. C. Collins replied that the Monitoring Committee would need to meet again before proposing a three-year plan so they could review the potential timeline.

T. Clark asked for more information about shorter planning cycles in other cities. M. Ross-Russell explained that some other jurisdictions had an annual cycle, in which they had continuing applications rather than having an RFP every year. She went on to say that this put more of a burden on the providers, because their contracts were not promised to continue each year. M. Milsop then noted that Chicago, Los Angeles, and San Francisco all used three-year plans.

The group agreed to revisit this topic at the next Monitoring Committee meeting.

- **New CDC Application**

D. Acosta stated that there new Funding Opportunity Announcements (FOAs) had been released the previous week, with a deadline of September 3. M. Ross-Russell explained that they had been asked to develop a plan to be implemented within three months. She went on to say that the Literature & Education Committee had held discussions about things they would like to do if they had more resources. She noted that they had talked about structural interventions like condom machines, which they did not have the capacity or funding to do. She went on to say that they had also discussed conducting incentivized interventions, or using social media to help prevent them from testing the worried well. She explained that this could help them to do some of the items on their "wish list." She then noted that the CPG would not need to have a letter of support, but rather a statement that they were aware that the city was applying for this funding.

D. Acosta then explained that they had considered massive condom distribution, similar to what New York City had done. He went on to say that they would like to hold a contest

related to the condoms. He then stated that they would also like to purchase syringes and create social marketing campaigns targeting specific populations, such as African-American MSM and young women. He went on to explain that they would have three months to plan, and then they would need to put the programs into place. He added that, after the first year, there would be a competitive federal RFP with three-year funding cycles. He noted that the CDC would do outcome evaluation on the projects, and that there was a clear focus biomedical and structural interventions in the FOA. M. Ross-Russell then stated that they already knew DEBIs and EBIs were effective, but they had to consider what they needed to do in their community to reach those unaware of their status.

D. Acosta next started a discussion on the importance of linking new positives to care. T. Clark added that they heard too frequently that someone was contacted with their results by phone call or email. M. Castillo then noted that CHOP has an employee that works with any agency to link people to care. T. Clark suggested the possibility of having testers in medical centers, or possibly training medical providers in testing. M. Castillo stated that it was more difficult to get people linked to care when the testing does not occur in a medical center. M. Ross-Russell replied that hospital settings had the worst numbers when it came to getting people linked to care. T. Daniel then related a story about a young African-American MSM that had been admitted to an emergency room for pneumonia. He explained that the doctor had asked this man several questions, but they did not offer a single STI test even though he was a young black MSM in a new relationship. M. Castillo then suggested having a risk assessor in the emergency room, which could be an example of a structural intervention. D. Acosta stated that this could be part of a social marketing campaign. He went on to say that they had not yet heard whether the application for expanded testing had been funded. He then explained that they had seen a great deal of resistance toward testing from the doctors and nurses originally, but that there was now a movement toward making testing a team effort. He added that they might be able to simply send test kits to the hospitals and reimburse lab fees in the future.

T. Clark stated that any social marketing campaign on condom usage should go hand-in-hand with getting tested. D. Acosta said they would have to stratify but they would have to consider what they would promote with social marketing.

T. Daniel stated that the Black HIV/AIDS Treatment Advocacy Training that had occurred in Philadelphia had been very thorough. He went on to say that a national movement had been kicked off in Philadelphia, but that most people were not aware of this.

- **Letter of Acknowledgement**

M. Ross-Russell stated that the CPG would need to discuss the letter of acknowledgement at their next meeting due to the deadline. She went on to say that they would initially plan for counseling and testing, syringe exchange, social marketing campaigns, and condoms. She added that they would not spend this funding on testing if additional testing funding came through.

**Old Business:**

None.

**New Business:**

M. Ross-Russell stated that they would have panel discussions, a presentation from the Literature & Education Committee, and the completion of two worksheets (one for populations and one for interventions) on the agenda at the next CPG meeting.

**Review/Next Steps:**

None.

**Announcements:**

C. Collins said he was looking for more participants for a 3MV retreat scheduled for September 10-11.

The group agreed to have their next meeting on Monday, September 20 from 2:30 p.m. – 4:30 p.m. M. Ross-Russell asked the group if they would like to do a formal presentation on the plan at the CPG meeting, and they agreed. The group then decided to conduct the presentation in September, and vote in October.

**Adjournment:**

The meeting was adjourned at 4:14 p.m. by general consensus.

Respectfully Submitted by,

Briana L. Morgan, Staff

**Handouts distributed at the meeting:**

- Meeting Agenda
- Meeting Minutes from May 13, 2009
- Excerpt from Bylaws on Attendance
- Purpose of CDC Application
- New CDC Funding Opportunities
- OHP Calendar

## **Comparing the Cost-Effectiveness of HIV Prevention Interventions**

The effectiveness measured that was estimated was the number of HIV infections prevented and the cost was determined as the cost of implementing a particular intervention. HIV prevalence in the population at risk and the cost per person reached were two factors that strongly influenced the cost-effectiveness for the different interventions. In a population with a low prevalence of HIV, it was determined that structural interventions, such as mass media and condom distribution, were the most cost-effective. In a population with a high prevalence of HIV, interventions that focused on the individuals were cost-effective. Two interventions that were likely to reduce HIV that were considered policy changes with no program costs were raising the taxes on alcohol and allowing the non-prescription sale of needles and syringes.

## **Can Cost Effectiveness Analysis Help in HIV Prevention?**

Cost effective analysis refers to the economic analysis of an intervention. One measure of cost-effectiveness is the cost per HIV infection averted. This can be affected by many factors such as intervention cost, number of people reached, and changing behavior. Cost-effectiveness models do not take everything into account. Factors such as family stability, freedom from HIV-related stigma and social justice. Some factors that aren't quantifiable are reducing a client's HIV risk, getting clients into stable housing, out of abusive relationships, or into drug treatment programs. Cost Effective analysis shows that interventions targets to high sero-prevalence areas tend to be more cost effective than interventions that are not targeted. However, lost cost doesn't always equal cost-effective. In some cases, if an intense intervention is needed, spending the money may be more cost-effective in this instance.

## **A model for allocating HIV Prevention resources in the United States**

- Uses the best data and estimates available on HIV incidence, prevalence, prevention program costs and benefits, current spending, etc.
- Projects HIV infections for the United States as a whole given different allocation strategies
- Provides information that could be considered in future decision-making processes for resource allocations
- Compares the outcome of interventions in terms of estimated HIV infections prevented when targeted to the general population and to risk populations defined by race/ethnicity, gender, and risk group.
- Directs resources for testing and behavioral interventions to those at greatest risk
- Increases allocation to behavioral interventions for diagnosed positives

## **New Directions in HIV Prevention**

- 5 Focus Areas:
  - #1: Status Awareness
    - To promote knowledge of HIV status and link all people who have HIV to medical care and support services through HIV testing, increasing frequency of testing, disclosure of HIV test results, partner services, and linkage to care.
  - #2: Prevention with Positives
    - Reduce the spread of HIV and other STIs, suppress viral load in order to promote positive health outcomes and reduce risk of HIV transmission, and to help

people living with HIV achieve and maintain health. This will be done by disclosure and partner services, engagement in HIV care, linkage to ancillary services, STI, viral hepatitis and tuberculosis screening and treatment, and treatment adherence.

- #3: Syringe Access
  - To ensure access to sterile syringes and injection equipment to eliminate the transmission of blood-borne viruses among people who inject drugs and their sexual partners. This will be done by having syringe programs that provide a range of sterile injection equipment and safer sex supplies, as well as education and referrals.
- #4: Drivers of HIV
  - Cocaine/crack, Gonorrhea, heavy alcohol use, methamphetamines, multiple partners, and poppers are underlying conditions that are directly linked to a large number of new HIV infections in San Francisco. All HIV Prevention Section programs will focus on populations who are also affected by one or more drivers.
- #5: Structural Change
  - Ensure HIV and STI screening and referrals | standard of care in medical settings, ensure universal healthcare coverage for PLWA, and establish a non-harassment policy for drug paraphernalia.

HPS (HIV Prevention Section) will integrate HERR (Health Education and Risk Reduction) efforts with multiple focus areas.

#### **Improved Allocation of HIV Prevention Resources: Using Information About Prevention Program Production Functions**

Information on program effectiveness is essential in determining the allocation of resources that maximize health benefits. Epidemiological data, such as the estimates of HIV prevalence or incidence, does not produce ample information to support allocating HIV prevention resources. Information for good allocation resources can be obtained based on basic information about prevention program product functions. If product functions aren't available for specific interventions, decision makers can improve the allocations decision with basic estimates of fixed cost and a point estimate of program cost and associated behavior change.

#### **An Overview of the Effectiveness and Efficiency of HIV Prevention Programs**

Several common elements have been described in an overview of successful, behaviorally based HIV Prevention Programs. Basing prevention programs on real specific needs and community planning was described as one of the several common elements, along with cultural competency, basing programs in behavioral and social science theory and research. Having clearly defined audiences, objectives, and interventions and quality monitoring and adherence to plans, along with using evaluation findings and mid-course corrections are additional common elements.

Examples of successful programs for those who engage in risky behaviors include Counseling, testing, referral, and partner notification. Also, individual or group information, education, and counseling as well as implementing community level interventions were included in the examples. Additionally,

Outreach and Drug treatment and other related activities, as well as needle and syringe exchange were mentioned.

## **No Time to Lose: Getting More from HIV Prevention**

### **ALLOCATING RESOURCES TO PREVENT AS MANY NEW HIV INFECTIONS AS POSSIBLE**

Prevention resources should be allocated to prevent as many new infections as possible. Such an allocation must take into account the cost and effectiveness of programs, in addition to estimates of HIV incidence. Evaluation should be a major component of resource allocation decision making. With better evaluation data reflecting the cost, efficacy, and reach of programs, resources could be more profitably invested in interventions that work. Interventions that do not work, or that are very expensive relative to the number of infections prevented, could be abandoned.

### **USING THE CLINICAL SETTING FOR PREVENTION**

Prevention services for HIV-infected persons should be a standard of care in all clinical settings (e.g., primary care centers, sexually transmitted diseases clinics, drug treatment facilities, and mental health centers). Health care providers should have adequate training, time, and resources to conduct effective HIV prevention counseling. Enabling this activity may require adjustments in health care provider time allocations and/or specific financial incentives from public and private sources of health coverage.

### **TRANSLATING RESEARCH INTO ACTION**

Key Department of Health and Human Services agencies that fund HIV prevention research and interventions should invest in strengthening local-level capacity to develop, evaluate, implement, and support effective programs in the community. The Committee further recommends that these agencies invest in research on how best to adapt effective programs for use in community-level interventions and research on what constitutes effective technical assistance for optimal research-to-community transfer of prevention programs; these agencies should also be responsible for the widespread dissemination of the results of this research. Such efforts will require the participation and collaboration of the funding agencies, researchers, service providers, and communities.

### **INVESTING IN THE DEVELOPMENT OF NEW TOOLS AND TECHNOLOGIES FOR HIV PREVENTION**

Federal agencies should continue to invest in the development of products and technologies linked to HIV prevention. In particular, the National Institutes of Health should place high priority on the development of anti-HIV microbicides and vaccines, and this prioritization should be accompanied by increases in funding. Similarly, the Food and Drug Administration should accelerate its efforts to approve prevention technologies that show promise in clinical trials (e.g., new antiretroviral therapies, new microbicial and vaccine candidates) or are already being successfully utilized elsewhere in the world (e.g., rapid testing assays other than the Single Use Diagnostic System [SUDS]). For all new prevention tools, investigations of cost-effectiveness and user acceptability should be included as part of the research agenda. Federal agencies should also seek to develop stronger research collaborations with private industry, and they should offer incentives to encourage private industry investment.

### **STRIVING TO OVERCOME SOCIAL BARRIERS**

Recommendations:

- Increase drug abuse treatment funding to levels that are sufficient to provide drug treatment to all those requesting it;
- Remove legal and policy barriers that limit access to sterile drug injection equipment;

- Eliminate congressional, federal, state, and local requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability programs in schools;
- Remove policy barriers that hinder the implementation of effective prevention efforts in correctional settings.

# **Philadelphia Prevention Community Planning Group (CPG)**

## **Bylaws**

*(Approved by the CPG in January 2009)*

### **Article I: Name and Establishment**

**Section 1.** The name shall be the Philadelphia Prevention Community Planning Group, hereafter referred to as the "CPG".

**Section 2.** The CPG shall be established by the Mayor of the City of Philadelphia. The Mayor shall be the grantee of awards made available through the U.S. Centers for Disease Control and Prevention (CDC) for the prevention of HIV infection in Philadelphia.

**Section 3.** The Mayor and the Mayor's appointees shall monitor, identify support for, and be apprised of the activities of the CPG through the staff of the Office of HIV Planning under the supervision of the Health Department.

**Section 4.** The City of Philadelphia's AIDS Activities Coordinating Office (AACO) shall act as administrative agent of the CPG in administering HIV prevention funds.

### **Article II: Purpose**

**Section 1.** The CPG shall recommend considerations to the City of Philadelphia on how best to meet the priorities for the allocation of funds, based on, as possible:

- a. documented need of those whose behavior puts them at high risk for HIV infection;
- b. cost and outcome effectiveness of proposed strategies and interventions;
- c. priorities of populations of target communities for whom the services are intended; and
- d. availability of other governmental and non-governmental resources.

**Section 2.** The CPG shall develop and adopt a comprehensive plan for the delivery of primary and secondary HIV prevention services in accordance with the written guidance of the CDC.

**Section 3.** For the purpose of prioritizing at-risk populations, the CPG shall both establish their own mechanisms for conducting needs assessment activities and utilize any surveillance reports, seroprevalence studies, surrogate marker data, census data on populations, behavioral research, or other tools with which they are provided.

**Section 4.** The CPG shall establish mechanisms for obtaining input on community needs and priorities that may include public meetings, conducting focus groups, and convening *ad hoc* panels, among other methods.

**Section 5.** The CPG shall develop and work toward attaining annual goals and objectives related to HIV prevention.

**Section 6.** The CPG shall evaluate the planning process and recommend changes as necessary.

**Section 7.** The CPG shall review the comprehensive plan and the grantee's application for prevention funding and provide a letter of concurrence or non-concurrence. This letter shall indicate the extent to which there are strong logical connections between the community planning process, the comprehensive plan, the continuing application, and HIV prevention resources.

### **Article III: Membership**

**Section 1.** The CPG shall consist of no more than thirty-five (35) and no fewer than twenty (20) members and shall reflect in its composition the demographics of the epidemic and of communities at high risk for HIV infection in Philadelphia with particular consideration given to disproportionately affected and historically underserved subpopulations.

**Section 2.** The CPG membership shall be consistent with CDC regulations and guidance including, but not limited to, at least one representative from each of the following categories:

- a. state and local health departments, education agencies, and other relevant governmental agencies (e.g., programs for sexually transmitted diseases, substance abuse, mental health, and corrections);
- b. experts in epidemiology, behavioral and social sciences, evaluation research, and health planning;
- c. governmental and non-governmental organizations providing HIV prevention and related services to people with HIV infection or at high risk for HIV infection;
- d. affected communities, including people with HIV infection and/or people from communities at high risk for HIV infection and historically underserved subpopulations

**Section 3.** It shall be the goal of the CPG that a minimum of fifty percent (50%) of the members are people with HIV infection and/or people from communities at high risk for HIV infection and that, among these members with or at-risk for HIV, at least fifty percent (50%) have no employment nor fiduciary relationship with any provider agency that receives HIV prevention funds.

**Section 4.** The Mayor or the Mayor's designee shall have responsibility for final appointment of all members to the CPG following a written open nominations process that includes:

- a. publicized criteria for membership;

- b. review of applications and subsequent recommendations of candidates by the Nominations Committee;
- c. conflict of interest standards; and
- d. a mechanism for filling vacancies.

**Section 5.** Any member may resign from membership by written or other form of notice to the Office of HIV Planning.

**Section 6.** Termination of Membership.

- a. In the event that CPG members acquire within a calendar year either three unexcused absences or five excused or unexcused absences of any combination, they shall be notified in writing that they are in violation of the attendance policy and, thereby, at-risk for removal from the CPG. Members in violation of the attendance policy shall be given an opportunity to appeal to the Nominations Committee, who shall ultimately be responsible for sending requests for removal to the Mayor or the Mayor's designee.
- b. If the Mayor or the Mayor's designee determines that a member has failed to perform his or her responsibilities as described in these bylaws (i.e., attending meetings, committee participation) or has engaged in conduct which has interfered with or would interfere with the work or reputation of the CPG or the City of Philadelphia or otherwise adversely affect its interests, then, the Mayor or the Mayor's designee may, by written notice to the member, terminate membership for cause.
- c. The CPG may recommend to the Mayor or the Mayor's designee that any member be removed from membership for cause, requiring a two-thirds (2/3) vote at any regularly scheduled meeting of the CPG with no fewer than seven (7) days' prior notice.

**Section 7.** Members are appointed initially for either a 1 or 2 year term length by the Mayor or the Mayor's designee.

- a. Members may be re-appointed for consecutive terms by the Mayor or the Mayor's designee, but may not serve more than three (3) consecutive terms.
- b. Exceptions to the term limits provision are members who represent institutions and local municipalities as mandated by the grantee.

#### **Article IV: Officers**

**Section 1.** The CPG shall be Chaired by three Co-Chairs: a government Co-Chair, and either a community Co-Chair and a community Co-Chair elect, or two community Co-Chairs. The government Co-Chair shall be appointed by the grantee and shall serve for a time period determined by the grantee. The community Co-Chairs shall be elected by the voting members of the CPG.

- a. In order for individuals to be eligible for the community Co-Chair positions, they must have been voting members of the CPG in good standing for at least

- one year. Good standing is defined as being in compliance with attendance and other membership requirements as outlined in these bylaws.
- b. Newly-elected community Co-Chairs shall assume the elect position. The community Co-Chair elect shall fulfill community Co-Chair duties as needed and represent the CPG at local, state, and national meetings/events as needed. After a period of one year, the community Co-Chair elect shall assume a full community Co-Chair position. As long as both community Co-Chairs wish to remain in the position and continue to win re-elections, they shall share the responsibilities of the position.
  - c. The annual election process for the community Co-Chair and/or community Co-Chair elect shall proceed as follows (unless otherwise determined by the CPG):
    - i. In September, CPG members shall be given the opportunity to nominate potential candidates for the community Co-Chair position. They may nominate either themselves or other eligible CPG members as described above.
    - ii. The nominated individuals will be notified by the Office of HIV Planning. Should they accept the nomination, they must submit a written biography to the Office of HIV Planning before the October meeting of the CPG. The biographies shall contain no more than 250 words and shall be limited to experiences relating to HIV/AIDS.
    - iii. Each nominee who meets these requirements shall give a brief presentation of their biographies at the October CPG meeting. CPG members who are not in attendance shall be provided with the written biographies.
    - iv. The community Co-Chair election shall take place at the November CPG meeting. The community Co-Chair and community Co-Chair elect terms shall begin in the following January.

**Section 2.** The Co-Chairs shall facilitate regular meetings of the CPG and carry out other duties as assigned by the grantee or the CPG including, but not limited to, representing the CPG at the local, state, and national levels.

#### **Article V: Meetings**

**Section 1.** The quorum of the CPG shall be more than one-third (1/3) of the membership. Neither absentee nor proxy votes shall be considered.

**Section 2.** The rules of parliamentary procedure as set forth in Robert's Rules of Order shall govern all meetings of the CPG, its committees, and any additional working groups. The CPG shall strive for consensus in its deliberations. Only a simple majority of the quorum of CPG members in attendance at a meeting is required for a motion to pass.

- a. Any person wishing to speak must first be recognized by a Co-Chair or facilitator of the discussion.
- b. Cross-talking or side bar conversation is prohibited.

- c. Speakers are asked to respect time. Long oratories are discouraged. Members do not need to reiterate statements
- d. Attacks of any nature (verbal or physical) will not be tolerated
- e. Individuals should agree to disagree with respect.
- f. A "Parking Lot" of ideas and topics should be maintained. This "Parking Lot" is to contain items that are tabled during larger discussion due to time constraints or items which require action later in the meeting.
- g. Respect confidentiality.

In the event that any member or non-member of the CPG is called out of order by the CPG or committee Co-Chair/s during a meeting, the following actions shall be taken to restore order to the meeting:

- a. First incident: The disruptive person/s is called out of order by the Co-Chair/s.
- b. Second incident: The individual/s is put on notice that he/she/they are out of order.
- c. Third incident: The Co-Chair/s shall call a five minute recess of the meeting.
- d. Fourth incident: The Co-Chair/s shall ask the individual/s to leave the meeting.
- e. If the disruptive individual/s refuses to leave, law enforcement officials will be contacted and asked to remove him/her/them.

**Section 3.** All members shall have one vote. In the event of a tie vote, the issue shall be further discussed or tabled if time does not allow.

**Section 4.** The CPG shall meet regularly at least six times annually and shall be open to the public. Special meetings may be called by agreement of both Co-Chairs or by written endorsement of one-third (1/3) of the membership of the CPG with notice provided to the Office of HIV Planning. Notice of special meetings shall be made at least seventy-two hours in advance of the meeting, to the maximum extent possible.

**Section 5.** The CPG shall have no role in determining the specific agencies or organizations with whom the grantee, its fiscal agents, or other designees may contract for the delivery of HIV prevention services. The rules contained in this section apply to all members, members of committees, work groups, task forces and technical advisory groups, staff members, contractors and consultants to the CPG, and all of whom shall be referred to as CPG for the purposes of this section.

- a. No CPG member shall use his or her relationship with the CPG for private gain.
- b. Whenever any matter arises with respect to which a CPG member either has a conflict of interest or has any question about the existence of a conflict, he or she shall make a full disclosure of such conflict or possible conflict before the matter is discussed.
- c. For the purposes of these Bylaws, conflict of interest shall be defined as a direct financial or fiduciary interest, which shall include, without limitation, ownership, employment, contractual, creditor, or consultative relationship to, or Board membership in, an entity or individual, or in a substantial affiliate of

such an entity including any such interest that existed at any time during 12 months preceding the vote, with respect to which a vote is to be taken.

- d. A member's receipt of CDC-funded HIV prevention services, regardless of whether CDC directly funded or through AIDS Activities Coordinating Office, is not to be construed, in and of itself, as a conflict of interest.

## **Article VI: Committees**

**Section 1.** The committees of the CPG shall be the Monitoring Committee, the Nominations Committee, the Planning Priorities Committee, the Literature and Education Committee, and the Positive Committee. Some of these committees may have joint functions with the Philadelphia Eligible Metropolitan Area Ryan White CARE Act Title I Planning Council (Planning Council). Committees do not have broad decision-making authority unless expressly granted by the CPG. In addition to the overall goal of informing, developing, and contributing to the Philadelphia Prevention Plan, these committees are responsible for the following:

- a. The Monitoring Committee is charged with tracking and advising the activities of the CPG and works closely with its Co-Chair(s). Duties include informing the CPG agenda, investigating governing body issues, devising and drafting goals and objectives, strategic planning necessary to facilitate the completion of the Prevention Plan, as well as other duties assigned by the CPG.
- b. The Nominations Committee is charged with reviewing and recommending candidates for membership to the CPG, monitoring the attendance of members, implementing strategies for recruitment and retention of members, as well as other duties assigned by the CPG.
- c. The Planning Priorities Committee is charged with making recommendations to the CPG concerning gaps in HIV/AIDS information of the most severely impacted populations, investigating the best practices for interventions for these populations, and other duties assigned by the CPG. To help accomplish its tasks, the committee works closely with the Philadelphia EMA Ryan White Title I Planning Council, the Literature & Education Committee and Office of HIV Planning Staff.
- d. The Literature and Education Committee is charged with ensuring that CPG members possess a working knowledge of the impact of HIV/AIDS in this region; keeping the CPG abreast of current trends, pertinent research, and emerging populations; working with Office of HIV Planning staff to coordinate the orientation and training of new and current members; and other duties assigned by the CPG.
- e. The Positive Committee is comprised of people with HIV infection only; it supports and enhances the role of people with HIV infection in the CPG and the Planning Council (both separately and jointly with the Planning Council, as appropriate) and other activities as assigned by the CPG.

**Section 2.** Each committee shall establish its own quorum that shall include the requirement that at least twenty percent (20%) of its members are people with HIV

infection (for joint CPG/Planning Council committees) or people from communities at high risk for HIV infection (for CPG-only committees).

**Section 3.** The rules of parliamentary procedure as set forth in Robert's Rules of Order shall govern all meetings of the committees. The committees shall strive for consensus in their deliberations.

**Section 4.** Each committee shall establish appropriate meeting schedules.

**Section 5.** Each committee shall elect Chairs or Co-Chairs as appropriate; for joint CPG/Planning Council work, committees shall elect one Co-Chair from each body.

**Section 6.** From time to time, working groups may be established by the CPG to address specific issues. Working groups shall operate under the rules established for committees.

### **Article VII: Management and Operations**

**Section 1.** The CPG shall be supported by the Office of HIV Planning under the supervision of the Health Department. The Health Department shall assist in the resolution of problems in the CPG on an as-needed basis.

**Section 2.** The Office of HIV Planning staff shall provide day-to-day management of the activities of the CPG and its committees. In addition, it shall administer the CPG support budget and provide the CPG, its committees, and its members with training, planning, and other administrative supports to ensure compliance with local, state, and federal law and regulations.

**Section 3.** The Office of HIV Planning staff shall have no voting authority in the CPG or its committees.

**Section 4.** AACO has the ultimate authority and responsibility for the expenditure of funds that are allocated to meet the priorities, for procurement of contracts to entities that carry out the work, and for considering the recommendations of the CPG in all its activities. AACO shall provide information as agreed upon to the CPG.

### **Article VIII: Amendments**

**Section 1.** These bylaws may be amended by the CPG at any regular meeting by a vote of two-thirds (2/3).

**Section 2.** Amendments to these bylaws shall be made only after members have been given thirty (30) days written notice of proposed amendments.