Community Planning Group
Planning Priorities Committee
Meeting Minutes
Monday, February 22nd, 2010
1:00 – 3:00 p.m.
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, Tony Daniel (Co-Chair), Andrew de los Reyes, Rick Feely, Denette Lienau

Staff: Aneeza Agha, Joseph Ellis, Michael Milsop

Excused: David Acosta, Marné Castillo (Co-Chair), David Powell

Call to Order:
A. De los Reyes called the meeting to order at 1:15 pm.

Approval of Agenda
After taking a moment to review the agenda, the group approved the document by general consensus.

Approval of Minutes (*January 25th, 2010*)
The group took a moment to review a draft of the minutes from their last meeting.
Motion: Afterwards, D. Lienau moved and D. Acero seconded to approve the draft of the minutes that was included in the handouts. **Motion Passed:** All in favor.

Report of Staff
None

Report of Co-Chair
None

Discussion Items:
- **Finish Planning Process for Weighting Factors**

M. Milsop directed the group's attention to Worksheet 1 in the handouts, noting that OHP staff had developed the document following the committee's determinations on factors for target populations, which had been discussed at their last meeting. He proceeded to read through the handout, noting that there were only a few points of clarification required from the committee on some of the factors.

A. de los Reyes asked why the CDC was not included as a data source for HIV/ AIDS prevalence and incidence. M. Milsop replied that the CDC culled its local information from the same sources listed in the worksheet.

M. Milsop informed the group that, in developing the last Prevention Plan, the group had decided to use only gonorrhea instead of all STDs as a key indicator of risk behaviors.

He explained that certain STDs, such as gonorrhea, were better indicators of HIV risk because their symptoms were more likely to cause those at high risk for HIV to go see a doctor. As a result, he asked the committee members whether they wanted to use all STDs as a key indicator of risk behaviors or concentrate on any specific STDs. D. Lienau felt that the group should use all STDs as key indicators because they all indicated risky behavior. However, A. de los Reyes supported using only specific STDs, noting that other STDs, such as chlamydia, would skew the data with large concentrations of populations at a lesser risk of HIV infection. He then specifically stated that, in his opinion, only syphilis should be used as a key indicator because the rate of the disease was increasing and it tended to affect populations that were also at risk for HIV. In response to a question by D. Acero, A. de los Reyes said that he did not feel gonorrhea should be included as a key indicator because currently the disease was mostly affecting populations that were traditionally not at high risk for HIV infection. As a result, the rest of the committee members agreed to use syphilis alone instead of STDs in general.

M. Milsop asked A. de los Reyes whether he would be able to provide data on syphilis rates to the committee for the purposes of their planning. A. de los Reyes replied that he could provide the information; however, he noted that it had also been posted to HIP (Health Information Project).

Moving on to the next factor, M. Milsop noted that using substance use as a factor could be problematic because the size of the population was uncertain. He explained that, since not all substance users sought medical treatment, the available data on the population was incomplete. A. de los Reyes asked whether any members of the CPG were representatives of substance abusers and, thereby, could provide some insights into working with data on them. M. Milsop said that he could contact OAS (Office of Addiction Services) but noted that last time he had asked them for data, he was only able to get information on individuals who had been in treatment. A. de los Reyes suggested speaking with Ricardo Tull, the Program Coordinator for OAS, on the matter because he could give a general overview on the population instead of just numbers on those who had been in treatment. M. Milsop said that he would contact R. Tull but reminded the group that they had wanted to base their decisions on concrete data.

A. Agha pointed out that Worksheet 1 still reflected the decision made during the development of the last prevention plan to use crack/cocaine use specifically as a factor instead of substance use in general. A. de los Reyes asked what the link was between crack/cocaine use and HIV risk. R. Feely replied that individuals under the influence of crack/cocaine were more likely to engage in unprotected sex. A. de los Reyes questioned the connection between crack/cocaine and HIV risk, saying that crack users tended to be disinterested in sex beyond what was required to obtain the drug. Additionally, he said that, if users were prostituting themselves in order to get money for crack, they could be wearing condoms or only engaging in oral sex, which was significantly less risky. He then stated that he did not believe that substance abuse was a necessary factor for prioritizing populations. He explained that the two possible risks that could be attributed to substance use – unprotected sex and the sharing of injection paraphernalia – were

already accounted for under other factors. As a result, he suggested dropping the factor and the rest of the group agreed.

For the next factor, which used injection drug use as a key indicator of risk behavior, M. Milsop noted that prevalence data on the issue should be easily obtained through Dr. Brady and Prevention Point. The rest of the group agreed and decided to keep the factor as it was.

R. Feely asked what the scale was for the riskiness of population behaviors. A. Agha replied that, following a scale provided by the AED Guidelines, sharing contaminated injection equipment was the riskiest behavior, followed in descending order by anal sex w/infected partner; vaginal sex w/infected partner; oral sex w/infected partner; and none, unknown, or low-risk behaviors. The group decided to maintain the factor as it was written.

A. Agha reminded the committee that they had developed the next factor on the list, multiple high risk behaviors, because some groups were at-risk for HIV infection through more than one behavior. However, she said that the factor was more subjective than some of the others on the list and, as a result, should not be weighted as highly as those that were more data-driven. She also noted that the committee would have to develop a scale for the factor and that the results of the weighting would rely on how much CPG members knew about the populations. R. Feely stated that data on multiple-risk behaviors of Trans populations were available through community needs assessments. He asked whether similar assessments had been performed for the rest of the at-risk populations. A. Agha replied that OHP staff would work to acquire all the data on at-risk populations that could be obtained, including literature reviews. M. Milsop agreed; however, he noted that the Health Department did not collect information on multiple-risk behaviors and that literature reviews might not reflect local population trends. Additionally, he said that, regardless of available data, some CPG members were likely to draw on personal experience when completing the worksheet. The group then decided to delay a decision on the factor until they could ascertain what data was available.

M. Milsop stated that the last two factors on Worksheet 1 were also susceptible to a level of subjectivity. D. Lienau agreed, noting that stigma, a barrier to reaching populations, was difficult to measure. R. Feely felt that, again, he could locate data on the last two factors as it related to Trans populations. M. Milsop reiterated that, although literature reviews could provide some insights into barriers to reaching populations, they often did little to represent local issues specifically, which would still leave room for subjectivity.

A. de los Reyes suggested advising the members of the CPG to research the at-risk populations so that they could make informed decisions during the weighting process. He pointed out that, even if the committee and OHP staff compiled all of the data ahead of time, it would be too much information for the group to absorb before they started the process.

A. de los Reyes doubted that the group would be able to find significant local data on the last three factors in Worksheet 1. As a result, he suggested giving the factors a lower weight than the rest of those in the handout. R. Feely informed the group that the last three factors in Worksheet 1 represented the only significant data available for Trans populations. As a result, he questioned whether the factors should be given a lower weight. A. Agha explained that, in order to counter that fact, those factors would get a higher rating for Trans populations in Worksheet 2.

M. Milsop told the group that, concerning the last three factors in Worksheet 1, they had to decide whether or not they were comfortable presenting the CPG with factors that could not be supported by hard data. He clarified that the committee would have to explain to the CPG that the factors would be more subjective than the rest. A. de los Reyes supported the idea, saying that the committee could also explain to the CPG that, because sufficient data was not being collected for some populations, the planning body would have to use professional judgment in making its decisions. The rest of the group agreed.

M. Milsop said that the CPG would use Worksheet 2 to assign final weights to the selected factors for each of the targeted populations. He explained that each member would assign a weight to each factor, all of which would then be added up and divided by the total number of responses to produce a final weight. He then told the committee that they would have to select a scale from which the CPG would make its selections, giving 1-5 and 1, 3, 5, & 8 as examples. A de los Reyes asked what the benefits were to each of the two scales. M. Milsop replied that 1-5 was an easier concept to grasp and that it had been used by both the prevention and care systems in previous prioritization exercises. However, he said that the scale could occasionally result in very small levels of differentiation, which made prioritization more difficult. As a result, he continued, the care system had just opted to switch to the 1, 3, 5, & 8 system, but had not yet tested it with a prioritization exercise. A. de los Reyes gave his support to the 1, 3, 5, & 8 system because he felt that it would result in clearer priorities. The rest of the group agreed.

M. Milsop noted that, regardless of which scale the committee decided upon, they would have to make it clear to the CPG that not every factor could receive the highest weight. He explained that, by doing so, the priorities would become meaningless. A. de los Reyes asked whether the worksheet could stipulate that each level of the scale could only be used once. A. Agha responded positively but noted that there were a number of ways of dealing with the problem. She said that the committee could also limit the number of times that the highest level of the scale was used. A. de los Reyes supported the idea and suggested limiting the amount of factors receiving a weight of ‘8’ to three. The rest of the group supported the decision. T. Daniel asked what would happen if members ignored the limit and used ‘8’ more than three times. M. Milsop replied that those responses would not be included in the calculation of the final prioritization.

M. Milsop asked the group how they wanted to handle responses that were off of the scale, such as a ‘6.’ A. de los Reyes suggested listing all of the numbers in the scale – 1,

3, 5, & 8 – and having the CPG members circle their selections to avoid responses that were off of the scale. The rest of the group agreed.

A. de los Reyes asked whether OHP staff would develop instructions for the worksheet based on the decisions that the committee had just made. M. Milsop agreed to develop the worksheet with the necessary instructions. He then suggested giving the CPG an explanation of the factors at their next meeting so that they would be more informed for the prioritization exercise in March. The rest of the group agreed and T. Daniel offered to give the explanation.

Old Business
None

New Business
None

Review/Next Steps
- The PPC continued planning the process by which the CPG would weight the factors for prioritizing populations.
- For Worksheet 1, they decided to remove a factor (substance use), delay a decision on a factor until they knew what data was available (multiple high risk behaviors), and note that the last three factors were more subjective than the others.
- For Worksheet 2, they decided to use a scale that included the numbers 1, 3, 5, & 8 instead of 1 – 5, and to limit the highest number (8) to being selected for only three factors per target population.
- The next meeting of the PPC will be on Monday, March 22nd, from 1:00 – 3:00 pm.

Announcements
None

Adjournment
The meeting was adjourned by general consensus at 2:04 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:
- Meeting Agenda
- Meeting Minutes (*January 25th, 2010*)
- Worksheet 1: Determining Factors for Target Populations
- Worksheet 2: Weighting Factors for Target Populations
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Planning Priorities Committee

Meeting Agenda
Monday, February 22nd, 2010
1:00 p.m. – 3:00 p.m.
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

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Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Finish Planning Process for Weighting Factors**

Old Business

New Business

Announcements

Adjournment

The next meeting of the Planning Priorities Committee is scheduled for
Monday, March 22nd, 2010 from 1:00 - 3:00 pm
At the Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org, for updated committee meeting information.

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

Community Planning Group
Planning Priorities Committee
Meeting Minutes
Monday, January 25th, 2010
1:00 – 3:00 p.m.
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Andrew de los Reyes

Guest: Robert K. Burns

Staff: Joseph Ellis, Michael Milsop

Excused: David Acosta, Rick Feely, Denette Lineau, David Powell

Call to Order
M. Castillo called the meeting to order at 1:05 pm.

Approval of Agenda
After taking a moment to review the agenda, the group approved the document by general consensus.

Approval of Minutes (*December 7th, 2009*)
The group spent some time reviewing a draft of the minutes from their last meeting. A. de los Reyes noted that, on page three of the document, his job title was incorrectly listed. He clarified that his correct title was "Assistant Program Manager." With the correction noted, the group approved the draft of the minutes by general consensus.

Report of Staff
M. Milsop reported that Dr. Fenton had recently given a lecture at Drexel University on the developing state of PCSI (Program Collaboration and Service Integration). He said that the new community planning guidance would likely include some language on PCSI because Dr. Fenton had stated his desire for the document to address it specifically. He reported that, although all the CDC disease systems were separate and would not have to merge, Dr. Fenton had stated that the systems would have to work together. A. de los Reyes added that language for PCSI would be included in future guidelines and RFAs and was already a standard in most applications for federal funding. He also noted that Philadelphia had already taken a number of steps towards integration measures and, therefore, would not likely have much difficulty adapting to any forthcoming mandates on the matter. Additionally, he noted that, although funding for the implementation of PCSI was likely, he had not yet heard of any specific information on the matter. M. Milsop also informed the group that, according to Dr. Fenton, new guidelines for the CDC portfolio of disease systems would make each of them more consistent with one another. A. de los Reyes supported the statement, saying that he believed the CDC was now fully aware of the discordance between the systems and working to correct it.

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Report of Co-Chair
None

Discussion Items:

- **Plan Partner Services Presentation**

A. de los Reyes noted that, as discussed at the last PPC meeting, the purpose of his presentation was to provide the CPG with information on the most up-to-date version of the partner services guidelines, which had been released nearly a year and a half ago. He said that he hoped the presentation would clear up some of the misconceptions about PS (Partner Services) that were still held by many. He told the group that, although the guidelines were integrated for use by all of the disease systems, his presentation would only focus on issues related to HIV in order to keep the presentation at a manageable length. He then asked the PPC to suggest any revisions for the presentation that came to their minds (see handout for more details).

M. Castillo asked to what degree the new guidelines affected the existing PS at the time of their release. A. de los Reyes replied that, while there were some challenges, the process was not as difficult in Philadelphia as it was in other cities because of the strong STD control system that had already been in place.

A. de los Reyes told the group that the CDC had already put a great deal of work into developing the new guidelines before they asked CBOs for suggestions on further revisions. He felt as though most CBOs had already offered some form of PS, even though it was sometimes done unconsciously, in order to increase testing. However, he said that available data showed that PS were more effective when offered by a Health Department specialist instead of a CBO. He told the group that, even though positivity rates did not differ much when the services were offered by the Health Department or CBOs, he supported having the Health Department conduct the process in order to avoid straining the relationships between counselors and their patients.

In response to the statement that the new guidelines targeted program managers, M. Milsop said that, according to Sam Dooley, the Associate Director for Science and Program Integration who was in charge of the guidelines, different levels of staff workers would be responsible for different aspects of PS notification. A. de los Reyes replied that many different levels of staff would attend the training and that there would be a number of strategies used for partner notification, including use of the internet and collaborations between counselors and the Health Department. However, he said that he would follow up with Sam Dooley on the matter before delivering his presentation in February.

On the matter of whether patients or providers would be responsible for referrals to PS, R. Burns asked whether there was any data available to show that certain populations found one of the two options more agreeable. He noted that, because many African American MSM did not identify as gay, they would likely be less inclined to agree to provider referrals. A. de los Reyes replied that there was data on the preferences of populations in the guidelines and that he would provide the PPC with the information at their next meeting. However, he could not recall any specifics at the moment.

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D. Acero pointed out that notification from providers could lead to domestic violence in some instances. A. de los Reyes agreed and reported that, unfortunately, there was not yet much investigation into whether there was a link between PS and domestic violence. However, he said that the guidelines required providers to ask about domestic violence because the authors were aware of its potential. He informed the group that, although the Health Department had a preferred approach for dealing with the matter, it was not always in line with the preferences of providers. He said that the discussion on a connection between domestic violence and PS needed to continue.

On slide 23, *HIV Partner Services PDPH/STD Control Snapshot 1/08 – 6/09*, A. de los Reyes noted that most of the 31 new diagnoses were newly infected. He said that he was working to get STAHRS data for confirmation but, preliminarily, it seemed that a vast majority of the diagnoses were new infections. He also clarified that not everyone interviewed had given the names of their partners for notification.

R. Burns asked whether information was available on the cost per service for each of the 352 partners elicited. A. de los Reyes replied that a medical epidemiologist was currently working on a cost/benefit analysis for the services. However, he said that, as there were only four full-time employees dedicated specifically for PS, the program was probably cost-effective by staffing measures. However, he noted that there would eventually need to be more staffing resources because four individuals would not be able to handle the services' future volume.

M. Castillo suggested including in the presentation a list of reasons why individuals would refuse PS. A. de los Reyes replied that PS did not collect such information. However, he asked the group whether they had any thoughts about why individuals would refuse the services. M. Castillo stated that youth would likely refuse PS because they feared the stigma attached to an HIV positive status. Additionally, she stated that some youth simply preferred to have anonymous sex. M. Milsop said that some individuals also rejected PS because they were unaware of how the law worked and feared prosecution for infecting others.

A. de los Reyes asked the committee whether they had any further suggestions for his presentation and whether they felt that its length was appropriate. The rest of the group offered no further suggestions.

- **Plan Process for Weighting Factors**

M. Milsop reminded the group that their next step in the prioritization process was to have the CPG weight the factors for prioritizing populations, which the PPC had selected at their last meeting. He explained that, once the factors were weighted, they would be applied to the draft list of prioritized populations to produce the final version. He then asked the committee how they wanted to explain the process to the CPG, noting that there were some exercises that could be used to give the CPG a chance to practice the process.

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M. Castillo suggested that the PPC first review their factors and draft list of priority populations for the CPG, in order to give them a sense of where they were in the process. After that, she continued, the committee would explain the weighting process and its importance. M. Milsop suggested that the PPC explain each of the factors to the members of the CPG, so they would fully understand what they were weighting.

A. de los Reyes suggested sending out an email before the meeting that would prepare the CPG members for the weighting process. He noted that, by doing so, the group could cut down on the amount of explanation that would have to be included in their presentation. Although the rest of the group supported the idea of a preparatory email, they did not feel that it would be able to replace explanation in the presentation because some members might not review the information in the email. However, M. Castillo suggested giving a preview of the process at the February CPG meeting and then sending out an explanatory email before the March meeting, at which the weighting process would take place. The rest of the group supported the idea. M. Milsop said that he would develop a worksheet for the weighting process so that the group could review it at their next meeting.

Old Business
None

New Business
None

Review/Next Steps
- A. de los Reyes gave the group a preliminary version of his upcoming presentation on Partner Services so that the committee could discuss any potential revisions.
- The PPC also planned how they would undertake their upcoming process of weighting factors for prioritizing populations.
- The next meeting of the PPC is scheduled for Monday, February 22nd, from 1:00 – 3:00 pm.

Announcements
None

Adjournment
The meeting was adjourned by general consensus at 2:23 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:
- Meeting Agenda
- Meeting Minutes (*December 7th, 2009*)
- Factors for Setting Priorities for Target Populations
- OHP Meeting Calendar

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WORKSHEET 1

Determining Factors for Target Populations

Purpose: *To select the factors your CPG will consider to make decisions about target populations and to identify sources of information about each factor.*

Directions: *Check those factors that your group will use to set priorities for target populations.*

Fill in the data source column to show where your group will find data for each factor you choose.

Factor	Definition	Data Source	Select Factor?
HIV/AIDS Surveillance: *These factors show the extent of the HIV/AIDS epidemic among the target population.*			
HIV Prevalence	How many people in the target population are living with HIV?	*AACO, PA State*	*Yes*
HIV Incidence	How many people in the target population tested positive for HIV in the past year?	*AACO, PA State*	*Yes*
AIDS Prevalence	How many people in the target population are living with AIDS?	*AACO, PA State*	*Yes*
AIDS Incidence	How many people in the target population tested positive for AIDS in the past year?	*AACO, PA State*	*Yes*

Factor	Definition	Data Source	Select Factor?
Documentation of HIV-Risk Behaviors: *This group of factors provides data about behaviors that may lead to HIV transmission.*			
Key indicators of risk behaviors: STDs	What were the reported STD cases among the target population?		
Key indicators of risk behaviors: substance use-crack/cocaine.	How many people in the target population obtained substance abuse treatment for crack/cocaine?		
Key indicators of risk behaviors substance use injection drugs.	How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data?		
Riskiness of population behaviors	What is the primary HIV risk behavior known to occur among the target population?		
Multiple high risk behaviors	Are there multiple high-risk behaviors occurring within the target?		

Factor	Definition	Data Source	Select Factor?
Socio-demographic characteristics: *This group of factors examines complex issues that may affect the provision of HIV prevention interventions.*			
Difficulty of meeting population needs	Has the target population's complex needs been reached by current programs?		
Barriers to reaching the population	Are there significant barriers to reaching the target population with HIV prevention interventions?		

WORKSHEET 2

Weighting Factors for Target Populations

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

Directions: *Create a scale for applying weights to your target population factors. Weights can be numeric or non-numeric. For example, you may use a scale from 1 to 5 or from low to medium to high.*

List the factors you chose from the worksheet that determined factors for target populations.

Discuss the weights with your CPG and agree on how each factor will be weighted.

Factor	Factor Information	Weight scale for Factor	Assign Weight
HIV Prevalence	How many people in the target population are living with HIV?		
HIV Incidence	How many people in the target population tested positive for HIV in the past year?		
AIDS Prevalence	How many people in the target population are living with AIDS?		
AIDS Incidence	How many people in the target population tested positive for AIDS in the past year?		

Factor	Factor Information	Weight scale for Factor	Assign Weight
Key indicators of risk behaviors: STDs	What were the reported STDs cases among the target population?		
Key indicators of risk behaviors: substance use-crack/cocaine.	How many people in the target population obtained substance abuse treatment for crack/cocaine?		
Key indicators of risk behaviors substance use injection drugs.	How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data?		
Riskiness of population behaviors	What is the primary HIV risk behavior known to occur among the target population?		
Multiple high risk behaviors	Are there multiple high-risk behaviors occurring within the target?		

Factor	Factor Information	Weight scale for Factor	Assign Weight
Difficulty of meeting population needs	Has the target population's complex needs been reached by current programs?		
Barriers to reaching the population	Are there significant barriers to reaching the target population with HIV prevention interventions?		