

**Community Planning Group
Planning Priorities Committee
Meeting Minutes**

Monday, April 26th, 2010

1:00 – 3:00 p.m.

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

Present: Dawn M. Acero, David Acosta, Marné Castillo (Co-Chair), Andrew de los Reyes, Rick Feely, Denette Lienau

Staff: Joseph Ellis, Michael Milsop

Guests: Terri Clark

Excused: David Powell

Absent: Tony Daniel (Co-Chair)

Call to Order:

M. Castillo called the meeting to order at 1:05 pm. Afterwards, everyone in the group took a moment to introduce his or herself.

Approval of Agenda

After reviewing the agenda, the group approved the document by general consensus.

Approval of Minutes (*March 22nd, 2010*)

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

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

Report of Staff

M. Milsop reported that the OHP would be at the Equality Forum on Sunday, May 2nd, to provide information and to recruit for the planning bodies.

Report of Co-Chair

None

Discussion Items:

• **Results and Outstanding Questions about Factors**

M. Milsop directed group's attention to the handout entitled *Discussion Items Going Forward*. For the first item listed, he reminded the group that, during the weighting process at the last CPG meeting, guests had participated in the process because the Bylaws made no statements on the matter and the committee had not decided whether to restrict the process to CPG members alone. As a result, he asked the committee whether they wanted guests' responses included in the final results. M. Castillo felt that guest responses should be included in the final results and the rest of the committee agreed.

Skipping to the fourth item on the list, M. Milsop informed the group that the available STD data was only broken down by males and females, not by risk groups. Since the rest of the worksheets would be completed by risk groups, he said that the committee would have to decide to either abandon the factor altogether or accept inconsistency in their worksheets. A. de los Reyes clarified that, while STD control had data by risk groups, it was only available as percentages and not whole numbers. M. Milsop told the group that they could decide to include language in the prevention plan that specified the need to target individuals with syphilis. By including such language, he explained, the committee would make a statement about the importance of syphilis to the spread of HIV without using inconsistent data for the prioritization process. A. de los Reyes supported the idea. He then suggested that the language in the plan mention that, because the symptoms of syphilis were so ideal for transmitting HIV, the disease was a good indicator of who was at-risk for HIV, with many MSM and young women being co-diagnosed. The rest of the group agreed to include the language in the prevention plan and remove the factor from their list.

For the fifth item on the list, M. Milsop explained that IDU data needed to be evaluated for two different reasons. Primarily, he explained, IDUs were already a targeted population so using them as a factor was somewhat redundant. Secondly, he said that the only current data on the population was from a single provider – Prevention Point – and they did not identify MSM within their data on IDUs. He then directed the group’s attention to the handout that contained the data from Prevention Point. R. Feely stated that Prevention Point’s data collectors only asked very basic questions because the organization’s collection tools were not very sophisticated. However, he added that they should at least ask about sexual behaviors moving forward. Looking over the data, R. Feely also stated that, while the demographic information was interesting, service utilization data did not give a clear picture of a population or its behaviors. However, he added that service utilization data was more important for groups such as Trans, for which there was little alternative data available.

M. Milsop stated that he had been unsuccessful in his search of IDU data from other organizations. Additionally, he told the group that the data from David Metzger’s study, which had been mentioned at the last meeting, was of no assistance. M. Castillo explained that the study went into a great deal of description on how difficult it was to develop an estimate of the size of the IDU population, which did not make their results very convincing. More importantly, she continued, the data was from 1998, was based on an estimate of the IDU population that was approximately half of the current estimated number, and gave no breakdowns for the population.

At A. de los Reyes’ request, M. Milsop clarified that the key indicator of risk behavior: substance use (injection drugs) factor asked how many people in the target population obtained substance abuse treatment for injection drugs or were identified as injection drug users through prevalence data. He then informed them that the factor had ranked last in the weighting exercise. M. Castillo suggested removing the factor since its inclusion was somewhat redundant and its required supporting data were either unavailable or insufficient. The rest of the committee agreed.

A. de los Reyes asked whether it would be possible for the PPC or the CPG to make recommendations that would provide them with better access to the data they required for their planning. He felt that the CPG would make a powerful point if they developed a comprehensive list of data gaps that were identified during the current process of developing the prevention plan. M. Castillo agreed and asked whether the committee should bring their idea to the CPG as an action item. However, J. Ellis noted that the PPC should develop their list of recommendations before bringing the matter to the CPG. A. de los Reyes agreed and stressed the need to make the list of recommendations comprehensive, noting that the committee had already found shortages of data for Trans and IDU populations and had not been able to retrieve any data from OAS. He also suggested looking into whether other jurisdictions struggled to gather data as such information could strengthen their case. R. Feely agreed and proposed discussing the matter with UCHAPS. M. Milsop suggested that the committee make the list of data recommendations a discussion item at a future meeting as there was still much to discuss on the current agenda. The rest of the group agreed.

M. Milsop proceeded to discuss the results of the weighting exercise, directing the group's attention to the handout which listed the scores given during the process. He reported that twenty-nine individuals had participated in the process and that none of their responses had been invalid. He then explained that G1 – G10 represented the guests who had contributed to the weighting.

M. Milsop also pointed out that the results of the weighting exercise placed the two most subjective factors – barriers to reaching the population and difficulty of meeting population needs – at the top of the list. D. Acosta responded that such a setup could be problematic because the two subjective factors were unquantifiable and, thereby, difficult to use for planning. A. de los Reyes agreed, specifying that the two factors would be difficult to use for any allocations decisions. M. Milsop reminded the group that the factors would not be the driving force behind the next prevention plan. He clarified that, even if the factors caused hard-to-reach populations to rise to the top of the weighting results, it would not necessarily affect programming. R. Feely agreed and noted that the factors still had to be weighted for each population, which would rely on the collective knowledge of the CPG and data. M. Castillo noted that the committee's process had relied on a great deal of data and was therefore not completely subjective. She said that the group would simply have to continue working as the process progressed to ensure that it remained driven by data. She suggested leaving the results of the weighting as they were and explaining the difficulties caused by the subjective factors to the rest of the CPG.

Progressing to the sixth bullet point on *Discussion Items Going Forward*, M. Milsop asked the group when they wanted to have the four population worksheets completed. He said that it would be preferable to have the worksheets completed soon so that the plan could be written early, which would allow greater time for the Health Department to reorganize the prevention system to whatever degree was necessary. He then suggested trying to complete two population worksheets at each of the next two CPG meetings. M.

Castillo supported the suggestion, noting that the CPG might not meet in June. The rest of the group agreed.

M. Milsop returned to the third bullet point on the *Discussion Items* handout, telling the committee that they would have to define the following factors – riskiness of population behaviors, difficulty of meeting population needs, and barriers to reaching the population. He also said that the committee would again have to decide which scale they would like to use for weighting the factors for each population. D. Lienau said that she preferred to use the 1, 3, 5 & 8 scale and to once again limit the use of the highest weight to three factors. The rest of the group agreed.

M. Milsop distributed copies of an excerpt from the AED Guidelines to assist the group in developing definitions for the three, previously mentioned factors. As the group read over the handout, he clarified that the CPG would be weighting the factors as they applied to each of populations, not each of the individual barriers or behaviors that could be identified. M. Castillo asked whether the recent prevention provider survey had included any questions that could help to define the factors. R. Feely noted that the needs assessments from the CSA might also have some data to define the factors. M. Milsop agreed and suggested reviewing the two data sources at the next meeting and then making decisions on how to define the factors. The rest of the group agreed.

A. de los Reyes stated that, after reading the definitions and discussions for ‘difficulty of meeting population needs’ and ‘barriers to reaching the population’ he was more uncomfortable with the two subjective factors being the highest ranked. D. Acosta agreed, saying that HIV prevalence and incidence were much better predictors for infection than the subjective factors. He pointed out that it was also contradictory to have the subjective factors ranked as the highest because they had spoken a great deal about the need for a data-driven process. He said that language in the prevention plan could make a case for having the subjective factors define an overarching structural approach to prevention in Philadelphia while the well-supported factors could define the actual prevention system. M. Castillo stated that she did not wish to alter the rankings of the factors because she believed the order showed that the CPG was not just comprised of individuals who were data-oriented. She suggested including language in the prevention plan to discuss how the differences in members’ backgrounds could have caused the subjective factors to be ranked the highest. R. Feely stated that many community members felt as though available data was not representative of the real state of HIV in Philadelphia. As an example, he noted that data on Trans populations were not even collected. As a result, he felt that it was positive to have subjective factors ranked highly because, in addition to hard data, the experience of CPG members could be used to qualify them. M. Castillo agreed, noting that there was still much to be done before the prioritization was completed. D. Acosta also supported the statement but felt that any future discussions on the matter should clearly separate what was known from what was believed to be true.

Returning to the third bullet point on the *Discussion Items* handout, M. Milsop pointed out that a list of available programs would be useful to the discussion on the ‘difficulty of

meeting population needs' factor. He then offered to ask A. Agha for other recommendations for documents or data sources that would enhance the discussion.

M. Castillo pointed out that it was easy to confuse the difference between 'difficulty of meeting population needs' and 'barriers to reaching the population.' M. Milsop agreed and said that 'barriers' described anything that kept targeted populations from accessing services while 'difficulty' described things that kept programs from being effective even though they could be accessed. M. Castillo supported the statement and added that 'barriers' were usually provider-based while 'difficulty' was population-based.

T. Clark informed the PPC that the Lit & Ed Committee would soon be holding panel discussions with prevention providers during CPG meetings in order to gather more data on programs in the city. She noted that the PPC could use the discussions to answer some of their own questions related to prioritizing populations. As a result, she asked the committee whether they wanted to add any questions to the list of those already developed by Lit & Ed. However, the PPC decided not to formally add any questions to the list as they would be able to pose their queries during the panel discussions.

The members of the PPC decided to delay discussion on 'data sources needed for allocations,' the penultimate bullet point on the *Discussion Items* handout, until their next meeting.

Old Business

None

New Business

M. Castillo suggested rescheduling the committee's next meeting in order to allow greater time for planning before the CPG meeting. The rest of the group agreed and rescheduled their meeting for Monday, May 17th, from 11:30 a.m. – 1:30 p.m. R. Feely asked whether the committee wanted to permanently reschedule their meetings for the week before the CPG meeting. The members of the PPC decided to continue discussion on the matter at their next meeting.

Announcements

- A. de los Reyes announced that there was an open position at STD Control for a Disease Intervention Specialist
- T. Clark announced that Action AIDS had two open CTR positions and that Dining out for Life was on Thursday, April 29th.

Adjournment

The meeting was adjourned by general consensus at 2:34 pm

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*March 22nd, 2010*)
- Discussion Items Going Forward
- Prevention Point Data
- Results of Weighting Process
- Step 3: Weight Factors (Excerpt from the AED Guidelines)
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Planning Priorities Committee

Meeting Agenda

Monday, April 26, 2010

1:00 p.m. – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Results and Outstanding Questions about Factors**
- **Next Steps**

Old Business

New Business

Announcements

Adjournment

*The next meeting of the Planning Priorities Committee is scheduled for
Monday, May 24th, 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, March 22nd, 2010

1:00 – 3:00 p.m.

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

Present: Dawn M. Acero, David Acosta, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Rick Feely, Denette Lienau

Staff: Aneeza Agha, Joseph Ellis, Michael Milsop

Guests: Eugenio Garcia, José Benitez

Excused: Andrew de los Reyes, David Powell

Call to Order:

D. Acosta called the meeting to order at 1:10 pm. Afterwards, each member of the group took a moment to introduce his or herself.

Approval of Agenda

After reviewing the agenda, the group approved the document by general consensus.

Approval of Minutes (*February 22nd, 2010*)

The group took a moment to review a draft of the minutes from their last meeting. D. Lienau noted that her last name was misspelled in the document. **Motion: With the correction noted, 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:

• **Outstanding Questions about Factors**

M. Milsop informed the committee that there were still a few data issues with some of their selected factors for prioritization. Concerning substance use (injection drugs) as a key indicator of risk behaviors, he said that Ricardo Tull, the Program Coordinator for OAS, had told him that there were no data available on the total number of people who had received treatment for injection drug abuse. He said that the data were unavailable because the city did not track the number of substance abuse patients and there was no way to obtain the information from insurance companies or hospitals. Since all the other factors had concrete ranges, he explained, the committee would have to decide whether to keep substance abuse (injection drugs) as a key indicator of risk behaviors and, if so, how

to measure the factor. In response to a question by D. Acosta, A. Agha clarified that the committee could decide to work with estimations as data. However, she said that they would want to give a lesser weight to any factors that were based on estimations. D. Lienau proposed keeping the factor and explaining to the CPG that it should receive a lesser weight because it was based on estimates and not hard data.

J. Benitez informed the group that research-based estimates on the number of substance users in treatment in Philadelphia were available from David Metzger, an Associate Professor with the Penn Center for AIDS Research. A. Agha asked whether the estimates could be broken down by age and gender since the factors would be decided separately for each of the target populations. D. Acosta replied that the research-based estimates should be available by age and gender and J. Benitez said that he could get the estimates from D. Metzger within a week or two.

J. Benitez suggested that the committee make a recommendation for the city to begin tracking the number of individuals receiving treatment for substance use. He said that the data would only become more important moving forward and that, by not pushing the city to collect the data, they would struggle with the same lack of data during the development of the next prevention plan. D. Acosta agreed, noting that the lifting of the federal ban on needle exchange programs would also make the data more important.

M. Castillo said that there could be another potential source of data on substance using populations in the city. She told the group that, a few years ago, an award had been released specifically for agencies dealing with substance abuse. She believed the award may have come from OAS and that the project was called Reach but, as she was unsure, she offered to investigate further. She then reiterated that, concerning substance abuse as a key indicator of risk behaviors, the committee would attempt to gather as much information as possible and then explain to the CPG that the factor should receive a lesser weight if the available data were inconclusive. The rest of the group agreed.

Concerning syphilis, the other key indicator of risk chosen by the committee, M. Milsop said that he had just received some more information on the factor from A. de los Reyes just before the meeting started. He reported that, although the disease was only tracked by gender, A. de los Reyes might be able to find out risk categories as well. Additionally, he said that the committee should investigate all types of syphilis: primary, secondary, and tertiary. M. Castillo asked whether the data on syphilis separated new infections from reinfections. She noted that, at the CHOP clinic, there was a high number of syphilis cases but, misleadingly, they were all attributed to the same few people who were often reinfected. D. Acosta believed that the data would be separated because syphilis was a reportable disease. M. Milsop said that he would investigate the matter.

D. Acosta asked whether the group had considered Hepatitis as a key indicator of risk for IDU populations. He felt that there would be a great deal of data on the disease available because he believed the jurisdiction was placing a priority on it. Additionally, he noted that attempts to include Hepatitis in HIV planning would do well for PCSI (Program Collaboration and Service Integration) efforts in the city. M. Milsop said that focusing

on individuals co-infected with Hepatitis and HIV could be a special instruction for the grantee.

M. Milsop informed the group that, according to Kathleen Brady, there was no information on the factor ‘multiple high risk behaviors’ because the Health Department did not currently collect it. As a result, he said that, if the group wanted to maintain the factor, they would have to develop a definition and a source of data for it. He then reminded the committee that, after the weighting process, they would be attaching the social drivers they had previously selected to each of the populations, which could be viewed as an alternative to multiple risk behaviors.

D. Lienau asked whether the data used to support the social drivers could also be used for multiple high risk behaviors. However, M. Milsop pointed out that the social drivers were too different from multiple risk behaviors for their supportive data to be interchangeable. As an example, he noted that lack of education, a social driver, could not be viewed as a risk behavior.

A. Agha told the committee that, if they decided to remove ‘multiple high risk behaviors’ from the list of factors due to the lack of supportive data, they could include a write up in the plan on the effects of multiple risk behaviors in order to keep it in consideration during the creation of the next prevention system. M. Castillo and D. Acosta both supported the idea, saying that it was probably the best option available due to the lack of supportive data. M. Castillo clarified that the factor ‘multiple high risk behaviors’ should be removed from the list and the rest of the group agreed.

M. Milsop directed the group’s attention to the two handouts entitled *Large Scale Rating Model for Target Populations*. He explained that, after the CPG had weighted the factors, they would then rate each of them as they pertained to each of the target populations based on available information. He noted that, as the sheets were currently written, the target populations would be outlined by risk category and by gender. However, he said that the group could also decide to define the populations by just risk category or gender, noting that there were advantages and disadvantages for each system. As an example, he said that, if they decided to use only risk categories, there would be less worksheets to complete but the process would not be as clear and Trans populations would likely be rated lower since data on the population were limited. A. Agha said that, if the group decided to categorize the populations by gender alone, they might want to select a score for Trans populations since there would not be any data available for them. She then informed the group that, during the development of the last prevention plan, the target populations had been defined by age (youth and adult) and risk category. M. Castillo felt that, for the second worksheets, the populations should be categorized by both risk behavior and gender for the sake of clarity. The rest of the group agreed.

Returning to the Worksheet entitled *Weighting Factors for Target Populations*, A. Agha reminded the committee that they would have to stress to the CPG that the more subjective factors should receive a lower weight because they lacked substantiated data for support. R. Feely said that there was some information available on the difficulty of meeting the needs of Trans populations. D. Acosta also reported that AACO had just

completed a needs assessment for MSM populations in the city, which he said would be presented to the CPG in the near future. M. Milsop noted that, despite what had been done for Trans and MSM, there still were no needs assessments for the other targeted populations. A. Agha pointed out that, even though the office could construct some level of needs assessment for the remaining populations using the CSA and information on available programs, the resulting data would still not be as substantiated as what were available for HIV/AIDS prevalence and incidence. As a result, she continued, information on ‘difficulty of meeting population needs’ and ‘barriers to reaching the population’ would still be relatively subjective.

D. Acero noted that a lack of data could be considered a barrier to reaching a population. A. Agha supported the statement and noted that, as J. Benitez had suggested earlier, the committee could make a recommendation about the need to collect specific data so that it would be included in the next prevention plan.

- **Allocation Percentages**

M. Milsop informed the group that, after the populations had been prioritized, the committee would have to focus on allocating percentages of funding to each of the targeted populations. He reminded the committee that, during the development of the last prevention plan, the group had opted to allow the Health Department to make the allocations decisions because data on HIV prevalence and incidence were not available. However, he suggested that the committee make the decision on their own this time and noted that the data-driven prioritization of the populations would make the process much easier. R. Feely asked whether the populations for the percentages would be categorized by risk or gender. M. Milsop replied that the categorization used would be up to the committee. R. Feely asked if the allocations percentages would be driven by the prioritization of the populations. M. Milsop responded that, again, the decision was the committee’s to make.

D. Lienau stated that she was concerned about LEP (Limited English Proficiency) individuals being underrepresented in community planning. As a result, she said that she wanted to address the matter at a CPG meeting. M. Milsop clarified that the concern over LEP populations could be included in the prevention plan as a recommendation. A. Agha agreed but suggested that D. Lienau gather some supportive data before initiating the conversation at a CPG meeting.

A. Agha informed the group that the care system had recently used the same weighting process that the committee had just agreed upon for the factors. She reported that, after the activity, some individuals had complained about the process, feeling that limiting the number of times the top weights could be used was equal to a forced decision. As a result, she asked the group whether they wanted to make any changes to their process. D. Lienau felt that no changes were necessary, noting that three uses of the highest weight was a third of the total factors. The rest of the group agreed.

R. Feely asked if he or other members of the CPG had to be present at the meeting in order to participate in the weighting process. A. Agha replied that she was unsure

whether the Bylaws made any specific dictates about the weighting process. As a result, she said that she would check and report back before the CPG meeting.

As the conversation was drawing to a close, M. Milsop offered to develop a Powerpoint presentation for the weighting in order to walk the members of the CPG through each stage of the process. The rest of the committee agreed that a presentation would be helpful for the process.

Old Business

None

New Business

A. Agha told the group that if anyone was interested in more information on the prioritization process, the OHP could provide them with such a document.

Announcements

R. Feely announced that TIP would become an independent organization that was fully run by Trans individuals in the spring.

Adjournment

The meeting was adjourned by general consensus at 2:07 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*February 22nd, 2010*)
- Weighting Worksheet 2010
- Weighting Model for Heterosexual Male Populations 2010
- Weighting Model for Heterosexual Female Populations 2010
- OHP Meeting Calendar

	Barriers of Reach.	Riski- ness of Pop.	Diff. of meet.	HIV Incid.	HIV Prev.	Key Indic: STD	AIDS Incid.	AIDS Prev.	Key Indic: IDU
1	5	8	3	5	8	8	3	5	3
2	8	8	5	5	8	3	5	3	5
3	5	5	8	8	5	8	5	3	3
4	5	5	3	1	1	3	1	1	1
5	5	8	5	8	5	5	8	1	3
6	5	8	5	8	3	5	3	3	8
7	8	5	8	5	5	5	5	5	5
8	3	8	5	3	8	8	1	1	5
9	8	5	8	1	5	5	1	5	8
10	8	5	8	5	8	5	5	5	3
11	8	5	3	8	5	8	5	3	3
12	8	3	5	8	8	3	5	5	3
13	8	3	5	5	8	5	5	8	5
14	8	3	8	8	5	5	5	5	5
15	8	5	5	8	8	5	3	3	3
16	8	8	5	8	5	5	5	3	1
17	1	8	1	8	8	1	3	3	1
18	8	5	5	5	5	5	8	8	5
19	5	5	8	5	5	5	5	8	3
G1	5	5	8	5	5	8	5	5	5
G2	1	8	3	5	5	8	5	8	3
G3	5	8	8	5	3	8	5	3	3
G4	8	8	3	5	5	5	3	3	1
G5	8	8	5	5	5	8	3	3	1
G6	5	5	3	3	5	3	8	5	3
G7	8	8	5	3	3	1	1	1	3
G8	5	8	5	5	3	8	5	3	3
G9	5	1	8	5	5	5	8	5	8
G10	8	5	8	5	5	5	5	3	3
total	180	174	159	158	157	156	129	117	106
N	29	29	29	29	29	29	29	29	29
Score	6.2069	6	5.4828	5.4483	5.4138	5.3793	4.4483	4.0345	3.6552

Prevention Point Data

Here is a brief summary of what we know in Philadelphia through Various studies conducted at Prevention Point:

- PPP currently Serves 7, 100 Clients.
- We estimate that there are about 100,000 IDU's in Philadelphia:
- 2, 500 of those are Syringe Exchange Participants (SEP) of those here is the breakdown

o Breakdown:

▪ Race:

- Black: 22.4%
- White 60%
- Latino 13%
- Asian .3%
- Other .3%
- Non classified 3.9%

▪ Gender:

- Male: 75.5%
- Female: 20.8%
- Trans (MTF): 0
- Trans (FTM): .1%
- Not identified: 3.3%

▪ Age:

- 18-25: 8.7%
- 26-35: 29.1%
- 36-45: 21.6%

- 46-55: 21.2%
- >55: 16%
- Missing Age: 3.4%
- Drug used: Injected
 - Heroin: 72.9%
 - Speedball: 2.9%
 - Cocaine: 6.3%
 - Speed: .5%
 - Insulin: .5%
 - Steroids: .1%
 - Hormones: .6%
 - Other: 11.2%
 - Unknown: 5%
- Some additional Information
 - o 51% of the clients have no health insurance
 - o 48% have Medicaid , Medicare
 - o 1% unknown
 - o 49% are homeless

Discussion items going forward:

- Guests completing worksheets
- Results of weighting exercise
- Defining- Barriers, Riskiness & Difficulty of meeting needs
- Using STD data
- Evaluating IDU data
- Timeline for completing population worksheets
- Data sources needed for allocations
- Questions for panel discussions e.g.: Difficulty of meeting needs? Barriers of meeting needs?

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.

FACTOR	DEFINITION	DISCUSSION
	Sociodemographic Characteristics	This factor, which can be measured in several different ways, examines complex issues that may affect the provision of HIV prevention interventions.
Size of target population	The estimated size of the target population in the geographic area where the program will be implemented.	Estimating target population size has been difficult for many project areas. CDC recommends using a World Health Organization methodology available at: http://www.who.int/docstore/hiv/Core/Chapter_9.10.html
Difficulty of meeting population needs	The complexity of needs and whether the population has been reached by current programs, whether service providers have capacity, etc.	<p>CPGs may use a variety of data sets, such as racial/ethnic composition, population density (urban, rural, frontier), education (especially level of completion and literacy rates), socioeconomics, service utilization data (services mapping, services access and utilization, etc.) to determine risk in a population.</p> <p>Review all available data and information sets, including the results of the gap analysis. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p>
Barriers to reaching the population	The extent to which barriers to providing HIV prevention programs exist in a high-risk population.	<p>CPGs may consider the following sociodemographic characteristics when looking for indicators of barriers — cultural, linguistic, socioeconomic status, family or social network structures, gender and sexual orientation studies, religion and spiritual beliefs, consumer preferences, provider preferences, and community norms and values. Studies that focus on knowledge, attitudes, behaviors, and beliefs will also provide information about barriers.</p> <p>Review all available data and information sets. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p>