HIV Integrated Planning Council
Thursday, May 10, 2018
2-4pm

Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Katelyn Baron, Henry Bennett, Michael Cappuccilli, Keith Carter, Mark Coleman, Lupe Diaz, Alan Edelstein, Dave Gana, Pamela Gorman, Gus Grannan, Sharee Heaven, La'Seana Jones, Gerry Keys, George Matthews, Lorett Matus, Nicole Miller, Jeanette Murdock, Nhakia Outland, Christine Quimby, Erica Rand, Ann Ricksecker, Samuel Romero, Clint Steib, Coleman Terrell, Gail Thomas, Adam Thompson

Excused: Juan Baez, Kevin Burns, Tiffany Dominique, Peter Houle, Leroy Way, Melvin White

Absent: Dorothy McBride-Wesley, Terry Smith-Flores, Lorrita Wellington, Jacquelyn Whitfield

Guests: Sebastian Branca, Ricardo Colon, Chris Chu, Janice Horan, Casey Johnson, Alex Shirreffs, Ameenah McCann-Woods, Christopher Wilson, Robert Woodhouse

Staff: Mari Ross-Russell, Debbie Law, Briana Morgan, Stephen Budhu

Call to Order: S. Heaven called the meeting to order at 2:07pm. Those present then introduced themselves.

Approval of Agenda: S. Heaven presented the agenda for approval**. Motion:** D. Gana moved, G. Keys seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes: S. Heaven presented the minutes for approval. **Motion:** S. Heaven moved, C. Steib seconded to approve the minutes. **Motion Passed:** All in favor.

Public Comment: None

Report of Chair: C. Terrell stated the Recipient has reviewed the budget for fiscal year 2017-2018. Upon review he states there was no underspending from the fiscal year.

Report of Staff: D. Law stated new member orientation preceded today's HIPC meeting, and those new members were in attendance. D. Law welcomed the new HIPC members to their first Planning Council meeting and encouraged the council to do so as well.

B. Morgan informed the committee the Integrated HIV/AIDS Planning Technical Assistance Group released their new Ryan White Part A Planning Council Primer. She explained the Primer is designed to help Ryan White HIV/AIDS Program Part A Planning Council members to understand the roles and functions of Planning Councils. The Primer explains what Ryan White HIV/AIDS Planning (RWHAP) does and what Planning Councils' role are in the planning decision making process. Copies are available in the office or online at www.careacttarget.org.

Special Presentations:

- **Information Services Unit─ *Sebastian Branca, AACO***

S. Branca greeted the council and explained his role at the Recipient. He explained he manages the Information Services Unit and they focus on quality management for the EMA. Quality management is the data-based review process of Ryan White services within the EMA. After review, guidance is sent

back to providers on how they can improve the services that they provide, whether it be a procedural process or an administrative one. Quality management (QM) includes:

- Quality assurance
- Outcomes monitoring and evaluation
- Continuous quality improvement (QI)

S. Branca stated the goal of the EMA's QM program is to use high quality data to continually improve access to high quality clinical HIV care. He explained in accordance with national goals, initiatives are being directed at all stages of the care continuum. Stages include diagnosis, linkage, retention, and viral suppression. Under the diagnosis and linkage stage quality management is focused on the CDC-funded 18-1802 and 15-1509 grants, and QI on prevention processes and systems. Under the retention and viral suppression stage quality management is focused on quality improvement projects (QIPs) in Ryan White outpatient/ambulatory health services and medical case management (MCM) and implementation of QI on health disparities.

S. Branca reported as of 2017, 86.1% of PLWH who are enrolled in Ryan White are virally-suppressed. This percentage has increased from 2016, he noted the difference was about 1000 people.

S. Branca reviewed the QI process within the EMA. The process of QI is as follows:

1. Collect and analyze data to assess client outcomes

    a. Local and HAB performance measures
    b. Other available data

2. Use data to improve client outcomes

    a. Provider use of CAREWare reports
    b. Ongoing feedback to providers
        i. Benchmarking and trends
    c. QIPs
    d. Regional QI Meetings
    e. Technical assistance and training with providers

S. Branca reviewed the outcome monitoring procedure within the EMA. Outcome monitoring is divided into three subcategories that include: performance measures, access to care, and health disparities. He noted the Recipient is updating its measures for implementation for outpatient ambulatory health services and medical case management. These changes may be in effect by summer 2018. He stated the Recipient evaluates access to care by conducting "secret shopper calls" that include feedback and corrective actions if necessary. Health disparities are connected to QI to improve health equity.

S. Branca expanded on the performance measures subcategory. He explained there are currently 26 measures for outpatient/ambulatory health services; however, it will be reduced to 23, after the summer update. There are 7 medical case management performance measures, and 3 for oral health services. Measures for all other services and health equity data are calculated from the Ryan White database on viral suppression and gap in medical visits.

S Branca reviewed the monitoring and feedback process within the EMA. He stated there is a strong emphasis on feedback in the EMA. Data validation offers opportunity for feedback and identification of training needs. Feedback reports that are issued to service providers include:

- Data visualization highlights strengths and needs
- Benchmarking data contextualization
- Assistance in prioritizing quality improvement projects

S. Branca explained consumers are actively involved within the quality improvement (QI) process. Consumers are on QI teams or committees. The Recipient also uses input from Consumer Advisory Boards during the QI process, as well as consumer focus groups. Client surveys are used to obtain client input relating to causes for low performance or proposed action steps.

S. Branca reviewed quality improvement projects (QIP) process. He explained outpatient and ambulatory health service providers and medical case management providers submit QIPs to the Recipient annually, and they are updated quarterly. The Recipient reviews all QIPs and provides written feedback. In 2017, the Recipient reviewed 70 QIPs in total. S. Branca explained from QIP data review key measures are defined and automatic thresholds are set for QIPs annually. In 2017 the focus was on viral load suppression, care retention, cervical cancer screening, and gonorrhea screening for men who have sex with men (MSM). Programs may still select other measures for improvement in addition to required QIPs.

S. Branca reviewed QIP efficacy. He explained over the past four years, 81% of QIPs for outpatient/ambulatory health services have resulted in better outcomes. The average improvement from outpatient/ambulatory health services QIPs in 2016 were 2% for viral load suppression, 10% for cervical cancer screening, and 29% for MSM receiving gonorrhea screening. The average overall improvement for services with QIPs in 2016 was 15% and without QIPs was 1%.

S. Branca reviewed viral load suppression QIPs in the EMA. He reiterated the viral load suppression rate in Philadelphia is 86.1%, which ranks first for all large EMAs. A large EMA is defined as an EMA with 10,000 or more PLWH. He stated in 2017, 19 out of 23 adult outpatient/ambulatory health services programs in the EMA met the National Goal of 80% or higher viral load suppression. He noted 4 programs had a viral load suppression rate of 90% or greater, 12 programs had 85% or higher viral load suppression, and the 2 of the 4 programs that did not meet the goal were between 79.5%-80.0%.

S. Branca concluded his presentation by reviewing the quality management initiatives for 2018. Initiatives include:

- Implementation of updated outpatient/ambulatory health services measures portfolio
- New medical case management model and measures
- Development of provider QM Plans
- QI on risk reduction measures, viral load suppression and Hepatitis C for outpatient/ambulatory health services
- QI on retention in care, viral load suppression and service care plans for medical case management
- Regional initiative around health disparities
- Reconfiguring and streamlining EMA's QM Plan

A. Ricksecker asked even though medical case management, outpatient/ambulatory health services, and oral health services were the main focus of quality improvement are there initiatives for other services such as transportation or foodbank/home-delivered meals that could help with HIPC priority setting. S. Branca replied there are smaller quality insurance measures that are in place for other services including transportation, he just did not present them today due to the interest of time. Since the viral load suppression is a main focus of quality improvement the Recipients collects data from suitable service

providers. A food bank provider may not be the best setting to collect viral load suppression data. He added there are plans to review transportation service providers and to issue quality improvement measures as necessary.

M. Cappuccilli asked if performance evaluation data was available for oral health providers. S. Branca replied it was available, it is often not sent out because many of the oral health providers have great performance. He noted the Recipient does have higher standards for quality improvement than that of HRSA. He stated if there was interest from oral health providers he would be happy to send out data.

C. Johnson asked how the quality assurance measures will change for the new medical case management model. She referenced his slide and asked if "regional initiative around health disparities and reconfiguring and streamlining EMA's QM Plan" are interrelated specifically to medical case management. S. Branca replied, yes, the Recipient is currently wrapping up its quality management cycle for medical case management and will review observations and issue guidance at some point in the future.

A. Thompson mentioned feedback from the Information services unit are great. He stated as a consultant for a quality assurance board they recommend providers only take on 1-2 quality improvement projects at a time. With more than two it is felt that it can lead to disruption of a system due to the staff time associated. In this case it seems as though agencies are being asked to take on many quality improvement projects. He asked how the Recipient keeps tabs on larger organizations that have multiple funding sources. Those organizations may submit many quality improvement projects but not actually carry through with any of them. S. Branca replied the Recipient tries to coordinate its activities with Part B and C Recipients. With coordinated effort the Recipient tries to make sure providers are not taking on too many quality improvement projects and also make sure they are actively working on their proposed projects. In most cases agencies only have 1-2 quality improvement projects, but that is not the case in New Jersey. A. Thompson suggested assessments could be given at site visits that look for the number of projects an agency is doing and how they are working towards them.

A. Thompson referenced a prevention quality improvement measure that is about sexual history. He stated in many cases the question "Did you use condoms during your last sexual encounter" is asked unaccompanied by other questions. He stated there should be exclusion criterion for asking that question because it is no longer valid in some situations such as PrEP use or undetectable (equals untransmittable). He also suggested that question should not be asked alone it should be accompanied with other questions and definitely not asked first. S. Branca agreed and stated Dr. Brady has sent out guidance that that question should be asked as part of a comprehensive risk reduction model. A. Thomas informed the council the AETC will host an integrated sexual health training on June 15, 2018. N. Outland stated the question is being asked that way because providers may not feel comfortable or know how to properly conduct a sexual health assessment with their client. S. Branca stated this topic will be discussed during the regional quality management meeting in the summer. At the meeting Dr. Brady will present on sexual history and present guidance.

- **Client Services Unit ─ *Ricardo Colon, AACO***

R. Colon greeted the council and explained what the Client Services Unit was. The Client Services Unit (CSU) is responsible for the intake to HIV positive individuals who are looking to link to medical case management as well as a place where clients can file grievances with the Recipient. The mission of the CSU is as follows:

- Help people living with HIV and at-risk individuals understand their needs and make informed decisions about possible solutions

- Advocate on behalf of those who need special support
- Reinforce clients' capacity for self-reliance and self-determination through
  - education
  - collaborative planning
  - problem solving

R. Colon reviewed medical case management services within the EMA. He explained the HRSA definition for medical case management is "The provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Includes all types of encounters (e.g. face-to-face, phone contact and any other forms of communication)"

R. Colon listed the key activities for medical case management within the EMA. Activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services
- Continuous client monitoring to assess the efficacy of the plan
- HIV treatment adherence counseling
- Client-specific advocacy
- Assessment of client needs is ongoing
- Re-evaluation of the care plan at least every six months

He stated there is a distinction between medical case management and non-medical case management. Nonmedical case management is more of a navigation model. According to Policy Clarification notice 16-02, "Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services." He noted the EMA allocates $8 million to Medical case management from Ryan White Part A/B and Minority AIDS Initiative. He explained in 2017 Recipient funded medical case management providers provided care to 8082 clients. 1976 intakes were completed through the CSU. In total the Recipient funds 23 medical case management service providers.

R. Colon reviewed the responsibilities of the CSU. Responsibilities include:

- Information and referral services for all other AACO funded programs
- Feedback about funded providers
- HIV Housing Advisory Meetings (DHCD)
- Homeless Death Reviews (MEO)
- Coordinated entry and assessment-based housing referral system (CEA-BHRS) Workgroups (OHS)
- HIPC Positive Committee
- Transitional Planning Initiative

R. Colon expanded on the CEA-BHRS initiative. He explained the program was run through the Office of Homeless Services and it is a process designed to coordinate program participant access, assessment, and referrals to homeless assistance services and housing. CEA-BHRS shifts the focus from a strategy that says "Should we accept this household into our program?" to one that says "What housing /service

assistance is best for each household and quickly ends their housing crisis permanently?" While Implementing CEA-BHRS alone does not increase housing, services, or other resources, the CEA-BHRS process helps ensure resources in the homeless system are used as effectively as possible.

R. Colon notified the council the CSU is available from 8am-5:30pm Monday to Friday. As of May 8, 2018, 40 people are on the CSU waiting list for medical case management. There is a waiting list due to the systemic capacity of providers.

R. Colon reviewed the demographic of 2017 CSU intake data. In 2017, 65% of clients were male, 31% were female, 4% were transgender. 70% identified as black, 15 % identified as white, and 14% identified as Hispanic. The most common mode of transmission reported was heterosexual contact at 39%, followed by MSM at 32% and nondisclosed reason at 13%. 80% of all clients reported having some form of insurance with 61% being insured through Medicaid.

R. Colon reviewed the number of intakes and need at intake for 2017. In total the CSU had 1976 total intakes, 1291 of them were male, and 604 were female. The most common need at intake identified was housing, with an average of 49.2% of all intakes seeking housing assistance. The next most commonly reported need at intake was treatment adherence.

R. Colon stated the AACO housing services program and its waitlist has transitioned to the Office of Homeless Services. The waitlist is 10 to 12 years for rent burdened and 2 to 3 years for homeless. He stated the city is no longer taking housing applications for those who are rent burdened. He stated there may be more opportunities to house people with the CEA-BHRS initiative and there will be a new housing application process in the near future. Through the CEA-BHRS initiative the housing process will be more streamlined and offer a standardized application for all housing needs. CEA-BHRS also offers homeless assistance services that include:

- Homeless Prevention
- Emergency Housing
- Transitional Housing
- Rapid Re-Housing
- Permanent Supportive Housing

R. Colon concluded his presentation by reviewing the consumer feedback process. The process includes:

- Addressing client feedback regarding any and all AACO funded Care/Prevention services
- All AACO funded subrecipients must have a grievance process
- Subrecipients must share this process with all clients
- Clients have the option of calling the Health Information Helpline

A. Ricksecker how CEA-BHRS can be supported with Part A funds. R. Colon replied the CEA-BHRS initiative does not fall under the Part A purview now, but he will bring up that the Part A planning body is willing to help at future CEA-BHRS work group meetings.

A. Ricksecker stated the Part A system should review its responsibility to people who inject drugs. She noted that housing is a basic need and it attributes to many deaths of PWID who are also PLWH. C. Terrell stated the Recipient is concerned that an HIV or HCV outbreak will spread due to the opioid crisis. The Recipient is working with other agencies to ensure they have the ability to identify and investigate potential outbreaks as well as the capacity to deal with them. The Recipient is aggressively working on controlling the opioid epidemic and viral suppression of both HIV and HCV.

- **HIV/Hepatitis-C Virus** – *Alex Shirreffs, HIV/HCV Project Coordinator*

A. Shirreffs greeted the HIPC and introduced the "C-YA" initiative. C-YA is Philadelphia EMA's Plan to Connect our Co-infected Community to a Cure for Hepatitis C. She stated before C-YA Philadelphia was a leader in viral Hepatitis surveillance as well as Hepatitis surveillance infrastructure. She explained Hepatitis C Allies of Philadelphia (HEPCAP) coalition is a city wide collective dedicated to improving the continuum of Hepatitis C prevention, diagnosis, care, and support services with the goal of eliminating Hepatitis C from the City of Philadelphia.

A. Shirreffs stated C-YA aims to identify systems-level opportunities to increase capacity to provide hep screening, care & treatment in the HIV infrastructure. C-YA also has 4 target areas that include: data and evaluation, training and capacity building, re-engagement in care, and service integration. For data and surveillance C-YA will use both quantitative and qualitative sources.

Quantitative sources include:

- Surveillance Databases
- Hepatitis Registry
- EHARS
- CAREWare
- Data Activities:
    - Routine Monthly Matches
    - Data-To-Care Integration (CoRECT)
- CAREWare Measures and Feedback Reports

Qualitative sources include:

- Clinical Site Visits
- HepCAP & Community Meetings
- Focus Groups
- Training Feedback
- CoRECT Case Conferences
- Cross-Program Meetings

A. Shirreffs reviewed the Hepatitis C Measures within CAREWare. Measures include Hepatitis C screening, Hepatitis C RNA screening if initial Hepatitis C screen was positive, and Hepatitis C treatment prescribed. She listed the strengths and weaknesses of the CAREWare measures.

Strengths include:

- Ability to create and update a HCV continuum
- Buy-in from AACO leadership to adapt CAREWare measures
- Provider flexibility adapting to new HCV measures
- QI process allows us to monitor HCV services and provide feedback

Weaknesses include:

- Surveillance limitations in PA and NJ

- Tracking outcomes for clients getting care from non-RW providers

- Creating a feedback loop with community partners to share data in timely way (ex: new infections)

A. Shirreffs reviewed training and capacity building under C-YA. She stated the goal was to encourage full integration of Hepatitis C clinical services from testing through cure at HIV care sites. She stated the care system is shifting towards using reflex testing for Hepatitis C screening. Reflex testing is the immediate follow up HCV RNA screening of an individual who received a positive HCV antibody test. In many cases those who have positive reflex tests can be linked to care the same day. She stated in 2016, of the 19 HCV testing sites, 8 used reflex testing. As of 2018, 15 of the 19 HCV testing sites now perform reflex testing. Of the 22 HCV care sites, 14 offered on site treatment in 2016, and 18 offered on site treatment in 2018.

A. Shirreffs listed the strengths and weaknesses of the capacity building under C-YA.

Strengths include:

- Coordination by Mid-Atlantic AETC
    - **17** HIV practice site visits
    - **5** providers from **4** sites trained
        - **2** new treatment sites
- Showcasing local providers and their best practices
    - Variety of models to share
    - Empowering clinicians to be leaders

Weaknesses include:

- Ongoing support for new treaters
- Outdated information about cost, access, etc prevents some providers from treating Hep-C
- Invite non-RW clinicians to participate in trainings
- Training topics to consider:
    - Monitoring liver health after cure
    - Harm reduction & drug user health

A. Shirreffs reviewed linkage to care under C-YA. She stated C-YA has prioritized co-infected HCV patients with HIV using CoRECT process. She stated CoRECT uses data from 7 sites, provider feedback, and DIS staff to re-engage clients. C-YA has adopted that same process and also cross trained DIS who do patient outreach in HCV. C-YA will also track care retention and treatment outcomes.

A. Shirreffs reviewed the re-engagement to care initiative under C-YA. Re-engagement to care would consist of data, discussion, and DIS. Data would include monthly uploads and matches between care sites and the Recipient. Discussion would consist of monthly case conferences with care sites either in-person or conference call. DIS would include cross-training of personnel to work with HCV positive clients.

A. Shirreffs listed the strengths and weaknesses the re-engagement to care initiative.

Strengths include:

- Integrated Hep-C into CoRECT protocols and procedures

- Piloted Hep-C in CoRECT at 1 site, 16 linked to care clients identified as needing DIS outreach

- 3-4 more sites in June/July
- Cross-trained 4 CoRECT DIS
    - Built Hepatitis C fluency among other Recipient staff

Challenges and Opportunities include:

- CoRECT is time and resource intensive process
- Clearly defining expectations of role case managers re: Hep-C
- Referring clients back into a "broken system"
- Reaching clients who are NOT engaged at all in HIV care or services

A. Shirreffs concluded her presentation by listing C-YA's next steps for data and surveillance, training and capacity building, and service integration.

- Data & Surveillance:
    - Assess new/re-infections; consider prevention strategies
    - Integration of Hep-C data-to-care activities at additional CoRECT sites
    - Annual Hep-C Screening Measure added into CAREWare
- Training & Capacity Building:
    - Outreach to case managers and clients
    - How can Hep-C be meaningfully but manageably incorporated into case managers' role
    - Co-infection prioritized for intensive case management in new model
    - Certificate program to ensure subset of MCM have Hep-C fluency?
- Service Integration
    - Identify strategies for AACO and providers to address drug user health
    - Collaborate with other program areas: HEP, STD, Opioids, etc

S. Romero commented he hopes that the new MCM model will allow for more customized care for those who are co-infected with HIV and HCV.

C. Steib asked how a site can get equipped for reflex testing. A. Shirreffs replied according to site visits many providers seem to already have the capacity for reflex testing. These providers who do not use reflex testing may be either unaware of it or unsure how its used.

A. Thompson asked if there is a cost benefit analysis of the annual measure of Hepatitis C screening compared to screening every few years. She explained C-YA was hoping to learn more about this and noted North Carolina and Louisiana are moving to recommend annual screenings. Possibly in future Philadelphia can gather information from those states to perform a cost benefit analysis.

Action Items: None

Discussion Items:

- **Planning Council Co-Chair Structure**

K. Baron stated the Executive Committee has discussed co-chair structure since the HIPC has integrated. K. Baron reviewed the current co-chair structure as per the bylaws. She stated "The Planning Council shall be chaired by four Co-Chairs. At least one Co-Chair shall be HIV-positive, and at least one Co-Chair shall represent the HIV prevention service system. No Co-Chair shall be a fiscal agent through which the City of Philadelphia contracts for Part A services or administrative support but may be an

employee of an agency that is a recipient of Part A funds. Three of the Co-Chair positions shall be elected annually and shall serve terms of three years, which will be staggered. The fourth Co-Chair will be selected by the recipient and will act as the governmental Co-Chair." She noted the Executive Committee recommends using a 3 co-chair structure. One of the co-chairs will be a "consumer" which is not necessarily a PLWH but someone who uses prevention services, one will be a member from the community, and the governmental based co-chairs.

B. Morgan stated the co-chair terms would be 2-year staggered terms under this recommendation, under current structure the terms are 3 years. She noted the governmental co-chair is appointed with an indefinite term length.

G. Thomas asked why the current structure of 4 was no longer being recommended. K. Baron responded it has been difficult to get all 4 co-chairs to attend and it was hard to get interest from members to run for the chair position. She explained the current structure is four, but four co-chairs have not been present at a HIPC meeting in quite some time.

N. Outland asked how prevention would be represented under the proposed 3 co-chair structure. K. Baron stated care and prevention are often intertwined. C. Terrell replied care and prevention services are being offered by providers now so care and prevention may not need to be distinguished from one another. A. Ricksecker stated there was concern in the past that prevention would not be represented but that may not be the case now. C. Steib stated there still is a Prevention Committee so the voice of prevention would not be lost during HIPC meetings.

K. Baron stated the conversation about PLWH representation and the redefinition of "consumer" will be discussed in the upcoming May 2018 Positive Committee meeting. The HIPC will await their feedback before moving forward with this recommendation from the Executive Committee.

M. Cappuccilli suggested the 3 co-chair structure may make it hard for attendance; in case one co-chair is absent there will be only two to chair the meeting.

M. Cappuccilli asked how the co-chair recommendation would be formalized. K. Baron stated first the Positive Committee would have their discussion and present their recommendations to the Executive Committee. At that point the Executive Committee will recommend the given course of action to the HIPC and then it will be voted upon. Upon approval vote, the HIPC bylaws will be amended after a 30-day comment period.

Report of the Committees:

Comprehensive Planning Committee─ Tiffany Dominque and Adam Thompson, *Co-Chairs*

A. Thompson stated the committee will meet next Thursday, May 17, 2018 from 2-4pm. The committee is reviewing the integrated plan and its data measures. The committee will also discuss the meeting times and meeting days of the committee.

Executive Committee

K. Baron stated the Executive Committee met in May 2018 and they discussed co-chair structure, conference calling and committee meeting times and structure. No formal recommendations from the Executive Committee have been made pertaining to conference calling or committee meeting times.

Finance Committee─ Alan Edelstein and David Gana, *Co-Chairs*

A. Edelstein welcomed the new members. He provided a brief overview of the Finance Committee which included their meeting times and duties. He stated the Finance Committee was responsible for monitoring the fiduciary duties of the Recipient, reviewing the annual EMA budget, hosting the allocations process, and recommending reallocation requests to the HIPC. He stated the committee meets the first Thursday of the month and the committee meets as needed.

A. Edelstein explained during the May 2018 Finance meeting the committee discussed the allocations materials are included in the meeting packet. From the discussion the committee decided to ask for a review of the allocation materials provided which would include: a description of what was presented in the meeting packet, the purpose of materials in the meeting packet, an explanation of the budgets presented, specifically that funds can be allocated to any service category based on need, and a review of the level-funding budget meaning. He explained in many cases members are unaware of what is presented during allocations meetings and with this review members can make information-based decisions about funding and fiscal budgets. The committee also asked for a review of service categories within the EMA and regional context as to why there are funding differences across regions.

Needs Assessment Committee─ Gerry Keys, *Chair*

K. Baron stated Needs Assessment still meets with Comprehensive Planning.

Nominations Committee─ Kevin Burns and Michael Cappuccilli, *Co-Chairs*

M. Cappuccilli stated the Nominations Committee did not meet in May 2018 because of new member orientation. The committee usually meets on the second Thursday of the month from 12-2 pm.

Positive Committee─ Keith Carter and Jeanette Murdock, *Co- Chairs*

K. Carter stated the committee meets on the second Monday of the month from 12-2 pm. An RSVP with an Office of HIV planning staff member is needed because lunch is provided. The committee has not yet met in May, but in its April meeting the committee discussed ideas for recruitment at the Prevention Summit in June 2018.

Prevention Committee─ Lorett Matus and Clint Steib, *Co- Chairs*

C. Steib stated the Prevention Committee did not meet in April 2018, but will meet next on May 23, 2018 from 2:30-4:30 pm. The committee is currently reviewing the integrated plan and data measures.

Old Business: None

New Business: L. Diaz stated she was concerned about a senior member's attendance. Usually that member is in attendance and stated she was worried. M. Ross-Russell she has contacted that particular member and stated they were unable to come due to health concerns.

Announcements: D. Gana announced **r**egistration for the Prevention Summit is now open online, if you want to register visit www.aidseductaionmonth.org. if you wish to register for more than one event a separate registration is required for each event you wish to partake in.

Adjournment: Meeting adjourned by consensus at 3:58pm.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar