HIV Integrated Planning Council
Thursday, November 8, 2018
2:00 p.m. – 4:00 pm.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Juan Baez, Katelyn Baron, Henry Bennett, Michael Cappuccilli, Keith Carter, Mark Coleman, Lupe Diaz, Alan Edelstein, David Gana, Gus Grannan, Sharee Heaven, Gerry Keys, Lorett Matus, Nicole Miller, Nhakia Outland, Christine Quimby, Joseph Roderick, Samuel Romero, Eran Sargent, Clint Steib, Gloria Taylor, Coleman Terrell (AACO), Adam Thompson, Melvin White, Jacquelyn Whitfield, Steven Zick

Excused: Maisaloon Dias, Tiffany Dominique, Pamela Gorman, Peter Houle, Dorothy McBride-Wesley, Erica Rand, Zora Wesley

Absent: Johnnie Bradley, Janice Horan, La'Seana Jones, George Matthews, Jeanette Murdock, Jason Simmons, Terry Smith-Flores, Gail Thomas, Lorrita Wellington

Guests: Kathleen Brady (AACO), Chris Chu (AACO), Ronald Lassiter, Ameenah McCann-Woods, SayBria Nelson, Nicole Risner, Kim Wentzel, Robert Woodhouse

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Stephen Budhu

Call to Order: S. Heaven called the meeting to order at 2:08 p.m. Those present then introduced themselves and participated in an ice breaker activity.

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

Approval of Minutes:
S. Heaven presented the October 11, 2018 minutes for approval. **Motion:** J. Whitfield moved, D. Gana seconded to approve the minutes. **Motion Passed:** All in favor.

Report of Chair:
C. Terrell reported the 2017 HIV surveillance report was now available, and that copies were available at OHP.

Special Presentations:

- **HIV Molecular Surveillance –** *Dr. Kathleen Brady, AACO*

K. Brady noted that the slides in her presentation had come from the Centers for Disease Control and Prevention (CDC), and that copies of the slides were not yet available. She added that she hoped that they would be made available soon.

K. Brady stated that she would discuss HIV molecular surveillance, including the following key points: Community Engagement, Public Health Practice, and Clusters & Molecular Surveillance.

Community Engagement
K. Brady stated that CDC and health departments were conducting community outreach to key partners with three main goals. She stated that the first goal was to increase partner understanding of how and why data is used for prevention purposes, the second was to increase CDC and health department understanding of community concerns, and the third was to identify ways to work together to address concerns and minimize risks.

K. Brady explained that HIV testing was faster and could detect new infections earlier. She went on to say that treatment had improved and there were options like PrEP and PEP for people who were HIV-negative. She then stated that there were still many HIV prevention challenges, such as prevention among groups with the highest lifetime risks of acquiring HIV and groups at risk of HIV outbreaks.

Traditional Public Health Practice
K. Brady stated that public health helps people and their communities. She went on to say public health is monitored through surveillance, which is the monitoring of illness and baseline demographics. She explained that public health surveillance guides policies and strategies to keep people healthy. She further explained that public health surveillance is used to identify outbreaks and finding and helping sick people. She noted that public health surveillance helps target limited resources to affected populations.

K. Brady then explained that the use of public health data has evolved over time. She stated that data collection offered fewer benefits to individuals with HIV/AIDS until antiretroviral treatment became available, particularly in the face of confidentiality concerns. She went on to say that these concerns were addressed through unprecedented confidentiality clauses. She further explained that, due to these strict policies, HIV surveillance was primarily used for descriptions of populations who were affected by HIV. She then stated that public health data could help public health practitioners to better understand people affected by HIV. She concluded that this information could also assist in identifying what types of prevention interventions are needed.

K. Brady stated that public health data collection had evolved over time. For example, she explained that data on sex and gender previously focused exclusively on sex at birth. However, she went on to say that data collection has expanded to include gender identity, which helps public health practitioners to better understand the needs of transgender populations.

Clusters & Molecular Surveillance
K. Brady explained that the use of public health data has also expanded in other ways, such as its use to identify people who are not currently in HIV care. She further explained that this information can help health departments to target services to areas that have unexpected increases in new HIV diagnoses.

K. Brady explained that a new way of looking at laboratory data allowed health departments to identify similar HIV cases, similar to methods seen in tuberculosis and food-borne illness. She displayed an image of an HIV cluster within a network. She explained a network is comprised of people who are interconnected, and that identifying partners of people within a network can help health departments to identify people at high risk of acquiring HIV. She stated that this process could also help in identifying barriers to services.

K. Brady explained that genetic sequencing is often used to determine the most effective treatment for any particular strain of HIV. She noted that this data was also called "molecular data", and that it helped to healthcare providers in making better treatment plans for individuals. She added that the collection of this information by health departments is often referred to as "molecular surveillance".

K. Brady next explained that HIV mutates over time, resulting in changes to the virus. She further explained that health departments can use molecular data to identify groups of infection that are very similar, and that these similarities indicate that HIV is spreading quickly within a network.

K. Brady stated that the CDC estimates that there are 4 HIV transmissions per 100 person-years within the United States. She went on to say that, among 60 priority clusters identifying through molecular surveillance, the transmission rate was estimated to be 44 per 100 person-years. She concluded that this rate was over ten times the national rate for HIV transmission.

K. Brady explained that prevention techniques could be deployed once clusters were identified, including social network testing. She went on to say that health departments were engaged in HIV education and analysis in gaps in services.

K. Brady shared an example of a cluster in San Antonio, TX, primarily among Latino men who have sex with men (MSM). She explained that the health department was able to identify improper testing procedures and educate HIV service providers on testing and acute infections. She stated that they had also identified barriers to access to PrEP in San Antonio. She added that they had also been able to create a coalition of providers in this area, and that they signed on as a "Fast-Track City."

K. Brady shared the benefits and risks of molecular surveillance. She explained that molecular surveillance could help in identifying patterns of HIV transmission, targeting resources, improving prevention and treatment, and reducing the number of new transmissions. She then stated that risks centered on privacy and misuse of data. She explained that these could result in stigma, damage to mental health, damage to the reputation of public health agencies, and possible incarceration and/or false arrest.

K. Brady stated that the CDC and the Philadelphia Department of Public Health were committed to maintaining ethical standards and minimizing risks. She explained that trust was the foundation of effective public health work, and that this required using data in a way that served the individual and community. She went on to say that personally-identifiable information was not sent to the CDC, and that the CDC requires safeguarding of data. She explained that health departments and the CDC used secure data systems, and only allowed access to data for people who needed it in order to perform their jobs. She noted that people with access to data were required to attend an annual data security training and to sign binding confidentiality agreements.

K. Brady stated that the CDC had been doing a great deal of public outreach on these subjects, and that there had been a number of concerns raised by the community. She stated that there were three main areas of concern: cultural sensitivity and non-coercive activities, security of data, and the possibility that this information could be used to identify who had transmitted HIV to whom. She noted that molecular analysis could not currently provide a direction of infection. She added that community members had also been curious as to how the CDC would engage the community. She noted that the CDC always recommended that health departments engage with their communities, and that it was particularly important with the new practice of cluster detection. She added that all health departments funded by the CDC were required to use multiple methods of engaging with their

communities, such as meeting with HIV planning bodies. Finally, K. Brady asserted that it was possible to end HIV.

G. Grannan asked if local HIV data collection and retention policies had been reviewed by someone with law enforcement experience. He also asked if it would be possible for law enforcement to obtain and use information from molecular surveillance in prosecution. K. Brady replied the CDC had very restrictive data collection and use policies throughout all jurisdictions. She stated that they were required to review those policies annually and update them every two years. She noted that CDC experts on security and confidentiality reviewed and then approved those policies. She stated that there were also state regulations that prohibit release of data. She added that the National Alliance of State and Territorial AIDS Directors (NASTAD) had also released some additional information on this earlier that day. K. Brady noted that this data had never been subpoenaed before, so it could not be used in HIV criminalization. She concluded that they could not currently identify directionality in HIV transmission through molecular surveillance.

A. Thompson stated that the risks seemed to outweigh the benefits for molecular surveillance. He explained that he was not sure that the public health system had the level of trust needed to conduct this type of outreach effectively. He went on to say that he was also concerned about data security, and questioned whether personal health information would be treated appropriately. He explained that he understood why this might be done, but that it was important to have better relationships with the community. K. Brady replied that she could see potential individual benefits, and that identification of sexual and needle-sharing partners could prevent new infections through harm reduction services, PrEP, and PEP, as well as get HIV-positive partners into care. She explained that this could also help in targeting resources to the people at highest risk. A. Thompson agreed, but went on to explain further reservations. He noted that there were already difficulties in getting people living with HIV into HIV care, and that he was not sure how effective this approach would be on the prevention side. He concluded that he was concerned about what would happen with his personal data, including who would have access to it and how it would be used. He added that he even had concerns about how his data was already being used. K. Brady replied that Philadelphia's data was currently stored in Harrisburg, and that there were very specific requirements regarding who could access data, including IP addresses. She noted that the information technology staff had many safeguards in place, including data encryption and password protection. A. Thompson emphasized that he was concerned about bad actors accessing this information.

K. Carter asked what would happen after a person's HIV status was reported to the health department. K. Brady replied that it was the information was added to the enhanced HIV/AIDS Reporting System (eHARS). She noted that the data was highly protected, and that there had never been a security breach. A. Thompson added that they were discussing communities that had already had traumatic experiences around their data being released.

G. Grannan asked whether disease intervention specialists were trained to identify if they were being followed by law enforcement. K. Brady replied that disease intervention specialists used their personal vehicles, and that they could be notifying partners about a number of different diseases, so law enforcement would not know the reason for a visit. She added that she would ask for more information.

G. Taylor asked if the community in San Antonio was made aware of the molecular surveillance used there. She also asked if the community had a right to decline to participate in molecular surveillance. K. Brady replied that everyone who was diagnosed with HIV was reported to the health department.

She went on to say that, in terms of community engagement, the current presentation was one example of how this happened. She then stated that AACO was doing a number of presentations around the community, including with community advisory boards and providers. She next stated that there was no requirement to tell a newly-diagnosed individual that they were part of a cluster. G. Taylor asked if it was legal not to tell a person that they were part of a cluster, and K. Brady replied that they were not required to disclose that someone was part of a cluster.

M. Coleman asked if a person who was HIV-positive and part of a cluster could face any criminal charges, particularly if they were actively using drugs. He added that many people in active addiction had fallen out of care. K. Brady replied that they could not be charged for their HIV status. She went on to say that many people with high viral loads were out of care, and that this could be related to high transmission. She noted that they were also using data to care to reengage these individuals in care. She added that they were using Antiretroviral Treatment and Access to Services (ARTAS) for this purpose.

- **AACO's Response to Inequities –** *Coleman Terrell, AACO*

C. Terrell stated that he would discuss some of the measures that AACO had taken to advance health equity, noting that equity was not just making things equal, but rather making things equitable. He then explained that AACO analyzed system-level disparities by race, gender, risk, age, and insurance status on annual basis, focusing on viral load suppression and retention in care. He stated that these informed the content of regional clinical quality management (QM) meetings, which help AACO to identify system-level interventions.

C. Terrell stated that provider-level disparities vary even when the system is performing well. He went on to say that they examined whether there were statistically significant differences across providers, and found that there were. He explained that, for example, one provider performed below average in viral suppression for MSM but above average for people who inject drugs (PWID), while the opposite was true for another provider. He stated that AACO asked providers to conduct root cause analyses for any disparities in their programs, and that they created quality improvement plans (QIPs).

C. Terrell stated that AACO staff had already received training on homophobia and transphobia, and would receive future training on racism. He noted that AACO encouraged providers to host similar training. He next stated that AACO had performed an internal health equity assessment, using tools to promote racial equity and LGBTQ health equity. He went on to say that the process had been very interesting, and had required staff to examine health equity issues within AACO. He stated that this assessment was then distributed to provider agencies. He noted that AACO did not ask providers for the results of their assessments, but that they did conduct key informant interviews with providers. He added that the results were currently being analyzed.

C. Terrell next introduced the DExIS initiative (Demonstrating Expanded Interventional Surveillance), which was funded through a 4-year demonstrative grant from the CDC. Key DExIS components include:

- Using HIV surveillance data to identify sentinel cases of recently HIV-infected individuals
- Conducting standardized confidential interviews and medical/prevention chart abstraction of the sentinel cases to determine missed opportunities for HIV testing and prevention services such as pre-exposure prophylaxis

- Identifying patterns of missed opportunities through, regular, structured, interdisciplinary Case Review Team (CRT)
- Implementing actionable recommendations based on system-level analysis of project program data and performance evaluation by a project-specific Community Action Team (CAT)
- Collaborating with funded agencies for community mobilization to implement action steps of the CAT

Action Items:

- **Racial Inequity Work Group**

A. Thompson stated that the Comprehensive Planning Committee had wanted to discuss racial inequities over the past several months, but that the committee was struggling with the breadth of the topic. He explained that they had decided to propose a workgroup that would specifically focus on racial inequities within the service delivery system, noting that they decided to propose an ad hoc workgroup since the subject touched on the work of every committee.

Motion: The Comprehensive Planning Committee moved to recommend a Racial Inequities work group that will focus solely on racial inequities within the service delivery system.

Discussion on the motion:
L. Diaz asked how frequently this workgroup would meet. A. Thompson replied that this would be up to the members of the workgroup. He explained that the Comprehensive Planning Committee felt that the topic was too broad to address alone, and that they were seeking the help of the HIPC to focus the conversation.

A. Edelstein stated that an ad hoc workgroup can address a single issue or a set of issues, and that it would dissolve once it had accomplished that task.

M. Cappuccilli asked if the workgroup would report to the Comprehensive Planning Committee or to the HIPC. A. Thompson replied that it would report to the HIPC.

N. Johns clarified that the Comprehensive Planning Committee was not sure whether the HIPC would want to limit the conversation to inequities within the HIPC, or whether they would also like to discuss inequities at the system level. She explained that they had not felt comfortable deciding the parameters of these conversations without input from the entire HIPC.

Motion passed: 20 in favor, 0 opposed, 5 abstentions.

- **Reallocation Request**

A. Edelstein stated the Recipient had requested a reallocation of $140,000 from the local pharmaceutical assistance program (LPAP) to outpatient/ambulatory medical care. He went on to say that the reallocation would result in a 28% decrease in the LPAP service category and a 2.83% increase in outpatient/ambulatory medical care. He noted that AACO had recognized decreased LPAP utilization and an increased need in medical staffing at the health centers.

Motion: The Finance Committee moved to approve the reallocation request as stated by the Recipient.

Discussion on the motion:
L. Matus asked if the increase to outpatient/ambulatory medical care would be spent on staffing. A. McCann-Woods agreed.

A. Thompson asked for additional information about the increase in uninsured patients, noting that this could speak to a need for health insurance at the state level. A. McCann-Woods replied that she did not have this information. C. Terrell stated the Recipient had identified that the $140,000 could not be spent within the LPAP category, and that there had been a request for funding to meet an increased demand at the city health centers. He noted that this would allow the health centers to provide more clinic hours. G. Grannan asked for clarification on underspending in the LPAP program, and C. Terrell replied that LPAP had increased its use of other available resources. C. Terrell added that providers were collecting information on uninsured clients and income levels, and that they did have this information available for the Ryan White system. A. Thompson clarified that he supported the reallocation request, but that he was interested in data on uninsured clients to help build a case for funding health insurance premiums/cost-sharing assistance.

K. Carter asked how the reallocation would support staffing. A. McCann-Woods replied that the health centers had capacity issues since they did not have enough provider hours available. She noted that this would enable clients on a waiting list to be seen. G. Keys asked if there was a waiting list for patients to be seen at the health centers, and C. Terrell replied that he had been told that there were not enough provider hours.

H. Bennett commented that clinics needed longer hours at least once a week, since more people needed services.

Motion passed: 20 in favor, 0 opposed, 6 abstentions.

Discussion Items:

- **UCHAPS Representation**

S. Heaven reminded those present that there had been a discussion on Philadelphia's community representation on the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) at the October HIPC meeting. She stated that this would be a continuation of that discussion. M. Ross-Russell stated that the Prevention Committee had also discussed UCHAPS representation. She noted that the Prevention Committee had asked the two potential candidates come prepared to share their prevention experience with the HIPC.

L. Matus explained that the Prevention Committee had wanted to discuss UCHAPS representation within their committee so the Prevention Committee's voice was not lost in this process.

M. Ross-Russell explained that there were eligibility requirements for community representatives to UCHAPS. She further explained that the primary community representative must be a past, present, or future co-chair of the HIV planning body as well as a current member. She noted that "future co-chair" typically referred to a designated "co-chair elect" position, commonly seen in other jurisdictions.

L. Diaz stated that she heard that the Prevention Committee was concerned about their voice being lost in the process, and asked if there would be anything preventing the community UCHAPS

representative from attending Prevention Committee meetings. L. Matus replied that this person would be welcome to attend committee meetings.

M. Ross-Russell stated that each of the two people who were eligible and interested in representing the community at UCHAPS had been asked to provide additional information on their prevention backgrounds. E. Sargent asked how community representation on UCHAPS works. M. Ross-Russell replied that there was typically a main community representative and a community alternate. She explained that the community representative would need to attend any face-to-face meetings, and that a governmental representative would also attend. She explained that UCHAPS financially supports the primary community representative's attendance for in-person meetings, although most meetings were now virtual. She noted that this representative would need to attend meetings, carry out any work assigned by UCHAPS, and report back to the HIPC about national prevention-related updates.

C. Terrell noted that Philadelphia would not have a vote at UCHAPS until it had both governmental and community representation at the meetings. L. Matus noted that there was work involved in attending the meetings, and that there would be a cost involved in attending as an alternate. C. Terrell added that UCHAPS would cover the cost of one person's attendance at the meeting.

A. Edelstein asked for more information about the role of the Prevention Committee in selecting community representatives to UCHAPS. K. Carter replied the conversation about representation at UCHAPS started at an Executive Committee meeting that had low attendance, and that L. Diaz had been nominated at that meeting. He went on to say that the Prevention Committee then had a meeting where they discussed the nominations process for UCHAPS, and the committee asked whether they would like to open the nominations up to past co-chairs of the HIPC. He then stated that two eligible HIPC members had expressed interest in participating in UCHAPS: L. Diaz and K. Baron. He noted that K. Baron had to leave the present meeting early. L. Diaz clarified that the Prevention Committee co-chairs had been aware that there would be a discussion about UCHAPS representation at the Executive Committee meeting. L. Matus explained that, before the HIV Prevention Planning Group (HPG) and Ryan White Planning Council (RWPC) integrated, the HPG community co-chair served as the UCHAPS community representative. She noted that neither of the Prevention Committee co-chairs had been able to attend the Executive Committee meeting where UCHAPS representation was discussed, but that after they had realized a nomination had been made, they had asked to further discuss it in the Prevention Committee meeting.

C. Terrell asked for clarification on the Prevention Committee's desired outcome. L. Matus replied that the Prevention Committee wanted to open up nominations to all eligible parties after the Executive Committee made its recommendation for the community representative and the alternate. She explained that the Prevention Committee had had this conversation, and that they had asked the nominees to prepare a statement about their interest in UCHAPS and their prevention backgrounds.

C. Terrell noted that Greg Seaney-Ariano would be the primary AACO representative to UCHAPS, and that Antar Bush would serve as AACO's alternate. B. Morgan noted that there were only three people who were eligible to serve as the HIPC's primary representative: L. Diaz, K. Baron, and S. Heaven. She noted that S. Heaven had declined. She explained that there was not currently a procedure in place for electing a UCHAPS representative, since this role was previously filled by the one community co-chair for the HPG. She noted that the Prevention Committee had asked the candidates to bring bios to the current meeting, and concluded that the HIPC would need to determine how they would like to proceed. L. Diaz stated that she had been under the impression that voting would happen during the current meeting, so she had brought materials about her prevention

work and was prepared to answer questions. S. Heaven asked if K. Baron had left any materials for the HIPC to review. C. Steib replied that K. Baron had left materials that she had requested C. Steib read to the group. K. Carter replied that this would not allow the HIPC to ask questions of K. Baron.

A. Edelstein suggested tabling the discussion to the next meeting. S. Heaven stated that they wanted everyone to be part of an open and transparent process, and concluded that they would revisit the topic at the next HIPC meeting. N. Outland asked what qualifications were required for the alternate community UCHAPS representative. S. Heaven replied that this person needed to be a current HIPC member in good standing.

- **2nd Quarter Underspending Review**

A. Edelstein stated that the HIPC had requested a review of the underspending report during its last meeting. A. McCann-Woods reminded those present that this report included six months of spending, and that not all invoices had been submitted. She noted that the picture of spending would be more complete at the end of the third quarter. A. Edelstein added that there was a time lag between the time services were provided and the time that the providers submitted invoices to AACO. He clarified that underspending in a category did not necessarily mean that services were not being provided. A. McCann-Woods added that there had also been a request to provide underspending reports prior to the meeting, but that this was not possible due to time constraints.

M. Ross-Russell noted that the Finance Committee had had some questions about the service categories that were overspent. A. Edelstein replied that it would be impossible to have a complete picture of spending this early in the year. A. McCann-Woods stated that there had been overspending in food bank/home-delivered meals in Philadelphia, and that this was typical. She went on to say that there had also been questions around transportation, and that there was high utilization in Philadelphia. She stated that the NJ Counties had also overspent transportation, and that the HIPC had approved a reallocation to this category.

M. Cappuccilli stated that the quarterly report provided the HIPC with the opportunity to identify patterns in service categories across the EMA. He stated that mental health therapy was underspent across all regions within the EMA. He asked if there was something unique about the way these services were funded that would result in significant underspending at midyear. He noted that underspending ranged from 35 – 65%. A. McCann-Woods replied that the answer was multilayered. She explained that this could include personnel vacancies, operating expenses, and the way that services were invoiced. She noted that she could not pinpoint the cause of underspending in any part of the EMA, but she could describe the possibilities. A. Edelstein noted that smaller organizations tended to invoice more quickly because they had tighter budgets. L. Diaz added that her organization provided mental health services, and they saw cycles of utilization throughout the year. She noted that they saw much higher mental health service use closer to the holidays in the winter.

M. Cappuccilli asked if AACO reached out to providers if they noticed any “red flags” when compiling the quarterly financial reports. C. Terrell replied that programs had program analysts who were very well-informed about issues at providers, such as staff vacancies. He explained that the quarterly underspending reports did not capture the nuance of each agency, but that AACO actively worked to recapture underspending throughout the year. He noted that they were aware of issues related to transportation, and that they were meeting with the transportation provider. He added that the LPAP provider had approached AACO to let them know that they were not going to be able to spend the allocation. He explained that, while the underspending reports were necessary, they

required a lot of commentary. He also noted that the underspending in mental health therapy across regions was notable, and that AACO would look into this and report back to the HIPC. A. McCann-Woods noted that program analysts contacted providers any time there was greater than a 10% departure from their expected spending in a category.

C. Terrell encouraged those present to call AACO at 215-985-2437 if anyone was having trouble getting services. He noted that the helpline staff could help link people to services, and that calling the helpline would allow AACO to document any issues with services in the system.

- **December Meeting**

S. Heaven stated the December HIPC meeting would fall during the 2018 National Ryan White Conference on HIV Care & Treatment. She explained that many HIPC members would not be in town for their regular meeting date. L. Diaz noted that each committee would also decide whether or not it would meet in December.

Motion: G. Keys moved, D. Gana seconded to cancel the December HIPC meeting. **Motion passed**: 19 in favor, 0 opposed, 4 abstentions.

Prevention Service Initiatives:

G. Grannan stated he was the new chair of the PrEP Workgroup. He explained that they were working to coordinate the efforts of the workgroup with the Prevention Committee, and welcomed those present to attend. He noted that there was also a co-chair from AACO. He added that they would next meet in January.

K. Carter stated that there had been issues with coordination on the PrEP Workgroup, explaining that there had been disconnects in communication around meeting times and other logistical issues. He went on to say that the PrEP Workgroup had not reviewed previous discussions on PrEP held at the Prevention Committee. He noted that the meetings had not been inclusive to community members, and that this had served as a barrier to HIPC recruitment. C. Terrell replied that recommendations from the PrEP Workgroup were reviewed by AACO, and that a report on the group's work was currently being drafted. He stated that this draft would then be presented to the PrEP Workgroup for feedback. He noted that multiple products would be presented for approval by the PrEP Workgroup. He stated that the PrEP Workgroup could then present those products to the Prevention Committee once the workgroup had approved them.

N. Outland asked for clarification. S. Heaven explained that it sounded as though there had been a breakdown in communication. G. Grannan clarified that there was a separate meeting for PrEP providers, and that information about these meeting had not been shared with the Prevention Committee and that they had not been publicly posted. N. Outland stated that the provider group was originally supposed to report back to the PrEP Workgroup. M. Coleman asked how many PrEP Workgroups were operating. G. Grannan replied that there were two: the main PrEP Workgroup meeting, which mainly included community PrEP providers, and a separate group for clinical providers. He noted that the clinical provider meeting had inadvertently began to operate as a closed meeting, and that this group needed to report back to the larger group as well as make information about its meetings open to the public. M. Ross-Russell noted that the clinician group was meeting at 8 a.m. to accommodate clinicians' schedules. She added that the PrEP Workgroup had agreed to have a separate clinical meeting as long as there was communication between the two groups. C. Terrell stated that AACO had provided a great deal of staff support for the PrEP Workgroup, and that they

were taking the work of the group and compiling it into a report. He stated that this report would be presented first to the PrEP Workgroup, then to the Prevention Committee, and then the HIPC could choose how to proceed.

Committee Reports:
Finance Committee ─ *Alan Edelstein and David Gana, Co-Chairs*
No report.

Comprehensive Planning Committee – *Tiffany Dominique and Adam Thompson, Co-Chairs*
N. Johns stated that the committee finalized its recommendations about medical case management competencies and forwarded them to AACO. She invited those present to their meeting the following week, in which they would discuss the opioid crisis throughout the EMA.

Executive Committee
No report.

Positive Committee ─ *Keith Carter and Jeanette Murdock, Co-Chairs*
K. Carter stated that the Positive Committee had met to discuss meaningful involvement of people with HIV/AIDS in planning, and that they would continue their discussion at their December meeting.

Nominations Committee ─ *Michael Cappuccilli and Sam Romero, Co-Chairs*
M. Cappuccilli stated the committee just met and they approved the HIPC online application, noting that OHP ensured that it was as secure and simple as possible. He noted that they had also elected S. Romero as the new co-chair of the committee.

Prevention Committee ─ *Lorett Matus and Clint Steib, Co-Chairs*
C. Steib stated that the committee was continuing its review of the baseline data from the Integrated Plan, and that they would next meet on Wednesday, November 28.

Old Business:
None.

New Business:
None.

Report of Staff:
M. Ross-Russell informed the Planning Council that S. Budhu will be resigning from the Office of HIV Planning to begin a new position at the AIDS Activities Coordinating Office (AACO).

M. Ross-Russell reminded the council that the new epidemiologic profile and updated integrated plan are available on the OHP website (www.hivphilly.org).

B. Morgan noted that the new online HIPC application had also been posted to the OHP website.

Announcements:
None.

Adjournment:
The meeting was adjourned by general consensus at 4:24 p.m.

Respectfully submitted by,

Stephen Budhu and Briana Morgan, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from October 11, 2018
- Philadelphia Region Reallocation Request
- Second Quarter Underspending Report
- OHP Calendar