Philadelphia HIV Prevention Planning Group (HPG)
Meeting Minutes of
Wednesday, September 24, 2014
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: David Acosta, Tiffany Dominique, Jennifer Chapman, Fred Graham, Gus Grannan, Eleanor Lundy-Wade, Lorett Matus, Brad Shannon, Nick Wood, Paul Yabor, Cody Poerio

Absent: Jacob Adeniran, Laura Bamford, Antonio Boone, Lawrence Frazier, Daniel Green, Alberto Lopez, Najia Luqman, Tiffany Thompson

Guests: Joseph Roderick, Leroy Way, Mark Coleman, Robert Woodhouse, Gladys Thomas, Brad Crothers, Jeff Glotfelty

Staff: Mari Ross-Russell, Briana Morgan, Nicole Johns, Jennifer Hayes

Call to Order: J. Chapman called the meeting to order at 2:45p.m.

Welcome/Moment of Silence/Introductions: J. Chapman welcomed HPG members and guests. A moment of silence followed. Those present then introduced themselves.

Approval of Agenda: J. Chapman presented the agenda for approval. **Motion**: C. Poerio moved, J. Chapman seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*August 27, 2014*): J. Chapman presented the minutes for approval. G. Grannan noted an error on pg.1 ("Whoever"). T. Dominique noted an error on pg.5 ("HCV" should be changed to "HIV"). **Motion**: J. Chapman moved, G. Grannan seconded to approve the August 27, 2014 minutes with 2 corrections. **Motion passed**: All in favor.

Report of Co-Chair: J. Chapman announced that the next all-member UCHAPS meeting would be held in Philadelphia on Sunday and Monday, December 14-15. She stated that the open portion of the meeting was still TBD but was usually held on the second day.

J. Chapman stated that she and D. Acosta were asked to attend a training in Chicago on Mapping Pathways, an initiative utilizing community input around ARVs for HIV prevention. She stated that the project analyzed the community in terms of political and economic factors and surveyed the challenges and successes of PreP as HIV prevention. She stated that she would keep the HPG informed about what she learned at the training.

J. Chapman reported that the CDC had released the state HIV prevention progress report earlier in September, and that the report was available online. She explained that it was broken down by state at the end of the report, so data was specific to Pennsylvania and not Philadelphia.

J. Chapman announced that the CDC had published the PS15-1502 Funding Opportunity Announcement (FOA). She noted that the membership Nominations Committee would want to think about how to involve new grantees in the HIV prevention planning process. She stated that it was expected the grantees would participate.

D. Acosta stated that he and J. Chapman had just finished presenting the prevention report and Ryan White report to the CDC earlier this month. D. Acosta stated that they would be getting a

prevention report card from the CDC and that representatives would go over the report card with the HPG next month. He said that the report card included feedback on what the region was doing well along with remaining challenges. He stated that it was important to take into account policy changes that AACO was undertaking and areas that still needed to be improved. He stated that one area that had dramatically improved was partner services. D. Acosta noted that work was already being done to improve many of the weak areas. He said that he would ask Coleman Terrell from AACO to come present the report card before the HPG and to explain some policy changes that would take place, for instance around screening procedures. He reported that the testing algorithm that AACO currently used would be changed to allow for earlier diagnoses. He stated that these changes would require retraining and a reframing of how people did testing. G. Grannan asked if there was any dialogue outside of AACO with other city agencies about changing city policies that may constrain public health goals. G. Grannan stated that one example was needle exchange, which was very hard to do in Philadelphia. D. Acosta responded that he was not aware of any such conversations but that he could ask. D. Acosta stated that in areas around testing (identification of new positives, for instance) we continued to encounter challenges in linkage and retention. He stated that some cities struggled with these goals and that others did better, and that we were in contact with other cities to find out how we could improve. He stated that there would be a Philadelphia report card that was similar to the state report card, but Philadelphia-specific.

D. Acosta stated that Philadelphia was chosen to take part in a study on capacity-building through videoconferencing. He stated that it was a program initiated by the University of Washington that used videoconferencing to allow physicians to learn from one another about best practices. He stated that this project would be replicated in the HIV/AIDS arena, specifically around critical care. He stated that Chicago and Philadelphia were involved in the project. He stated that Kathleen Brady was the primary contact and would speak on the project at a later date.

D. Acosta stated that Philadelphia submitted a grant to the CDC for the Correct Project. He stated that other states involved included CT and MA. He explained that the project was looking at linkage and retention in care, and would have a development and implementation phase. He stated that there would be opportunities as part of the project to improve prevention, care, and linkage. P. Yabor asked how screening would be done, and if the project would be on the city or state level. D. Acosta said that he could only speak for the city but that there would be statewide participation in the project. B. Shannon clarified that it would not be a blood draw, but was blood based, so would require a finger stick. B. Shannon explained that the technology has changed and that currently blood-based testing offered the most accurate tests and found HIV sooner.

Report of Staff:
B. Morgan noted that the state has an integrated care and prevention planning body, which met last week. She stated that most of what the state was doing right now was around part B (care, priority setting, and resource allocations). She stated that it worked differently than the part A Planning Process in the Philadelphia EMA. She stated that the state HPG made recommendations for resource allocations, whereas our RWPC determined allocations which had to be followed by the Health Department. She stated that the state HPG's Needs Assessment Committee was focusing on linkage to care, which blended care and prevention. She stated that they just got results back from key informant interviews on rural linkage to care, with rural defined as not in Philadelphia or Pittsburgh. She stated that some findings were expected, e.g. transportation was a factor, especially in more remote areas where it may be 2-3 hours back and forth by car to a doctor. She said that there were also some surprises, with recommendations for improvement. She stated that having testing and care available in one location made it easier to link someone to care. She stated that Ryan White Part B was going to look into which care providers they had that

didn't currently offer HIV testing and try to get testing to these providers. She stated that other next steps included looking into telemedicine. She noted that initiatives like this had been started under Ryan White Part F, Special Projects of National Significance (SPNS), in states such as Alabama. She explained that the state HPG would assess the feasibility of doing something like this in PA given current funding, policy, and infrastructure. P. Yabor stated there was talk about working to integrate different databases. He stated that there were challenges because of differences between the recording systems used by different organizations. B. Morgan stated that uploads to CAREWARE across different organizations were hard to integrate.

Special Presentation:

- **Perspectives on Partner Services –** *Dr. Felicia Lewis, PDPH, Department of STD Control*

J. Chapman stated that the speaker had not arrived yet, so the group would move to their next topic on the agenda. D. Acosta later confirmed that the presentation would be rescheduled for a future meeting.

Discussion Items:

- **Focus Group Recruitment** – *OHP Staff*

N. Johns stated that the OHP had just held the first of their focus groups with high-risk heterosexual women. She stated that recruitment for the high-risk heterosexual focus groups had gone very well for men over 40, but that she still needed help recruiting women. She stated that yesterday 4 out of the 7 women that were scheduled to attend the focus group came. She stated that any help with women or men under 40 would be great. She noted that there would be another focus group with men held tomorrow night. She said that there would be no focus groups held next week, and that there would be 2 held the following week. She stated that there were a few weeks left for additional recruitment. P. Yabor asked if the CVS card incentive for participating in the groups was set in stone, and N. Johns replied that it was. She noted that all the participants really appreciated the CVS card. She stated that she wanted to thank FIGHT for their help recruiting participants. N. Johns explained that Dr. Kwakwa at the CARE Clinic downstairs had been helping recruit and that she would be encouraging people at the health center to pass information on to applicable patients. N. Wood suggested that CHANCES would also be a good place to recruit.

- **HPG Nominations** – *Jen Chapman, HPG*

J. Chapman stated that she had sent out an email with slides from the last meeting. She stated that the slides went over her proposed subdivisions of 3 membership committees. She noted that she had received a few responses to her survey. She said feedback had been mostly positive. She reminded the group that the proposal was to have one group focused on recruitment, nominations, and application review. She noted that another group was meant to be centered around professional development, training, and education. She said that this group would do needs assessment about the HPG's mission and goals. She said that the third group was to focus on new member orientation. She stated that the NMAC HIV Planning Bootcamp held last October had been informative, but had only benefited people who were there at the time. She noted that new people had joined since then.

J. Chapman stated that respondents to the survey selected a variety of committees. She explained that it would be helpful to come up with a stock answer to questions like "What is the HPG? What does it do? What is its role?" She stated that these issues could be discussed as a group or that one of the committees could come up with an elevator speech. C. Poerio asked if J. Chapman

had already divided the HPG into the three committees. J. Chapman stated that maybe since there was time those present could divide up into groups now.

G. Grannan noted that J. Chapman had spoken of a requirement that grantees be represented in the planning body. He asked if there was a rough estimate of how many grantees would serve on the HPG. D. Acosta said that J. Chapman had been referring to the CDC FOA PS15-1502, which concerned money that went directly from CDC to community-based organizations. He stated that previous grantees, including FIGHT, had received this type of funding in the past. He said that these organizations, as a requirement of receiving the grant, must participate in the community planning process. He explained that the CDC had left it up to jurisdictions to decide what kind of involvement that would be. He noted that we could not yet say how many grantees there would be, and that, although there was a bigger pot of money this grant cycle, fewer grants were going to be given. He stated that in the past we'd had 2 or 3 providers involved in the HPG at a time, but that this year we may have only 1 or 2. He noted that the grant application process was going to be very competitive, and that the expectations would be as high as scoring 90% in most categories. M. Coleman suggested that community-based organizations like FIGHT should work together to help one another meet the performance expectations. D. Acosta replied that the FOA highly encouraged community partnerships and coordination. G. Grannan asked if there was funding available to help organizations meet these expectations. D. Acosta responded that there would hopefully be money dedicated to this purpose, but he noted that there were different kinds of partnerships: formal and informal, with or without MOAs, etc.

P. Yabor asked for clarification on the idea that the jurisdiction could define grantee "involvement" in the planning process. He asked if the HPG would be working on defining what constituted involvement. D. Acosta stated that we had to take into account the HPG bylaws (regarding the number of voting members, non-voting members, stakeholders, and so forth). He stated that, after factoring in our own requirements, we could decide and report back to the agencies receiving grants. He explained that it would be up to us as well as the Health Department to determine the extent of the grantees' involvement. He stated that most organizations applying would be those with a track record of HIV prevention. He explained that it would be difficult for newcomers to the prevention arena, like hospitals, to receive the grants because performance standards were so high. He noted that the grant application included expectations around PreP and PEP (Post-exposure Prophylaxis), and that the use of social networks was a mandatory part of the application. G. Grannan stated that, in order to meet the requirements concerning social networks, agencies were required to provide documentation.

J. Chapman stated that while the group was waiting for the speaker to arrive, they could break into membership committees. She directed members to select the group that interested them most and to convene for discussion in three different parts of the room. She reminded the group that the first of the three subcommittees would be Nominations, which would review guidance on membership and the stakeholder profile, identify gaps, recruit and select members, as well as look at recruitment materials and the new member application. She noted that the second group, Membership Development, would conduct membership needs assessment, training, education, and professional development. She stated that the third group was focused on New Member Orientation, and would discuss what kind of orientation was needed, what resources already existed, what kind of materials could be developed, and in general brainstorm the best way to orient people to the HPG and its processes.

[Groups met for roughly 50 minutes.]

J. Chapman asked a representative from each of the three groups to give a brief report.

B. Shannon presented on behalf of the Orientation group. He reported that the group talked about the development of new member materials. He stated the group also addressed the initial face-to-face orientation meeting and what should be involved. He stated that the group got a lot of groundwork laid but that there was more work to do.

P. Yabor represented Membership Development. He reported that the group discussed membership needs assessment as well as the satisfaction survey. He said that the group developed a number of points on preparation, sustainability programs, gathering and sharing information, and attendance, along with clarification of members' responsibilities. He stated that the group had discussed the development of a "What is the HPG" blurb, starting a listserv and Dropbox, drawing up an information piece about different ASOs and what they do (distinct from the FIGHT resource guide), and creating a casual space (for once a month or bi-monthly meet-ups). Finally, he said the group had discussed membership retention.

J Chapman pointed out that several areas might overlap between all the groups: for instance the "What is the HPG" blurb might be developed collaboratively.

G. Grannan spoke on behalf of Nominations. He stated that there would be a Nominations review process. He said that, on a yet TBD schedule, the group would gather all applications that came in and meet before the HPG meeting to evaluate potential applicants. He stated that, ideally, the accepted members would be prepared for orientation by the next meeting. D. Acosta stated that wait times should be minimal for membership approval. He stated that the group was going to review current demographics and attendance and that he and J. Chapman would reach out to members with attendance issues. He stated that individual commitment to recruitment was important. He offered C. Poerio's recruitment of N. Woods as an example. He noted that there were gaps in membership. B. Morgan stated that there was a distinction between voting and non-voting members and that the differences between the two would be ironed out in future discussions. She noted that membership was capped at 20 people.

J. Chapman stated that there should be a central reference source for information on the HPG, for instance a Prezi slideshow. M. Ross-Russell reported that there was discussion of developing a "What is the HPG" Prezi similar to the "What is the RWPC" Prezi that the OHP had created. She noted that developing an FAQ or new-member handbook/manual was also discussed. She said that a glossary of terms/acronyms would be included.

J. Chapman stated that the Co-Chairs would make sure there was time in the future to finish the discussions and thanked everyone for participating. D. Acosta stated that today's speaker would be rescheduled.

Old Business:
J. Chapman stated that the date on the calendar for the next meeting should be the 22nd rather than the 29th.

New Business: None.

Research Updates:
T. Dominique stated that the Penn Mental Health/AIDS Research Center had funded 8 new pilots, at least 4 of which would start recruiting within the next few months. She stated that the studies would be covering topics such as cognitive decline based on HIV status, in addition to whether or not PTSD was a predictor of loss to care. He stated that IRB and IMH approval were still

pending, but that that internally it looked like the studies would be funded and ready to go in November or December.

J. Glotfelty reported that the NHBS YMSM feasibility study (involving AACO, CHOP, and St. Christopher's Hospital) would be submitting to the IRB for approval on October 1st. He stated that approval was anticipated by October 15th and studies would start in late October or early November.

Announcements:
B. Shannon stated that the CDC project officer to Philadelphia, Angie Alvarado, had transitioned to a position in capacity-building. He explained that she was still with the CDC but was no longer a project officer. He stated that her supervisor was filling in until a new project officer was appointed. He also noted that the morning of Sunday October 19th was the AIDS Walk and that he would be participating.

D. Acosta stated that Jane Baker of AACO had been appointed Assistant Health Commissioner and that Coleman Terrell would be filling in as acting director of AACO.

L. Manus reported that October 11th would be the 11th annual National Latino AIDS Awareness day (NLAAD) event. She stated that 6 Latino agencies would be supporting it this year, including Prevention Point, Congreso, GALAEI, YHEP, P-HOP, and Kensington Hospital. She stated that the event would be held from 12-5pm at Fairhill Park on 4th and Lehigh. P. Yabor asked if there would be a table-setting fee for organizations and L. Manus replied that there would be a fee this year.

J. Chapman reported that Thursday, October 16 from 5-6:30pm there would be a talk at Penn entitled "Substance Abuse, Violence, and HIV: Changing Environments to Reduce Risk in North Philadelphia." She stated that 2 speakers from Penn would be present, and that the talk was sponsored by the Center for Public Health Initiatives. J. Chapman said that anyone interested in attending should contact her, and that she'd forward them information about the event via email. J. Chapman noted that Membership Development had discussed a more efficient way to get announcements out to members in the future.

Adjournment: The meeting was adjourned by general consensus at 3:30p.m.

Respectfully submitted by,

Jennifer Hayes, OHP

Handouts distributed at the meeting:
- Meeting Agenda
- August 27, 2014 Meeting Minutes
- OHP Calendar

MEETING AGENDA

Wednesday, September 24, 2014
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Moment of Silence/Introductions

Approval of Agenda

Approval of Minutes (*August 27, 2014*)

Report of Co-Chairs

Report of Staff

Special Presentation:

- Perspectives on Partner Services – *Dr. Felicia Lewis, PDPH, Department of STD Control*

Discussion Items:

- Focus Group Recruitment
- HPG Nominations

Old Business

New Business

Research Update

Announcements

Adjournment

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

The next HIV Prevention Planning Group (HPG) meeting will be held on
Wednesday, October ~~29~~ 22, 2014 2:30-4:30p.m. at
the Office of HIV Planning, 340 N. 12TH Street, Suite 203, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

HIV PREVENTION PLANNING GROUP (HPG)

Philadelphia HIV Prevention Planning Group (HPG)
Meeting Minutes of
Wednesday, August 27, 2014
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: David Acosta, Jacob Adeniran, Tiffany Dominique, Jennifer Chapman, Lawrence Frazier, Fred Graham, Gus Grannan, Eleanor Lundy-Wade, Paul Yabor, Cody Poerio

Excused: Najia Luqman, Lorett Matus, Brad Shannon

Absent: Antonio Boone, Laura Bamford, Daniel Green, Tiffany Thompson, Nicholas Wood

Guests: Joseph Roderick, Leroy Way, Mark Coleman, Daniel T Harris, Brett Palmer (HHS)

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Jennifer Hayes

Call to Order: J. Chapman called the meeting to order at 2:48p.m.

Welcome/Moment of Silence/Introductions: J. Chapman welcomed HPG members and guests. A moment of silence followed. Those present then introduced themselves.

Approval of Agenda: J. Chapman presented the agenda for approval. **Motion**: T. Dominique moved, J. Chapman seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*July 23, 2014*): J. Chapman presented the minutes for approval. **Motion**: G. Grannan moved, F. Graham seconded to approve the July 23, 2014 minutes. **Motion passed**: All in favor.

Report of Co-Chair: D. Acosta thanked the HPG for the letter of concurrence they'd voted to issue in their previous meeting. He said AACO would be working on the Interim Progress report (IPR) covering January through June. He said the IPR was a report to the CDC on activities conducted under the auspices of prevention plan.

J. Chapman reported that UCHAPS had received a funding award from the CDC to provide technical assistance to directly-funded AIDS directors and HIV prevention partners in urban jurisdictions. She reported that she was on the grant-writing committee. She stated that the next all-member meeting for UCHAPS would be held in Philadelphia, most likely in December, though a date had not yet been set. She promised to keep the committee updated. She said that the state would make an announcement to their HPG and that anyone was welcome to come to the open portion of the meeting.

J. Chapman directed the committee to the US HIV Workforce Survey flyer (*see-attached sheet*). She stated that there was one more week left to fill out the survey. D. Acosta explained that the National Black AIDS Institute was doing a survey of the workforce to assess knowledge around prevention. He stated that the prevention landscape had undergone dramatic shifts in the last 5 years, particularly in the areas of biomedical prevention, prevention with positives, and retention in care. He said this meant the knowledge base needed for prevention workers had changed. He stated that the survey was designed to identify knowledge gaps affecting people on the front lines of HIV prevention. He said the survey would help to build knowledge of the workforce.

D. Acosta stated that first-round results of the survey were surprising because they revealed a gap in the knowledge base between people doing HIV/AIDS work on the front lines and policymakers. He stated the Black AIDS Institute asked for help distributing the survey more widely. He said some organizations who were helping to disseminate the survey included NMAC and NASTAD. He urged members to complete the survey themselves. J. Chapman welcomed members who found any questions particularly striking to bring them to the HPG's attention for possible future discussion at meetings. F. Graham asked if there were particular stakeholders who the survey targeted. D. Acosta said the survey was for prevention workers.

Report of Staff: M. Ross-Russell introduced new OHP staff member Jennifer Hayes to the HPG.

Special Presentation: J. Chapman introduced B. Palmer, the Regional Resource Coordinator for HIV/AIDS for Region III (DE, DC, MD, PA, VA, WV) at the U.S. Department for Health and Human Services.

- **HIV Prevention in the Biomedical Era –** *Brett Palmer, HHS*

B. Palmer stated that he was unattached to any organizations that may receive funding from HHS, including HRSA, CDC, NIH, and SAMSHA. He stated that the Office of the Assistant Secretary for Health at HHS was a small independent office. He stated that he and the program he runs were responsible for organizing and presenting to regional HIV directors, governmental and non-governmental about National HIV/AIDS Strategy, the ACA, Viral Hepatitis, and the HIV/AIDS Treatment Cascade Model. He said he hoped to foster communication between stakeholders for better local coordination in HIV/AIDS prevention, planning, and service delivery consistent with the NHAS's priorities and principles. He stated that he worked at the regional headquarters here in Philadelphia. He stated that he has been working in his position for less than 2 years, and that previously he had worked on HIV/AIDS research at CHOP. He explained that today he intended to talk about HIV/AIDS prevention in the current biomedical era. He stated he had presented these same slides at the Adolescent Trials Network (ATN) in Bethesda, MD. He stated that the ATN did research on adolescents with HIV. He said they had 15 sites across the country. He said he would cover some of the initiatives that had been happening around prevention in the current technological landscape. J. Chapman interjected that there were many points of intersection between the work Brett was doing and the work the HPG does.

B. Palmer said he wanted to note recent changes in federal funding. He stated that HIV/AIDS funding was currently at $30.4 billion, the highest level ever. He pointed out that funding had steadily increased since 2009. He also noted that many prevention organizations, including the HPG, were still constrained by a lack of funding at the local level. He pointed out that in the President's budget request to Congress, 57% of the budget for HIV/AIDS was for domestic care and treatment. He said 3% was for domestic prevention, 9% for domestic research, and 10% for domestic cash assistance and housing assistance. He also said 20% was for global HIV/AIDS efforts. D. Acosta asked how realistic it would be to expect this budget to pass. B. Palmer stated that it was always uncertain if and when congress would pass the budget. F. Graham asked if the percentages in the budget were based on research. B. Palmer stated that funding was allocated based on needs. He stated that there were programs like Ryan White that had their budgets set by multi-year statutory requirements. He noted that the Ryan White program had expired. However, he went on to explain that the funding earmarked by Ryan White did not expire. He stated that because there was no sunset clause in the funding portions of the Ryan White CARE Act, the law did not need to be renewed for funding to continue. He noted that there was talk about whether or not Ryan White should be brought up again so funding could be shifted around to suit today's needs.

B. Palmer distinguished between care and prevention. He pointed out that from 2009 to 2014, funding for care had increased by roughly $4 billion. He said that a lot of money was being put into treatment and care across the country. He also pointed out that funding for prevention had stayed stagnant over the past 5 years, and that some organizations felt that there was a squeeze on the prevention end. He stated that HIV funding was previously concentrated in major metropolitan areas, but that it was now distributed more widely (for example, in Southern states, where we've seen a rapid increase in HIV/AIDS cases). B. Palmer noted that if the President's budget passed, prevention funding would stay the same and care funding would go up by about $1 billion. He stated that it was important to keep in mind how costs were changing in care.

B. Palmer also noted that biomedical prevention had changed the HIV prevention landscape. He stated that male circumcision decreased the risk of HIV/AIDS transmission by about 33%. He stated that male circumcision lowered the risk of acquiring HIV from a female partner, other STIs, and penile cancer. He said male circumcision also reduced the risk in women for HPV and cervical cancer, genital ulceration, bacterial vaginosis, and trichomoniasis. He stated that in the US, this effect was mostly confined to heterosexual populations. B. Palmer noted that there was much discussion happening about the benefits of PrEP, or pre-exposure prophylaxis. He stated that Truvada was a daily PrEP pill that had many benefits. He stated that Truvada had been around for over 5 years as a medication for PLWHA. He stated that it must be taken once a day and carried a low risk of side effects. He said common side effects included headaches and nausea and tended to diminish within a few months. He stated that if Truvada was taken daily it was effective in reducing the risk of HIV transmission in MSM, MSW, and WSM. He stated that it reduced the risk of HIV by over 90% in people who took it. He said that it was FDA approved as a pre-exposure prevention method and that it was covered by many insurance carriers.

B. Palmer explained that full prevention benefits of treating HIV infection had 4 tenets. He stated that HIV testing was the foundation for prevention and care efforts. He noted that early identification and early treatment empowered individuals to take action and reduced the risk of transmitting HIV to others. He stated that the prevention benefit of HIV/AIDS treatment could only be realized within the continuum of care. He continued that ARV treatment as prevention may be effective if there was widespread testing and early identification of infected persons. He said ARV as prevention also required ongoing counseling about safer sexual behaviors, clinical follow-up to monitor the effects of treatment, and geographic and financial accessibility of treatment. He stated that if someone was in treatment and had an undetectable viral load, not only would they have good health and a nearly-normal life expectancy, but they would also have a reduced risk of transmission to sexual partners. G. Grannan asked if there was research on interactions between PrEP and ART medications for Hepatitis C Virus (HCV). B. Palmer stated that more research was being done on this. He stated that some research had found that some new ARV medications for HCV reduced the risk of transmission of HIV as well. B. Palmer noted that more funding was being put into HCV research. He stated that HCV related deaths in the last year had surpassed AIDS-related deaths.

B. Palmer stated that federal spending on care and treatment for HIV had gone up consistently while prevention dollars had remained the same. He explained that the cost-effectiveness of HIV testing was one reason. He stated that in a healthcare setting the cost of HIV testing may be $1,900-10,000. He stated that in a non-healthcare setting (like a CBO) the cost may range from $10,334-20,413. G. Grannan asked if it was fair to compare costs in these very different settings. B. Palmer explained that the higher numbers for non-healthcare settings were related to costs of doing post-test counseling, linkage to care, paying providers, etc. He stated that people going to CBOs may also receive added benefits not reflected in the costs. G. Grannan noted that the clinical approach failed to address the issue of stigma and its relation to disease transmission. B.

Palmer acknowledged that stigma affected the treatment of PLWHA by providers, customer service workers, and others, and that this was a direct barrier to people receiving HIV services and other services. He stated that people who were HIV positive may be part of other stigmatized populations (sex workers, IDUs, LGBT individuals, or members of minority races). He said that decreasing stigma required appropriate training and awareness. P. Yabor noted that decision-makers may not see beyond "healthcare is cheaper to do". B. Palmer stated that there was an increase in revenue for care and treatment with prevention staying stagnant, and that people had made decisions based on these numbers. B. Palmer stated that the cost of HIV treatment annually was about $23,000, and over a lifetime was $379,668. F. Graham asked for clarification on the meaning of "healthcare setting". B. Palmer stated that "healthcare settings" included ERs, FQHCs, doctor's offices, or anywhere with a staff of doctors/nurses. A participant stated that from a CBO standpoint it made sense to focus on services that could be provided at manageable costs. T. Dominique stated that David Holtgrave, who sits on the President's Advisory Council on HIV/AIDS (PACHA), conducted cost-effectiveness analyses for HIV services and was mindful of issues like stigma. B. Palmer stated that policy-makers recognized non-measureable costs and benefits of services. He continued to a breakdown of costs in non-medical settings. He said that the list was organized from lowest costs to highest. He said that in urban settings costs may be lower and that in rural settings they may be higher.

B. Palmer transitioned into the next part of his presentation, which reviewed three major policies impacting biomedical prevention. He said the first was routine HIV testing in clinical settings. He stated that the CDC had guidelines for HIV testing. He said that the US Preventative Services Task Force (USPSTF, a division of HHS) was the agency that made policy for preventative testing measures. He stated that the USPSTF's rationale and guidelines must be followed by insurance companies when they paid out for services. He said that, unlike CDC recommendations, USPSTF recommendations were binding. He said the USPSTF rationale for HIV testing in clinical settings was that identification and treatment of HIV infection reduced the risk of HIV progressing to AIDS, of AIDS-related events, and of death in individuals with immunologically advanced disease. He said that earlier ART reduced the risk of AIDS-related events or deaths and of transmission, and that identification and treatment in pregnant woman reduced the risk of mother-to-child transmission. B. Palmer quoted the task force, noting "the overall benefits of screening for HIV infection in adolescents, adults, and pregnant women are substantial".

B. Palmer stated that the USPSTF recommended screenings for HIV infection in adolescents and adults ages 15 to 65, younger adolescents and older adults at increased risk, and all pregnant women. He reported that the USPSTF recommended one-time screening of adolescent and adult patients and repeated screening "at least annually" for those at very high risk, including MSMs and active IDUs. He said that screening was recommended at "somewhat longer intervals" (every 3 to 5 years) for those at increased risk based on behavioral risk factors, including unprotected vaginal or anal intercourse, the exchange of sex for drugs or money, or sex partners who are HIV-infected, bisexual or IDUs. D. Acosta noted that a substantial community push was needed before the USPSTF would require insurance to pay for HIV testing. B. Palmer explained that the task force issued grades (A through E), reflective of the relative needs for screening for various types of infections based on demographic variables. He stated that anything with a grade of A or B had to be covered by insurance. He said that anything with grades of C, D, and E did not have to be covered by insurance. B. Palmer referred back to the list of HIV screening intervals recommended by the USPSTF. He said that many felt these testing intervals were too infrequent, but that these were the intervals insurance companies would pay for. A participant asked why insurance companies heeded the recommendations of the USPSTF but not those of the CDC, which were often more generous. He noted that many of the people engaged in advocacy were

from the CDC. B. Palmer stated that the USPSTF engaged in a cost-benefit analysis in making its recommendations. He stated that the task force found the overall benefits for screening in the cases they recommended far outweighed the costs. G. Grannan asked, in instances of workplace exposure, if the employer or the employee's insurance was required to pay for testing. B. Palmer stated he guessed the employer's insurance would pay, possibly under the umbrella of workman's comp. B. Palmer stated that the USPSTF had a website and a smartphone application where one could look up personal eligibility for services. P. Yabor asked if the USPSTF welcomed any feedback from the public. B. Palmer stated that prominent task force analyses were advertised and open for public comment. He stated that, as a case in point, Hepatitis C testing was originally going to be designated as a grade lower. B. Palmer explained that the grade was bumped up in response to public advocacy. T. Dominique pointed out that the grade for HIV screening was changed to an A over the course of the last 2 years.

B. Palmer stated that he'd be discussing the ACA next. He noted that images from the next few slides were taken from the Kaiser Family Foundation. He pointed the HPG to a pie chart reflecting insurance coverage for non-elderly adults with HIV in 2009. He stated that 17% of adult PLWHA were not insured in 2009. He said that the biggest reason for the coverage gap was discrimination based on pre-existing medical conditions. M. Coleman said that he believed some people would seek care from a district health center rather than a hospital due to stigma. B. Palmer stated that many people had confidentiality concerns. He stated that PA had mandatory reporting for people diagnosed with HIV, and that this has only been in place since 2006. He said that required reporting was previously confined to AIDS diagnoses. He stated that in New York automatic reporting had been in place for many years. He said that there may still be confidentiality concerns amongst consumers but that leaks of information were rare. B. Palmer returned to his discussion of the uninsured. He pointed out that there was a group of people who did not have insurance and were not receiving Ryan White benefits. He stated that some people were being left out of care altogether due to a lack of insurance. He said that, under the ACA, insurers could no longer deny coverage to anyone based on pre-existing conditions. He explained that insurers could also no longer impose annual limits on coverage or lifetime caps on insurance benefits. He noted that tax subsidies were available based on financial need and only through the Health Insurance Marketplaces. He stated that Medicaid expansion was not available in all states, including PA. He noted that an estimated 600,000 people were not insured in PA due to lack of Medicaid expansion. B. Palmer stated that, under the ACA, the Medicare Part D prescription drug benefit "donut hole" would be closed. B. Palmer explained that the next slide covered uninsured adults with HIV in care. He stated that, if all states expanded Medicaid, nearly every person who had HIV would be covered either by insurance or Medicaid. He noted that, without Medicaid expansion in every state, 29% of people who would otherwise be eligible for Medicaid would not receive it. He stated that Medicaid expansion was important because it increased access to healthcare, and that it would allow PLWHA to automatically be eligible for healthcare without receiving an AIDS diagnosis.

B. Palmer explained the ACA was intended to ensure quality coverage. He stated that the ACA required insurance companies to provide user-friendly information, comprehensive care through 10 essential health benefits, preventative care through HIV screening, and coordinated care under the patient-centered medical home model of care. B. Palmer continued by listing free preventative health services available through the ACA. He stated that these included HIV screening for everyone ages 15 to 65 (and other ages at higher risk), HIV screening and counseling for sexually active women, and HIV screening for adolescents at higher risk. He stated that major investments were already being made in community health centers to provide more opportunities for HIV care delivery. He noted that technical assistance was going out particularly to providers in rural areas where there weren't many HIV treatment centers, especially for minority communities. He said

cultural competency funding was included in the ACA and that this could potentially help to reduce stigma. He stated that the ACA started a National LGBT Health Education Center, funded by HRSA, which operated out of the Fenway Institute in Boston and conducted trainings nationwide to raise awareness. He concluded that the ACA encouraged prevention wellness through investments, improvements in public health surveillance, outreach to health departments, increased coverage for HIV testing, training in diversity and healthcare competency, and incentives to move healthcare providers to underserved communities.

B. Palmer stated that the final portion of his presentation would cover the HIV Continuum of Care. He pointed out the graph of the national continuum of care[1]. He stated that the model was used to improve services for people living with HIV in the areas of HIV Diagnosis, Linkage to Care, Retention in Care, Prescription of ART, and Viral Suppression. He said it's estimated that 82% of people along the continuum were diagnosed with HIV, 66% were linked to care, 37% retained in care, 33% prescribed ART, and 25% virally suppressed. He explained that states were being encouraged to develop their own state-specific continuums of care. He said that some states were better than others at implementing the continuum, and that some were hampered by laws regarding data collection. He explained that information from the continuum model could be used on federal, state, and local levels to prioritize and target resources. He said that in Philadelphia, for instance, we could see which neighborhoods have particularly high HIV rates and allocate resources accordingly to get more people virally suppressed. He stated that the cascade could also be used to monitor national progress on HIV/AIDS. He asserted that it would play a big role in the future in determining where money would be allocated.

B. Palmer stated that the continuum was important because it pinpointed where gaps existed, promoted better health for PLWHA, and helped to achieve the goals of the NHAS. B. Palmer stated that getting people virally suppressed through the continuum of care had been determined to be more cost-effective than other prevention methods. M. Ross-Russell asked if targeting referred to funding of providers of services in specific areas or some other form of targeting. B. Palmer stated that in Philadelphia we knew that certain zipcodes had higher rates of PLWHA. He said that in those zipcodes providers may get more money, or the city of Philadelphia may get more money based on them. M. Ross-Russell stated that individuals often left their neighborhood to receive services because of stigma. She explained that targeted funding may not take into account that people did not always receive services in the same area codes where they lived. B. Palmer stated that many people from West Virginia received testing in Pittsburgh due to confidentiality concerns. N. Johns observed that the cost of providing care services along with other costs like housing were partially high because the services themselves cost a lot of money. B. Palmer stated that the advertising of services in neighborhoods with high incidence rates may itself help reduce stigma. P. Yabor asked how the apparatus based around the Continuum accounted for people who were lost to care or not medication compliant. B. Palmer stated that some kind of infrastructure must be in place in order to get someone from diagnosis to suppressed viral load. He said there were many examples in best practices where linkage to care providers and coordinators helped move people through the process of diagnosis to suppression of viral load. He said there were programs in place, for instance, at his old workplace, where social workers made immediate appointments for individuals directly following their diagnosis. P. Yabor noted that best practice may not be common practice. B. Palmer stated that even routine testing was not common practice. B. Palmer stated that thanks to the ACA there was progress being made, and money being spent in areas where it was needed. He noted that a new project between CDC and HRSA was going to be starting soon in 3 states (including Maryland) which would investigate community health centers' ability to provide primary care for PLWHA. He said

[1] http://aids.gov/federal-resources/policies/care-continuum/

that there was a lot of negative history between community health centers and people with HIV. He stated that the goal was to start a major training program for staff in cultural competency and HIV training and awareness. He stated there were a lot of funds going into moving people along the continuum of care.

B. Palmer noted that there were challenges associated with the continuum of care. He said the largest was collection of data. He explained the state of PA had policy issues surrounding collection of data. He said there was currently a policy in place that prevented state and local health departments from collecting certain pieces of data around people linked to care and receiving ARV therapy. He stated the policy needed to be changed and that the governor could make the changes without action on the part of state government. He stated PA's continuum of care had major drawbacks as a result. B. Palmer noted that another problem was lack of resources at the state and local level. He said that DE and WV were two states that had not developed a statewide continuum of care. He said this was due to lack of needed infrastructure and resources. F. Graham asked what impacts these challenges in PA might have. B. Palmer replied that states and localities that had developed a good continuum of care and good data collection were likely to receive more funding. G. Grannan stated that on the Eastern Corridor of the United States there were people who moved on a seasonal basis that were difficult to track. B. Palmer concurred that seasonal movement was a tricky issue with data collection, and that it may be specific to certain localities, like DC—Virginia—Maryland corridor. He stated that different jurisdictions sometimes used different data collection processes and that their data may not even be comparable. He said in some cases laws needed to be changed and that much education and work would be required. M. Coleman asked about HIV criminalization. B. Palmer stated that the CDC had a list of recommendations regarding HIV criminalization laws, and a listing of these laws was available online by state[2]. He noted that Iowa recently de-criminalized HIV transmission.

B. Palmer directed the HPG to a website called HIV continuum[3]. He said that the site used numbers from Philadelphia from 2012. He stated that the website used various components of the continuum of care and mapped them out in an interactive way, broken down by zipcode, age, and other demographic variables. He stated this kind of tool gave an example of how gaps might be pinpointed using the continuum. He said the site was only available for 3 cities right now: Philadelphia, Washington DC, and Atlanta. He said the website was run by the same people responsible for AIDSVu[4]. He asked the group if they had any more questions and stated that he would be passing along his card for further questions.

Discussion Items:

- **Focus Group Recruitment – *OHP Staff***

N. Johns stated that recruitment for focus groups with high-risk heterosexuals of low SES would begin today. She stated that the OHP had cards available for men and women as well as poster-sized handouts. She stated that the first four focus groups were tentatively scheduled for the last week of September and the first week of October, with dates and times TBA. She said that Dr. Kwakwa from the PHMC Care Clinic downstairs was going to help recruit through the clinic. She reported that recruitment would also be conducted through health centers. N. Johns stated that the OHP would appreciate the HPG's help with recruitment. She said that this round of focus groups would likely be completed before the end of October. T. Dominique asked what age ranges were being targeted. N. Johns replied that the target age range included adults from age 25 to around 40 or 50. She said that participants must identify as heterosexual. She explained that the focus

[2] http://www.cdc.gov/hiv/policies/law/states/index.html
[3] http://hivcontinuum.org/
[4] http://aidsvu.org/

groups were meant to study how to target services for prevention, so HIV-negative individuals or those with unknown status were preferred. F. Graham asked if participants would be compensated. N. Johns stated participants would be given a $20 CVS gift card and would also be provided with SEPTA tokens and a meal. N. Johns stated that focus groups lasted around 2 hours or less.

- **HPG Nominations**

J. Chapman explained that she would be presenting some ideas to the HPG about forming a Nominations Committee. She said that she had sent out emails about this in the past and that it was discussed at the last meeting. She suggested that Nominations might be added to the agenda as a discussion item for the next few HPG meetings. She noted that everything in her presentation was merely a proposal and that she was open to suggestions.

J. Chapman proposed a structure consisting of three groups -- a Nominations Committee and two other groups, one for membership development and another for new member orientation. She stated that, at the last HPG meeting, she had discussions with individual members that revealed information gaps. She said she hoped her proposed committees could help close such gaps.

J. Chapman stated that the Nominations Committee would review the CDC's HPG Guidance document, which contains a membership and stakeholder profile that must be filled out annually. She said the Nominations Committee would assess membership and identify gaps. She stated this group would also be in charge of membership and stakeholder recruitment and selection. She said members would be recruited actively (directly) and in passive ways (through flyers and Youtube videos). She said the Nominations Committee would review application materials and would also review completed applications from potential members for selection and appointment. She said the Nominations Committee would also focus on membership retention, including attendance, follow-up, and re-engagement.

J. Chapman said that the Membership Development group would assess how things were going with membership. She stated that this group would gauge member needs and satisfaction. She said members would be asked about their satisfaction with the location, time, date, frequency, and length of meetings. She said membership needs assessment could include identifying topics and speakers for meetings. She also brought up the possibility of doing an HPG membership satisfaction survey, which the RWPC had done in the past. She stated that a short post-meeting survey might also be an option.

J. Chapman continued to the third item, a New Member Orientation. She said orientation sessions might cover what the HPG is, why it exists, and what it does. She stated that people who were new to the HPG would want to familiarize themselves with basic elements like what the Prevention Plan is and how it can be accessed. J. Chapman said materials could be developed for these orientation sessions. She suggested the HPG brainstorm ideas for things potential members should be familiar with. She said they could develop a "what is the HPG" elevator speech, or make a succinct summary of 3 things the HPG had been working on. J. Chapman noted that many printed materials that could benefit new members were already available on the OHP website (including the Prevention Plan and Epi Profile). However, she said their existence might not be well-communicated to members. She also noted that acronyms may be unclear to new members. She suggested an orientation packet be put on the OHP website.

J. Chapman reviewed the mission statement of the State HPG, and stated that it could be revised in minor ways to reflect the vision, values, and mission of the Philadelphia HPG[5]. She asked the HPG to decide if the 3 Nominations subdivisions made sense to them, and to identify a group they'd personally like to participate in. She said she would mail out the slides from today's presentation to members. She said she'd include a SurveyMonkey link to collect feedback and so members could select one of the 3 groups. C. Poevio said he'd appreciate the opportunity to think about the suggestions and reply at a later date. J. Chapman stated that she would send an email out to members regarding the proposed Nominations structure before Labor Day.

D. Acosta asked HPG members to think about what kind of informational presentations would be helpful to them. D. Acosta said there would be a presentation from Melinda Salmon in the future on partner services, which were becoming critical for prevention. J. Chapman stated that the HPG was hoping to bring in Kathleen Brady of AACO sometime in the fall to deliver an update on the Philadelphia Continuum. D. Acosta stated that AACO has worked hard to get the data it had collected back to providers and to break it down into groups (e.g. MSM) for planning purposes. He said programs like AIDSView reflected a lot of movement on the part of the surveillance unit and a drive to get data out to the public.

Old Business:
None.

New Business:
None.

Research Updates:
None.

Announcements:

[5] VISION. The vision of the Pennsylvania HIV Planning Group is to ensure that all persons living with HIV and those identified most at risk have access to current prevention, treatment and care, interventions, and services through a continuum of engagement that includes testing, linkage and maintenance in the health care and supportive system.

MISSION. The purpose of the Pennsylvania HIV Planning Group is to provide a forum for key stakeholders across the Commonwealth to formally provide input to the PA Department of Health on issues related to HIV/AIDS care, prevention, and testing in order to address goals of the National HIV/AIDS Strategy.

VALUES. The Pennsylvania HIV Planning Group embraces these values in achieving our vision and mission:

Parity – equal participation in carrying out tasks or duties in the planning process; an equal voice.

Inclusion – meaningful involvement in decision making to insure that the needs of the affected community and care providers are actively included.

Representation – defined as the act of serving as an official member reflecting the perspective of a specific community. A representative should truly reflect that community's values, norms, and behaviors (members should have expertise in understanding and addressing the specific HIV needs of the populations they represent).

N. Johns stated that in October or November, the Planning Council would welcome Kathleen Brady of AACO to talk about Federal Infant Mortality Review (FIMR) process. N. Johns said that she would confirm the date at the next HPG meeting. B. Morgan stated the CDC has just released flyers targeting the Latino community and that they could be downloaded online[6]. P. Yabor presented a flyer for an International Overdose Awareness day event. He stated that the event was being put on by the Philadelphia Student Harm Reduction Coalition. He said this group would also be hosting a movie night once a month. He expressed a hope that the cause of harm reduction would spread to more schools in the area. T Dominique stated that M. Ross-Russell was just honored with the Policymaker Award as a part of the University of Pennsylvania's Center for AIDS Research (CFAR)'s CAB Red Ribbon awards. J. Chapman stated that tomorrow at 2pm the CDC NPIN would be hosting a webinar on PrEP and what it means for the Hispanic/Latino community.

Adjournment: **Motion**: The meeting was adjourned by general consensus at 4:26p.m.

Respectfully submitted by,

Jennifer Hayes, OHP

Handouts distributed at the meeting:

- Meeting Agenda
- July 23, 2014 Meeting Minutes
- HIV Prevention in the Biomedical Era Slides
- OHP Calendar

[6] cdc.gov/OneConversation