Philadelphia HIV Prevention Planning Group (HPG)
Meeting Minutes of
Wednesday, August 17, 2016
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Jennifer Chapman, Caitlin Conyngham, Tiffany Dominique, Gus Grannan, Lorett Matus, Clint Steib

Absent: Fred Graham, Daniel Harris, Mark Anthony Wilson, Jr., Nick Wood, Paul Yabor

Guests: Joseph Roderick, Leroy Way, Mark Coleman

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

Call to Order: J. Chapman called the meeting to order at 2:40p.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**: L. Matus moved, L. Way seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*July 21, 2016*): J. Chapman presented the minutes for approval. G. Grannan asked that "safe injection" be amended to "safer consumption" on pg. 4. **Motion**: J. Chapman moved, G. Grannan seconded to approve the July 21, 2016 minutes as amended. **Motion passed**: All in favor.

Report of Co-Chair: None.

Report of Staff: N. Johns reported that the Integrated HIV Prevention and Care Plan was nearly complete. She stated that it would be posted on the OHP website in September.

B. Morgan reported that the City of Philadelphia had posted a community health explorer tool, which could be accessed on their Github page[1].

Discussion Item:

- **Care/Prevention Integration**

J. Chapman stated that the HPG and RWPC had considered integrating several years ago. She noted that collaboration between the two bodies had increased in the past several years, and several joint meetings had been held. She added that the HPG and RWPC worked together on the integrated plan. Therefore, the Integrated Executive Committee had discussed reintroducing the discussion of care and prevention integration.

J. Chapman stated that today's slides came from a CDC/HRSA presentation at the 2015 United States Conference on AIDS (USCA). She stated that integrated planning was the process by which HIV planning groups work together to review information about the HIV epidemic in the jurisdiction, provide recommendations for and/or allocate resources for interventions and services to address the epidemic, and review needs assessments and/or service utilization to further inform

[1] http://cityofphiladelphia.github.io/community-health-explorer/

recommendations. She noted that integrated planning could be accomplished through collaboration on joint projects, integration of planning products, and partially or totally integrating planning bodies.

J. Chapman reviewed a list of reasons why the groups might integrate their planning activities. She said these included developing a coordinated jurisdictional response to HIV, avoiding duplication of processes, intersections and shared knowledge, sharing resources economically, and increasing collaboration and communication. She noted that prevention and care were increasingly overlapping in both activities and funding. Further, many national policies supported integration, including the National HIV/AIDS Strategy (NHAS).

J. Chapman noted that new strategies for HIV prevention impacted care settings. She added that prevention planners should pay attention to both care and treatment because of a great deal of overlap in the areas of PrEP, treatment as prevention, and linkage to care, among other topics.

J. Chapman reviewed common goals of prevention and care. These include ensuring that individuals learned their HIV status; ensuring that HIV positive individuals were linked to medical care, supportive services, and prevention services that met their needs; and ensuring that high risk HIV negative individuals were linked to prevention services.

J. Chapman stated that there were several possible barriers to integrated planning. She said that prevention tended to focus on Philadelphia, whereas the care side focused on Philadelphia along with 8 surrounding counties in Pennsylvania and New Jersey.

J. Chapman reviewed some potential benefits of integrated planning. She said integrated planning allowed development of a common mission, encouraged sharing of knowledge and data, maximized limited resources reduced planning costs, created comprehensive services, and fostered integration of prevention into care services and vice versa.

J. Chapman explained that many states had successfully integrated their care and prevention planning bodies, including the commonwealth of Pennsylvania. She noted that the group could look to these jurisdictions for guidance and experience. She stated that integration had gained wide acceptance.

J. Chapman stated that the HPG and RWPC would work together to establish a timeframe for integration. She noted that the groups would be able to use materials from their previous discussions about integration, which would shorten the timeframe needed for the integration process.

C. Steib said he supported the idea of care and prevention integration. He stated that it could facilitate the sharing of information. He asked how integration would affect voting in the RWPC and HPG. He noted that there had been a transition to integration on a federal level.

G. Grannan stated that he was concerned that prevention voices would be silenced by integration. He noted that Ryan White took a medical approach to HIV/AIDS care. He stated that it did not address social determinants that were relevant to prevention. He noted that Ryan White funding was much greater than CDC prevention funding.

C. Conyngham noted that HIV treatment was one form of prevention. She stated that there was a great deal of overlap between care and prevention, and one affected the other. She discouraged the mindset that the two groups were competing over resources. She stated that combining care

and prevention could be a step toward decreasing stigma, because the planning process would address both HIV positive and negative people.

G. Grannan reiterated that prevention funding was scarcer than care funding. C. Conyngham noted that linkage to and retention in care helped to prevent HIV. G. Grannan noted that many people were not in medical care. He stated that some prevention work was distinct from clinical work.

M. Ross-Russell noted that most providers represented in the RWPC offered prevention services as well as care services. She reiterated that national goals, including the NHAS, encouraged integration. She stated that the city received a significant amount of prevention funding. She noted that the HPG did not have the same legislative authority as the RWPC. She suggested that integration could actually help to amplify prevention voices. She stated that the Planning Council had embraced discussion from a prevention standpoint in the past. She noted that stigma and social determinants were parts of the conversation on the care side. She stated that the HPG and RWPC could benefit from one another. She noted that the HPG and Planning Council would both decide whether or not they wanted to pursue integration, and the OHP would provide support according to their decision.

C. Steib encouraged the group to take steps to ensure the prevention side was heard at integrated meetings. He suggested that prevention representatives place relevant items on the agenda.

T. Dominique asked if there would be long-term consequences if the planning bodies did not merge. M. Ross-Russell replied that there may not be repercussions, but the federal government (HRSA and the CDC) encouraged integration. She noted that one obstacle to integration could be the differences between Philadelphia and 8 NJ and PA counties. She added that there were some barriers and disconnects around PrEP, syringe access, and other services between care and prevention and the different regions of the Ryan White Part A EMA. J. Chapman noted that prevention providers could contribute expertise on many topics like PrEP.

J. Chapman stated that she'd like to ensure care and prevention were treated as equals if integration was to occur. She noted that this included collaborating on dates and times for the meetings. She stated that some other regions had dissolved both planning bodies and formed a new integrated planning body. She said some planning bodies had asked members to reapply. B. Morgan reported that the commonwealth of PA had formed a temporary integrated body, and all members of the interim planning group were included as members when the new integrated planning body formed. She noted that integrating the HPG and RWPC may proceed more quickly than state-level integration had.

C. Steib asked if the Planning Council was generally supportive of integration. J. Chapman stated that many Planning Council committee co-chairs had expressed support for the idea at the most recent Integrated Executive Committee meeting.

N. Johns noted that she provided staff support for the Comprehensive Planning Committee of the RWPC. She stated that the Comprehensive Planning Committee addressed many topics that overlapped with prevention. She said some of those topics included social determinants, substance use, and access to primary care. She stated that these issues were not exclusively clinical or medical. She noted that representatives of the HPG could provide expertise on some of the topics that the Comprehensive Planning Committee discussed.

J. Chapman asked participants if they'd like to move forward with their discussions about integration. **Motion**: J. Chapman moved, C. Steib seconded that the group move forward with the process of integrating the RWPC and HPG, pending Planning Council support. **Motion passed**: 5 in favor, 1 opposed, 0 abstained.

L. Matus suggested that the group review materials that they'd developed during their previous discussions of integration. J. Chapman distributed a handout comparing the care and prevention planning bodies (*see-attached sheet*). She stated that there was also a draft version of bylaws for an integrated group. B. Morgan noted that the bylaws were in an early stage. She stated that some Planning Council subcommittees would need to remain, including the Finance Committee and Positive Committee. However, committees may be added (e.g. a prevention committee). She noted that the group might also include other bylaws that ensured equitable participation of care and prevention in the integrated planning body. She stated that the prior draft bylaws did not include any such provisions. She noted that the draft bylaws were used as a guide for the HPG's bylaws when the PPG was dissolved and the HPG was created several years ago.

J. Chapman noted that an ad-hoc governance committee had been formed several years ago, when integration was initially being discussed. She stated that the group was charged with creating written recommendations for integration. She said they drafted a list of principles. She asked the HPG if they were interested in forming a similar ad-hoc governance committee concerning integration. She noted that both HPG and RWPC members would participate. She stated that the group had met once a month in the past. Several members expressed interest in joining such a committee.

J. Chapman stated that she'd speak with colleagues from other jurisdictions that had pursued care and prevention integration. She said she'd compile materials to bring to the first meeting of the designated governance committee.

J. Chapman stated that the group would continue their discussion after hearing back from the RWPC. She asked the group to think about topics they'd like more information about. She stated that it would be necessary to orient HPG members to RWPC terminology and procedure. N. Johns said that an orientation could be held to share information about the Planning Council with HPG members.

- **RWPC Report** – *OHP Staff*

B. Morgan stated that the RWPC met on August 4th. She said visitors from HRSA had attended the meeting, as a site visit was being held that week. She reported that the Planning Council voted on EMA-wide allocations for the 9-county area.

Old Business: None.

New Business: None.

Research Updates: T. Dominique reported that the Wistar Institute had received a $23 million grant for HIV cure research. She noted that many collaborators would participate in the project, including Philadelphia FIGHT. She stated that the site was one of 5 chosen across the country.

Announcements: T. Dominique stated that on September 19th the Center for AIDS Research Community Advisory Board (CFAR CAB) would hold a policy briefing for elected officials on HIV, starting at 9am at the Doubletree hotel at Broad and Locust. She said that on September 30th the University of Pennsylvania Mental Health AIDS Research Center CAB was having an event

called Connecting the Dots, discussing mental health and HIV. She said the training would be held from 8am-3pm at Community Behavioral Health (CBH) at 801 Market St. She said that registration for the event would be organized by COMHAR. She stated that AACO and American Public Health Association (APHA) credits would be offered for attending the event.

M. Coleman stated that August 26th was the anniversary of women's suffrage in the United States.

Adjournment: The meeting was adjourned by general consensus at 3:41p.m.

Respectfully submitted by,

Jennifer Hayes, OHP

Handouts distributed at the meeting:

- Meeting Agenda
- July 21, 2016 Meeting Minutes
- RWPC/PPG Comparison Chart
- OHP Calendar

MEETING AGENDA

Wednesday, August 17, 2016
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Moment of Silence/Introductions

Approval of Agenda

Approval of Minutes (*July 21, 2016*)

Report of Co-Chairs

Report of Staff

Discussion Item:

- Care/Prevention Integration
- RWPC Report – *OHP Staff*

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, September 28, 2016 from 2:30-4:30p.m.** at the Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

HIV PREVENTION PLANNING GROUP (HPG)

Ryan White Planning Council (RWPC) of the Philadelphia Part A EMA
Comprehensive Planning, Needs Assessment, & HPG Joint Meeting
Meeting Minutes
Thursday, July 21, 2016
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: Katelyn Baron, Keith Carter, Karen Coleman, Lupe Diaz, David Gana, Ann Ricksecker, Adam Thompson, Lorrita Wellington, Tre Alexander, Gerry Keys, Leroy Way, Mark Coleman, Joseph Roderick, Jennifer Chapman, Gus Grannan

Absent: Tyler Berl, Peter Houle, Cheryl Dennis, Pam Gorman, Caitlin Conyngham, Tiffany Dominique, Fred Graham, Daniel Harris, Lorett Matus, Clint Steib, Mark Anthony Wilson, Jr., Nick Wood, Paul Yabor

Guests: Nicole Miller

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

Call to Order/Introductions: L. Diaz called the meeting to order at 2:06p.m. Those present then introduced themselves.

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

Approval of Minutes *(June 23, 2016)*: L. Diaz presented the Comprehensive Planning minutes for approval. D. Gana noted that he'd asked to be excused from the meeting. **Motion**: G. Keys moved, K. Coleman seconded to approve the June 23, 2016 minutes as amended. **Motion passed**: All in favor.

Approval of Minutes *(June 29, 2016)*: L. Diaz presented the HPG minutes for approval. **Motion**: J. Chapman moved, G. Grannan seconded to approve the June 29, 2016 minutes. **Motion passed**: All in favor.

Report of Staff: None.

Report of Chair: None.

Discussion Item:

- **Review Integrated Prevention and Care Plan**

N. Johns noted that the Comprehensive Planning Committee, Needs Assessment Committee, and HIV Prevention Planning Group (HPG) were all invited to today's meeting. She referred the group to the draft of the Integrated HIV Prevention and Care Plan in their packets. She stated that some edits had been made, and some information had been added to the plan since last month. She noted that the appendices for the plan were not included in the packet. She stated that the current draft appendices included demographic maps, information about activities, the retention navigation model developed by the Comprehensive Planning

Committee and approved by the RWPC last year, a workforce capacity list, a glossary, and a letter of concurrence from the co-chairs of the RWPC and HPG.

N. Johns explained that Section II examined the goals and objectives for the whole plan. She stated that Section I discussed the epidemic, general populations served in the EMA, risk behaviors, the care continuum, area resources, and needs/gaps in services.

L. Diaz asked if any changes have been made to the plan based on email feedback that had been received. N. Johns replied that some changes had been made, though many were typos or issues with organization. She said B. Morgan had also touched up the data section of the plan. B. Morgan clarified that the changes had been made in the data sources section but not the data in the epidemiological overview. She added that part C would be reorganized in the final version of the plan. She said that the plan addressed health insurance premium/cost-sharing assistance and housing based on recent discussions during allocations.

N. Johns noted that the National HIV/AIDS Strategy (NHAS) and NHAS populations were used to identify goals, objectives, strategies, and activities in Section II. She noted that each goal was required to have at least 2 objectives, 3 strategies, and 1 activity. She explained that not all activities that were being conducted in the EMA would be included in the plan.

N. Johns said the first goal in the plan was to reduce new HIV infections. She stated that the goals, objectives, strategies, and activities were numbered and broken down into sub-items. She stated that each objective included a timeline, responsible parties, activities, target populations, and data indicators.

L. Diaz asked the group to take turns reading through the goals, objectives, and strategies. K. Carter read off Objective 1.1 and Strategy 1.1.1 along with the associated activities (*see plan for text of each item*). A. Ricksecker asked why the first row in the spreadsheet said "PDPH and partners." M. Ross-Russell replied that "partners" was non-specific because the organizations involved might change over the five years of the plan.

G. Keys read Strategy 1.1.2 and the associated activities. K. Carter asked for a definition of 4th-generation testing. M. Ross-Russell explained that 4th generation tests were processed by particular equipment. N. Johns said the equipment was available to identify infections earlier than previous methods. G. Keys noted that the 4th generation tests were done in a lab. N. Johns added that 4th generation testing technology was available in hospitals and other healthcare settings. She said the Philadelphia Department of Public Health (PDPH) was working to make this testing more broadly available.

D. Gana read Strategy 1.1.3 and the associated activities. M. Coleman asked who was considered a partner for the purposes of partner services. N. Johns said partners referred to any sexual and drug using partners. She explained that people who tested positive for HIV were asked to share information about their recent sexual partners, and then outreach was conducted to these partners, who were then tested for HIV. G. Grannan noted that partner services representatives had presented at a meeting last year. He stated that partner services workers did not seem adequately prepared to track drug using partners. He added that stigma and HIV were closely related, which may get in the way of identifying partners. He noted that sex workers were not a risk group identified in the NHAS.

A. Ricksecker suggested adding an activity about cultural competency training for partner services workers. M. Ross-Russell noted that an activity could be added under several goals or objectives, depending on where the group felt it fit best. N. Johns stated that a strategy could be added under Objective 1. G. Grannan noted that all goals of the NHAS required cultural competency. A. Ricksecker stated that cultural competency training may be paired with other initiatives (e.g. a particular organization being enlisted to help meet certain goals or objectives).

M. Ross-Russell stated that the plan could note that the lack of inclusion of sex workers in the NHAS was a barrier. She noted that a limited definition of cultural competency may also be included in barriers. A. Thompson noted that key populations and target populations were different. He stated that the distinction reflected a change from incidence-based targeting to transmissibility. He noted that some traditional target populations were removed from the strategy because they did not have transmission statistics in the data.

N. Miller read Objective 1.2, Strategy 1.2.1, and the associated activities. A. Thompson noted that condoms were not the most effective method of HIV prevention for young men. N. Johns stated that condom distribution programs had been very effective. M. Ross-Russell noted that some of the strategies and activities would be carried out primarily by the PDPH. N. Johns noted that the condom distribution program was not designed exclusively for gay and bisexual men. She said it also included all youth. M. Ross-Russell noted that CDC grant 15-1509 focused on prevention with gay and bisexual men of color.

K. Coleman read Strategy 1.2.2 and the associated activities. A. Thompson noted that New York state was cross-training people involved in the PrEP screening and intake process on accessing insurance so they could help patients get access to PrEP. N. Johns noted that insurance counseling was a component of 15-1509. K. Carter asked if there was a problem paying for PrEP in NJ. A. Thompson replied that some consumers who were seeking PrEP were not insured, but were now eligible for Medicaid. N. Johns pointed out that patient assistance programs were not a permanent solution for helping people access PrEP. A. Ricksecker suggested that providers be trained on prescribing PrEP. She disclosed a conflict of interest, as an employee of an organization that provided training.

B. Morgan referred the group to Strategy 3.1.2 on pg. 69. She noted that access to PrEP was covered by this strategy as well.

M. Coleman read Strategy 1.2.3 and the associated activities. He noted that there were many community resources available for syringe access and people who inject drugs. G. Grannan stated that more resources were needed for medication-assisted treatment for opioid addiction in the Eligible Metropolitan Area (EMA). He pointed out that some recovery programs did not support medication-assisted treatment. A. Edelstein stated that syringe exchange programs were controversial, and changes were needed to expand access outside Philadelphia. N. Johns noted that there was advocacy on the state level for the expansion of syringe access programs. She pointed out that syringe access was a significant program in some of the PA suburban counties. She noted that the activity was left vague in terms of how syringe access would be expanded. A. Thompson noted that syringe exchange programs were not the only forms of syringe access available. He stated that syringes could be prescribed as well.

A. Ricksecker referred to the wording "related harm reduction services." She asked if the strategy intended to expand access to medication-assisted treatment. She noted that there was a statewide standing order to expand access to Narcan. She stated that the goal could apply not just to HIV prevention, but also death prevention. G. Grannan noted that the strategy could potentially refer to safer consumption spaces as well. N. Johns noted that the barriers section of the plan could be updated to include barriers to treatment and syringe access.

N. Johns clarified that bolded items in the section addressed points along the care continuum.

J. Roderick read Strategy 1.2.4 and the associated activities. G. Grannan asked how the reduction of community viral load would be measured. A. Thompson suggested changing the wording to "reducing the amount of virus present in a community" because it did not imply a specific population.

L. Way read Strategy 1.2.5 and the associated activities. A. Ricksecker noted that several local organizations were involved in the Fetal Infant Mortality Review (FIMR) process. She noted that the goal was 0 perinatal HIV transmissions. G. Grannan asked about the number perinatal transmissions in Philadelphia. N. Johns stated that it was usually 0 per year, and 2 was the highest number in the last several years. B. Morgan said the frequency of perinatal transmission was slightly higher in the suburban counties.

A. Ricksecker read Strategy 1.2.6 and the associated activities. A. Thompson asked how many days linkage to care was supposed to take. N. Johns said it needed to be done within 30 days. T. Alexander read Strategy 1.2.7 and the associated activities. M. Coleman stated that peer support was an effective means of youth outreach.

Attendees broke into 3 groups to discuss goals 2-4 for 20 minutes.

After the large group reconvened, M. Ross-Russell, speaking on behalf of the Goal 2 group, began with Strategy 2.1.1. She stated that there was a need to look into "evidence-based" versus "evidence-informed". She stated that, for 2.1.3, they added the AIDS Education and Training Center (AETC) in New Jersey. Under 2.2.1 the group proposed adding a behavioral health assessment. For the first activity under 2.2.2 she suggested that satisfaction data be added to the data indicators. A. Thompson stated that service providers could ask consumers "are the services provided linguistically and culturally competent for you?"

M. Ross-Russell read Strategy 2.2.3. N. Johns asked if target populations for the second activity should be expanded to service providers as well as clients. She asked who would be the responsible party. A. Thompson stated that trainers could be responsible for providing this information to providers. M. Ross-Russell proposed adding NJ AETC to all items that had Mid-Atlantic AETC listed.

K. Baron read on behalf of the Goal 3 group. She began with Strategy 3.1.1. She noted that the target population for the first activity specified HIV-negative MSM of color. She explained that the target population was chosen due to the focus of 15-1509. However, the group suggested noting the need for navigation services for other populations as well. They also suggested including criminalization of sex work and nondisclosure under barriers. N. Johns stated that she'd put these items in section D. For Strategy 3.1.2's first activity, the group recommended that PrEP and nPEP be distributed in communities where it traditionally

was not provided. A. Thompson noted that nPEP was frequently accessed at hospitals. K. Baron stated that some people were not aware that PrEP and nPEP were available in a primary care setting, and they didn't need to go to Center City to find it.

K. Baron stated that the group requested a definition of trauma-informed services. N. Johns said the term could be defined in the glossary of the plan. K. Baron said one group member had wondered what "trauma" meant. A. Thompson replied that there was no comprehensive list for what qualified as trauma. He stated that, under Goal 3 of the NHAS, one strategy was the active inclusion and promotion of PLWHA in leadership positions. He stated that consumer involvement in leadership could help improve cultural competency within organizations.

T. Alexander spoke on behalf of the Goal 4 group. He read 4.1.1 and stated that the group was satisfied with the activities. Under 4.1.2, he said the group would like to take the term "TA units" and change it to something like "training and capacity building units". He said the group suggested that 4.1.3 include data that the Planning Council had gathered. He stated that under 4.2.3 the group suggested outreach to Latino communities. He brought up access to translation services as well. He stated that the group would like to see more participation of Latino people in subcommittee meetings. N. Johns noted that a large Spanish-speaking group attended Positive Committee minutes. She noted that interpretation services and translated documents were made available to them. She stated that the services could be provided as needed and requested due to cost. A. Thompson noted that 4.1.3 didn't explicitly state what relevant public data was. He suggested that performance data from providers be made more available to the public. G. Grannan suggested developing capacity within the Positive Committee for community input.

M. Ross-Russell noted that Spanish-speaking participants in meetings requested information and were provided with it whenever possible. She stated that outreach was being done to the Latino community and efforts were being made to be inclusive. She added that the OHP wanted Latino people to be comfortable attending meetings, and was currently in the process of expanding their access. D. Gana noted that 2 Latino people who attended Positive Committee meetings had expressed interest in joining the RWPC. A. Ricksecker noted that Spanish-speaking people had attended allocations this year. She added that it would be good to see them attending other meetings as well. She suggested giving all stakeholders training and making sure meetings were understandable for all. A. Edelstein suggested giving presentations about the RWPC in the community. N. Johns stated that, many years ago, the Positive Committee regularly conducted community outreach events. She said many of these events had been very successful. A. Thompson added that HRSA planned to conduct trainings in the community for people to take on leadership roles in community planning.

N. Johns urged all participants to send her further comments on the plan via email at nicole@hivphilly.org. She asked they note the page number and paragraph when giving input. She stated that she would also take calls and visits to talk about the plan as well. She noted that all feedback needed to be received by next week, as a draft of the plan would be completed by mid-August.

M. Ross-Russell noted that the co-chairs were invited to sign a letter of concurrence with the integrated plan. She asked the group if they felt comfortable with providing the signed letter of concurrence. A. Thompson asked if the letter of concurrence was used to express

reservations that were not at the grantee or Planning Council level. M. Ross-Russell stated that the HPG had expressed reservations before in their letter of concurrence. The group agreed by consensus to endorse the co-chair's signing the letter of concurrence.

Old Business: None.

New Business: L. Diaz stated that she'd be stepping down from her position as co-chair of the Comprehensive Planning Committee (CPC).

Next Steps: N. Johns stated that the final draft of the integrated plan should be completed by the next CPC meeting. She asked the group to look through Section III on their own and send in any suggestions. She noted that Needs Assessment and the CPC would begin working on the Consumer Survey in the fall. She said that the CPC would also conduct priority setting this year.

Announcements: None.

Adjournment: The meeting was adjourned by general consensus at 3:59p.m.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- June 23, 2016 Meeting Minutes
- Integrated HIV Care and Prevention Plan (draft)
- OHP Calendar

Care (RWPC)	Prevention (PPG)
Service Area(s): NJ (Burlington, Camden, Gloucester and Salem) PA (Bucks, Chester, Delaware Montgomery Philadelphia County)	Service Area(s): Philadelphia County

Federal Legislative Mandate (required by law RWPC must):
• Allocation of regional funds (annual)
• Prioritization of services
• Monitoring the administrative mechanism
  o ensuring funds are rapidly distributed
  o making sure spending and allocations match
  o service to be delivered are consistent with areas of greatest need as identified in the RFP
• Needs Assessment Activities
  o Determine needs of consumers
• Develop a Comprehensive plan
• Letter of Assurance
	Requirement of CDC grant:
	• Engage stakeholders (so they can inform the jurisdictional plan)
	• Identify, encourage, and facilitate the participation of key stakeholder who can inform the HIV planning process
	• Review of prevention plan (plan written by HD)
	• Letter of concurrence (annual)
	  o documentation that HPG informed the development of the plan
	  o the plan shows that programmatic activities and resources are being allocated/directed to the most disproportionately affected populations/geographic areas

Membership requirement:
• 17 membership categories
  o Health care providers, incl. fed. Qualifying health centers
  o CBOs serving affected populations and ASOs
  o Social service providers, incl. housing & homeless service providers
  o Mental health providers
  o Substance abuse providers
  o Local public health agencies
  o Hospital planning agencies or other health care planning agencies
  o Affected communities, incl. PLWH & historically underserved subpopulations
  o Non-elected community leaders
  o State Medicaid agency
  o State Part B Agency
  o Part C grantees
  o Part D grantees
  o Grantees of other Federal HIV programs, incl. HIV prevention programs
  o Formerly incarcerated PLWH or their representatives
  o Members of Federally Recognized Indian Tribe as represented in the population
	Stakeholder requirement:
	• 16 membership categories
	  o HIV clinical care provider
	  o Community Health Care Centers
	  o Social service
	  o Homeless Services
	  o Mental Health
	  o Substance Abuse
	  o Local Education Agencies/Academic Intuition
	  o PLWHA
	  o Corrections (Prison)
	  o Health Dept (HIV, STD, TB, Hepatitis
	  o Faith Community
	  o Behavioral or Social Scientist
	  o Epidemiologist
	  o Business/Labor
	  o Intervention Specialist
	  o HOPWA
	Stakeholder HIV risk population: should reflect the local epidemic
	• PLWHA
	• MSM
	• MSM/IDU
	• Heterosexual
	• TG
	• TG/IDU

Note: *This is information relates solely to the planning processes and does not include all of the grantee and/or OHP's roles and responsibilities.*

○ Individuals co-infected with Hepatitis B or C or their representatives • 35minimum, 55 maximum • 33% unaligned consumers (50% PC goals) • Must reflect regional representation (NJ, PA and Phl)	
AACO/OHP's roles in planning process: • Administrative agent (HD only) ○ Distributing CARE Act funds in accordance with Planning Council allocations • Monitor, identify support for, and be apprised of the activities of the RWPC • Produce Epi profile • Produce care plan	**AACO/OHP roles in planning process:** • Allocation and fiscal oversight of prevention funding (HD) • Determine target populations and interventions • Documentation of the process • Documentation of stakeholders • Review and document epidemiologic and other data sources • Produce a jurisdictional prevention plan • Conduct needs assessment activities

Note: *This is information relates solely to the planning processes and does not include all of the grantee and/or OHP's roles and responsibilities.*