PROTOCOLS
of the
PENNSYLVANIA
HIV PLANNING GROUP (HPG)

Adopted: Sept. 19, 2013
Latest Revision: January 4, 2019

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SECTION I: NAME AND LOCATION

1.1. NAME. The name of this advisory group is the Pennsylvania HIV Planning Group. This group is organized and sponsored by the Pennsylvania Department of Health (Department), Bureau of Communicable Diseases, Division of HIV Disease. The group may be referred to, in shortened form, as the HIV Planning Group (HPG).

1.2. OFFICE/LOCATION. The HPG can be contacted through the Department's Bureau of Communicable Diseases, Division of HIV Disease. The Director of the Division of HIV Disease can be reached by mail at: PA DOH, 625 Forester St., Harrisburg, Pennsylvania 17120, or by calling 717-783-0572.

Meetings of the HPG will take place in a hotel or other venue selected by and paid for by the Department through a bid proposal process. Representatives of the Department will consult HPG regarding meeting locations. However, the final decision regarding venue is at the discretion of the Department.

A list of the HPG members can be found at www.stophiv.com, a website sponsored by the PA Department of Health, Division of HIV Disease and maintained by the HIV Prevention and Care Project. In addition to through the website, HPCP can be reached at 412-383-3000.

SECTION II: CREATION AND DISSOLUTION

2.1. CREATION OF HPG. The HPG was formed to respond to the integration of care and prevention planning. Prior to 2013 the Integrated Planning Council (IPC) focused on care and the Community Planning Group (CPG) focused on prevention as directed by the Pennsylvania Department of Health (Department). These two planning bodies decided to integrate care and prevention in response to the recommendations from the Health Resources & Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC). This integrated planning body will function as an advisory group to the PA Department of Health to assist in meeting legislative requirements and expectations, to review best practices for use in PA, and accomplish all HIV Disease planning activities for the Commonwealth.

2.2. DISSOLUTION OF HPG. The Department is required by its funding agreement with HRSA and the CDC, to conduct HIV jurisdictional planning as part of its comprehensive HIV care and prevention programs. The HPG may be discontinued by the direction of HRSA and/or the CDC or as a result of the termination of the Department's grant with HRSA and/or the CDC.

2.3. CREATION OF SUBCOMMITTEES, AD HOC SUBCOMMITTEES, and WORK GROUPS. Subcommittees have been created within the HPG as described below in section 5.3. These subcommittees may be revised at the discretion of the HPG when properly presented and with a majority vote. Ad Hoc committees can be formed at any time by the HPG when a short-term task is identified by presenting a motion and a majority vote is received. Work groups have been established to address several on-going needs of the HPG. Additional work groups may be presented to the HPG for consideration by motion and implemented by majority vote. All

committees and work groups have a defined purpose, goal, and objective(s) and elect a chair person to guide their work.

2.4. DISSOLUTION OF SUBCOMMITTEES, AD HOC SUBCOMMITTEES, and WORK GROUPS. Subcommittees may be dissolved and new subcommittees established by presenting this recommendation to the HPG. The Steering committee will then further discuss the recommendation and decide whether or not to bring the recommendation to the HPG for a vote. As long as the HPG exists there will be a need for subcommittee work and therefore any recommendation of dissolution of current subcommittees would require a suggestion for new subcommittees. Ad Hoc subcommittees are short-term committees and will be dissolved at the completion of their assigned task. Work groups participate in on-going activities and therefore dissolution of a work group would need to be presented to the HPG for discussion, Steering committee for determination, and potentially the HPG for a vote. Any Ad Hoc committee or Work Group that has not met for a period of six (6) months shall be deemed suspended and that committee's chair shall be relieved of his or her obligation and shall cease to be a member of the Steering Committee. The Steering Committee may, at its discretion, choose to reorganize the ad hoc committee or work group or dissolve the Ad Hoc committee or work group. Any action taken is to be presented to the members of the HPG and voted upon.

SECTION III: VISION/MISSION/VALUES

3.1. 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.

3.2. MISSION. The purpose of the Pennsylvania HIV Planning Group is to provide a forum for key, representative stakeholders across the Commonwealth and to formally provide input to the PA Department of Health on the Division of HIV Disease's *Integrated HIV Prevention and Care Plan* (IHPCP) for Pennsylvania, issues related to HIV/AIDS care, prevention, and testing, and the goals of the National HIV/AIDS Strategy.

3.3. 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 ensure that the needs of affected communities 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).

Reflectiveness – Overall membership and consumer members reflect Pennsylvania's epidemic in such factors as race, ethnicity, and age, as well as geographic diversity, including urban and rural areas.

SECTION IV: SCOPE

4.1. SCOPE. The broad scope of the Pennsylvania HPG ties directly to the Continuum of HIV Services in Pennsylvania and as defined by the Department of Health, Division of HIV Disease in the context of Prevent, Test, Link, Treat and Retain/Re-engage. Further, the HPG supports the Vision Statement of the Division of HIV Disease and the National HIV/AIDS Strategy: *Pennsylvania will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life extending care, free from stigma and discrimination.* To accomplish these goals the HPG engages in and supports these planning activities: Needs Assessment (including the epidemiological profile, identified gaps and resources); Priority Setting; IHPCP development and revision; IHPCP Implementation Assessment and Evaluation.

SECTION V: STRUCTURE

5.1. NATIONAL HIV/AIDS STRATEGY. In 2010 the National HIV/AIDS Strategy (NHAS) was developed by the Office of National AIDS Policy after broad consultation nationwide. This policy, which was updated in 2015, now guides the federal response to HIV/AIDS prevention and care. As the policy guides the federal response, PA has also embraced the policy and it guides all work and activities of the HPG as well as shapes its structure. Within the Strategy, the following broad goals were created:

- *Reducing new HIV infections*
- *Increasing access to care and improving health outcomes for people living with HIV (PLWH)*
- *Reducing HIV-related disparities and health inequities*
- *Achieving A More Coordinated Response To The HIV Epidemic*

The HPG will have a steering committee and two subcommittees. The subcommittees will be based around assessing the implementation of the IHPCP goals and recommending updates to the IHPCP document. The IHPCP goals are designed to mirror the goals of the NHAS.

5.2. STEERING COMMITTEE. The Steering Committee is comprised of the HPG Co-chairs and the Chair of each of the two (2) subcommittees, Chairs of any ad hoc subcommittees, and the HPCP designated planning coordinator. The Steering Committee exists to assist in strategic planning and agenda development for the larger HPG. Also welcome to attend the Steering Committee meetings are the DOH support staff and the University of Pittsburgh staff (contracted planning coordinator) as these individuals play a key role in the facilitation of all HPG activities (these are considered non-members with no voting privileges).

5.3. SUBCOMMITTEES. The HPG originally formed subcommittees to specifically address the goals of the National HIV/AIDS Strategy. Now that these goals are codified in the IHPCP—the

guiding document for Division planning and activities for 5-year planning cycles—the subcommittees function to ensure that IHPCP goals are being successfully carried out and completed, and that the IHPCP document itself is kept up-to-date and revised in line with ongoing assessment. Members of each subcommittee serve as leaders within their specific communities and/or professional networks (e.g., consumer, Part C provider, regional representative, etc.). These leaders serve as liaisons to disseminate and gather feedback from key stakeholders (e.g., TB, STD, Corrections, Education, SEP, Hepatitis) in their respective communities in line with the questions or issues their subcommittees are addressing. HPG subcommittee members should understand how funding streams (e.g., HRSA: Care, CDC: Prevention, HUD: HOPWA, Medicare/Medicaid, Affordable Care Act, and private insurance coverage), medical advances, and sociological community factors affect the planning goals. Community members, Planning Partner members, and support staff (see membership section below) may join and participate in all subcommittees; however, if any votes are taken in subcommittees only Community Members vote.

Themes and data throughout the IHPCP that subcommittees may engage with include epidemiological data, statewide goals for prevention and care, barriers/gap analysis, stakeholder and consumer engagement, and needs assessment (including the needs of youth). This Integrated Plan seeks to answer four basic questions: 1) What is the current state of HIV infection and risk of infection in PA? (Where are we now?); 2) What are PA's goals for prevention and care? (Where do we need to go?); 3) What steps can we take to develop and reach these goals? (How will we get there?); *and* 4) How will we monitor our progress? The subcommittee structure allows for these two subcommittees to be engaged in the activities related to plan assessment and process evaluation.

If and when it becomes necessary for the HPG to engage in providing feedback and input in other, specific areas of the statewide continuum of services and/or priority setting, the larger group will be engaged in these discussions and will form ad hoc subcommittees as necessary to address these topics or activities.

5.3.1. IHPCP Process Evaluation Subcommittee:

Members of this subcommittee are tasked with evaluating the processes described by the IHPCP goals and the *progress* being made in PA towards fulfillment of those goals. Findings and approved recommendations will be generated and documented by date as needed for review and revision by HPCP and Division. This group may also generate recommendations for revisions to the current or future IHPCP, which would be forwarded to the IHPCP Assessment subcommittee.

5.3.2. IHPCP Assessment Subcommittee:

Members of this group will work to review and, if necessary, recommend revisions to the IHPCP document. Revisions may include, but are not necessarily limited to: the goals; formatting; updating data or component descriptions; changes in the NHAS or other federal or state changes; other document components. The revision recommendation process and all proposed revisions will be documented throughout the subcommittee's work by the planning coordinator (HPCP). All efforts should be based on current data (epidemiological and qualitative), HPG and Division input, and the overall form and functioning (process evaluation) of the document.

Any proposed changes recommended for the IHPCP must be approved by a majority of the IHPCP Assessment Subcommittee's voting members. If approved, the recommendations will be presented to the full HPG with ample time in meeting for debate and discussion. A simple majority of voting members is required to formally recommend changes to the Division for the IHPCP. The HPCP

will be responsible for integrating approved recommendations subject on Division guidance, and reporting IHPCP integration results back to the HPG as necessary.

5.4. AD HOC SUBCOMMITTEES. Ad hoc subcommittees may be requested by the Division or established by a majority vote of the HPG when specific issues arise in the planning cycle that need particular attention. Planning partners and staff are also permitted to participate on ad hoc subcommittees. Any ad hoc subcommittees that are formed will function for a specified period of time to accomplish a specific task. After completion of the task the ad hoc committee will issue a final report and dissolve. For example, the occasional but critical nature of statewide Priority Setting falls within this category.

5.5. WORK GROUPS. These are groups whose necessity is anticipated on a yearly or semi-yearly basis. These groups can be activated by the Division or a majority vote of the HPG, and can be filled by any member. However, some or most workgroup activity may take place outside of regular meeting hours. This may include meeting via conference call, the evening between face-to-face meetings, or other outside times depending on availability and group goals. These work groups will provide updates to the larger HPG and request feedback when necessary.

5.5.1 Recruitment and Nominations Work Group. This work group facilitates an open nominations process and ensures that the membership of the HPG is reflective and representative, as defined above. This work group may review and recommend revisions to the recruitment letters and nomination forms, review the submitted nominations forms for potential members, and recommend nominations based on gaps identified in the current HPG membership and the unique strengths of the applicants. The following are specific activities conducted to facilitate the work of this Work Group or specifically conducted by this Work Group.

5.5.1.a. Soliciting Nominations: The Department distributes HPG recruitment letters and nominations forms to all HPG members, Department HIV staff, HIV grantees (county and municipal health department and regional grantees), HIV prevention program field staff, PLWH groups, and a variety of agencies identified as potential resources for recruiting disproportionately affected and traditionally underserved communities on an annual basis. Applicants from disproportionately affected communities, traditionally underserved communities, and applicants that fill gaps in current HPG membership are specifically encouraged to apply; however, *all* applications will receive serious consideration.

5.5.1.b. Application Process: Applications will be available online at www.stophiv.com website, and may be requested and secured at Department of Health offices from the Division of HIV Disease. Applications may also be obtained from Community Co-Chairs, members of the Nominations and Recruitment Work Group, and general HPG members. Applications will be distributed widely across the Commonwealth and to every organization receiving Department of Health funds that provides HIV care or prevention programming. The process is open and on-going.

5.5.1.c. Application Submission: Completed applications may be submitted online or sent to: The Pennsylvania Department of Health, Director of the Division of HIV Disease, 625 Forester St., Harrisburg, Pennsylvania 17120. Applications should not be sent

to the HPG membership or to an individual HPG member. Following the application deadline, all applications will be distributed to the HPG Nominations and Recruitment Work Group for review.

5.5.1.d. Application Review: Membership applications are to be reviewed by the Nominations and Recruitment Work Group during a meeting held for this specific purpose. Nominations and Recruitment Work Group members review the applications and recommend new membership nominations based upon gaps identified in the current HPG representation and the unique strengths of the applicants.

5.5.1.e. Membership Invitations: The Nominations and Recruitment Work Group will make a telephone call to each applicant elected by a majority vote of the HPG. The purpose of the phone call is to confirm prospective member's commitment to participate in the scheduled meetings and answer any questions. The Division of HIV Disease will review member invitations and forward successful applications for final review and approval to the Pennsylvania Department of Health. Upon receipt of DOH approval, the Division will issue membership invitations, in letter form, to those applicants who were identified by the Nominations and Recruitment Work Group. As many new members will likely have a wide range of skills, insights, and experiences, this letter must inform new members of which categories they are specifically representing on the HPG.

5.5.1.f. Membership Selections: Any applicant receiving a membership invitation letter who confirms their commitment to participate in the HIV Planning Group (verbally or in writing) will be selected to serve on the HPG. If an applicant is invited to participate and declines to participate, another applicant may be chosen to fill the position.

5.5.1.g. Applicant Rejection: Remaining candidates who have not been selected will be sent letters stating that they have not been selected with a reason for this decision, along with an invitation to apply again in the future. The Division of HIV Disease (Department Co-Chair) will send these letters to denied applicants. A priority pool of key stakeholder applicants will be maintained by the Department. Applicants will remain in the pool to potentially fulfill any mid-term vacancies on a rolling basis. The workgroup retains flexibility when creating recommendations to fill (or not fill) vacant positions in order to ensure parity, inclusion, representation and reflectiveness.

5.5.2. Protocols Work Group. The purpose of this work group is to examine, refine, and revise these procedures. Specifically, this work group will focus its attention on developing these Protocols, the Governing Ground Rules, expectations of confidentiality, and other guiding principles to which the HPG should adhere to achieve efficient and effective group processes.

SECTION VI: MEMBERSHIP

6.1. GENERAL MEMBERSHIP. The HPG is convened by the Department's Division of HIV Disease and is comprised of approximately 20 Community members and 15 Planning Partners. These members and partners represent key stakeholders, consumers, and demographic groups, and serve to provide input and feedback to the HPG. Both HRSA and CDC Guidance recommend that

the HPG reflect the diversity of characteristics of the current and projected epidemic in the jurisdiction.

6.1.1. Membership Guidelines: Membership in the Pennsylvania HIV Planning Group (HPG) is ultimately driven by the guidance of the Health Resources & Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) as funding administrators of the Ryan White Care Act. The values listed in Section 3.3 provide the framework for HPG membership selection. All HPG community member applications recommended by the Nominations and Recruitment workgroup are reviewed and approved by the Pennsylvania Department of Health.

6.1.2 HPG Community Members:

Description: HPG Community members are chosen for their ability to advocate for and represent the voices and perspectives of a wide range of key stakeholders: people representative of, or impacted by, the HIV epidemic throughout Pennsylvania. Members may be people working with at-risk populations, living with HIV, or conducting HIV care and prevention activities. HPG members represent the perspectives of HIV risk populations through their life experiences, work responsibilities, or other activities. HPG Community members must be residents of (that is, reside solely in) the Commonwealth of Pennsylvania, and may be employees of agencies receiving Department of Health funding. HPG members are invited to serve by virtue of their life experience and expertise and are not understood to function as official representatives of any agency or organizational affiliation. Community members apply to serve on the HPG through an ongoing application process (see section 5.5.1).

Responsibilities: Community members sit at the HPG table and fully participate in all HPG activities, lunches, and workgroups. In addition to developing recommendations to the Division (as described in Section V), it is expected that HPG Community Members will help disseminate updates, approved plans, and HPG surveys to their stakeholder networks as well as bring feedback to the HPG/Division around both planning and other critical issues in the commonwealth.

Because these members were selected based on their knowledge, experience and perspectives on HIV-related issues in Pennsylvania, attendance is carefully recorded for each member. Members who do not attend 75% of the yearly meeting days will forfeit their spot. These members volunteer for a three-year (3) term. At the end of their term members may, if they wish, reapply through the normal application process to begin another three-year (3) term. Community members vote on all recommended changes to the IHPCP or other matters for which votes are called. All qualifying travel costs are reimbursed by the DOH. These members elect a Community Co-Chair each year (to a 1 year term) to work with the Division Co-Chair to run meetings and lead yearly HPG planning.

Composition Examples: There are approximately 20 Community member positions. Stakeholders invited to apply include (but are not limited to) those identifying as: People living with HIV (PLWH); LGBTQ; MSM; African or African American; Latinx; Native American; current or former IDU; Ryan White Parts B-D; MAI, EIS, CBOs, and health care providers; state grantees; people of all ages (esp. youth), socio-economic backgrounds, citizenship statuses (within PA), and geographic locations within PA (including Philadelphia).

6.1.3 HPG Planning Partners:

Description: Partners serve on the HPG at the invitation of the Division and represent relevant agencies and partner organizations working on key issues related to HIV.

Responsibilities: Planning Partners sit at the HPG table and fully participate in all HPG activities, lunches, and workgroups. In addition to assisting in developing recommendations to the Division (as described in Section V), it is expected that HPG Planning Partners will help disseminate updates, approved plans, and applicable HPG surveys to their professional networks or agencies as well as bring applicable feedback or updates from their agencies or departments to the HPG/Division around both planning and other shared, critical issues in the commonwealth. Because these members represent agencies and organizations, they do not necessarily need to be the same person each meeting and do not have term limits. For these reasons, they may not make motions or cast votes during meeting business or subcommittee work. Respective agencies are expected to cover any travel costs for these members, if applicable.

Composition Examples: There are 15 Partner slots. Examples include: STD Program; TB Program; Viral Hepatitis; HIV Epidemiology; HOPWA; DOH Office of Health Equity; MAAETC; Medicaid; Mental Health; D&A; Dept. of Education; Dept. of Corrections; Philadelphia's Part A and HIV Prevention Planning; SPBP Advisory Board.

6.1.4. Composition of Membership:

The following is the targeted composition of the HPG:

- HPG Community members (20):
  - Consumers – 5 members
  - RW Part B Direct Service – 4 members
  - RW Part C/FQHC – 3 members
  - RW Part D – 1 member
  - HIV Testing/Prevention Providers – 4 members
  - RW Part B sub-recipients – 2 members
  - County/Municipal Health Department – 1 member
- Planning Partners (15):
  - PADOH STD Program -1
  - PADOH TB Program -1
  - PADOH Viral Hepatitis Program -1
  - PADOH HIV Epidemiology -1
  - HOPWA -1
  - PADOH Office of Health Equity -1
  - MA AETC -1
  - Medicaid -1
  - Mental Health -1
  - Drug & Alcohol -1
  - PA Department of Education -1
  - PA Department of Corrections -1
  - Part A (HRSA Grantee/Philadelphia) -1
  - Philadelphia Planning Representative -1
  - SPBP Advisory Board -1

6.1.5. Member Involvement with Other Organizations. Members may be involved in a variety of organizations. While members are encouraged to share information about the HPG and its activities with other individuals or organizations, their participation on these groups should not

be understood as official representation from the HPG. Members are informed of the perspectives and communities (per the target list in Section 6.1.2) they were chosen to represent in the HPG upon initial notification of membership.

6.1.6. Vacancies: Vacancies are a natural process of the HPG membership. Recruitment is conducted on a rolling, as-needed basis to fulfill the representation of the HPG and to generally fill vacated seats due to expired terms.

6.1.7. Removal: The HPG shall have the right to remove HPG members for good cause by a simple majority vote of the members. Members may be removed at the sole discretion of the HPG Co-Chairs if they are considered "not present" for over 25% of the meetings (discussed in Section 7). In addition, any individuals appointed by the Department may be removed with notification to the HPG and their home agency and replaced as necessary. Agencies which appoint or delegate representatives to serve as Planning Partners can replace said representative(s) by notifying the HPG and the Division.

6.1.6 Confidentiality Policy: A sign of a well-functioning HPG is the inclusion of individuals as members that are HIV positive and individuals that represent target and at-risk populations. This means that some members may engage in behaviors that put them at risk for HIV infection or have experience working with populations that engage in behaviors that put them at risk for HIV infection and other health risks. Furthermore, HPG members are encouraged to share their unique personal perspectives with the HPG, as they relate to jurisdictional planning and the needs and perspectives of targeted populations. For these reasons HPG members shall keep confidential other members' personal information that they do not want shared. HPG members are reminded that the HPG meetings are open to the public and that there is no expectation of privacy during the meetings. Documents produced as part of HPG members' process work may also be posted in public forums such www.stophiv.com or the HPG's cloud-based filesharing system. These products may include plans, newsletters and meeting minutes. HPG members are also reminded that HPG meeting minutes reflect members' names for attendance purposes, and these documents are considered a public record—hence there is no expectation of anonymity. Members are advised that if they wish to make comments during the HPG meeting that they do not want to be recorded in the meeting minutes, they must indicate this to the HPG meeting recorder. This request for an exclusion from the meeting minutes will be documented in the meeting minutes.

6.2. SUBCOMMITTEE MEMBERSHIP. All HPG members are encouraged to serve on at least one (1) subcommittee. At the beginning of each year, existing HPG members will be asked by leadership to maintain their current subcommittee membership. It is preferred that members attempt to work consistently with one subcommittee. However, if a member feels that they might make a greater contribution to another subcommittee they will be permitted to begin working with a new subcommittee of their choice.

6.3. AD HOC SUBCOMMITTEE MEMBERSHIP. Ad hoc subcommittees will be formed on an "as needed" basis at the request of members of the HPG. Ad hoc subcommittees should be formed and convened to accomplish specific work tasks. Ad hoc subcommittees will accomplish short-term goals. HPG members can request to form ad hoc subcommittees during full HPG meetings. Ad hoc subcommittees may not be formed during subcommittee meetings. When a

motion to convene an ad hoc subcommittee is approved by a majority vote of the HPG, the Community Co-Chair should solicit volunteers from the larger committee for ad hoc subcommittee membership. Ad hoc subcommittees should be comprised of at least four (4) HPG members. Ad hoc subcommittees should be charged with specific tasks and a time frame in which to complete their task and report results back to the HPG membership.

6.4. WORK GROUP MEMBERSHIP. Each of the work groups identified in section 5.5 will have at least 4 members. The tasks for these work groups are ongoing and therefore membership of the work groups may be revised over time. The Division or University of Pittsburgh staff will participate in the activities of the work groups to facilitate progress where necessary.

SECTION VII: MEMBERSHIP EXPECTATIONS

7.1. GENERAL MEMBERSHIP EXPECTATIONS:

7.1.1. Terms: HPG members from the community are elected for three (3) year terms commencing in January of their first year. Members may reapply through the regular application process for another three (3) years, with a maximum total of six (6) years in service. Members serve on a rotational basis to target the guidelines for the *Composition of Membership* as outlined in section 6.1.2. Representatives from state agencies have terms that are set at the discretion of the Division of HIV Disease. Representatives from government offices may be added and removed at the discretion of their administrators regardless of the planning process timeline.

7.1.2. Orientation: All new HPG members will be required to attend a mandatory one (1) day orientation training session, either held prior to the first meeting of the year or during the first applicable HPG meeting. Each new member will receive a membership binder during orientation.

7.1.3. Attendance: Members are expected to be on time for meetings and attend at least 75% of the meetings annually. Members not present for more than 25% of meetings annually are subject to removal and replacement from the applications for HPG membership. The minutes will reflect those members who are present and those members who were not present for each meeting. There are no 'excused' absences; occasionally being unable to avoid missing a meeting (illness, emergency, etc.) is recognized through the 25% of meetings members are allowed to miss. Members should routinely notify the Division and Community Co-Chairs of any known absence or unexpected illness to ensure the safety and care of our members and expected guests.

7.1.4. Absence, Lateness & Early Departures: In order for the business of the HPG to be effectively conducted it is imperative that members are courteous and notify HPG Co-Chairs of their expected absence, lateness or early departures at least 24 hours in advance of a scheduled meeting. It is understood that due to work constraints, travel delays, personal emergencies, and health**,** HPG members may be at times need special accommodations.

7.1.5. Participation: A meaningful involvement in the planning process with an active collegial voice in decision-making by all HPG members is essential and encouraged. The views, perspectives, and needs of all members are welcome, respected, and equal.

7.1.6. Recruitment and Nomination: Members of the HPG are encouraged to nominate community members who may be candidates for future HPG membership to the Recruitment and Nominations Work Group open nominations process as described in section 5.5.1. Members of the community-at-large may also recommend individuals for membership by contacting a Co-Chair or the Chair of the Recruitment and Nominations Work Group.

7.1.7. Member Resignation: HPG members wishing to resign shall notify the Co-Chairs in writing. The vacant position shall be filled in the next nominations cycle or from the recent, rolling applications for HPG membership. If an individual holds an appointed membership position representing an agency/organization (Department of Corrections, Department of Education, HIV Prevention Program Field Staff, etc.) and that individual's affiliation changes, that individual shall resign their position and the designated agency/organization shall appoint a replacement. Resignation does not prohibit someone from reapplying for HPG membership in the future.

7.1.8. Travel: Travel and travel reimbursements are governed by the Commonwealth of Pennsylvania and updated periodically. The Department will provide HPG Community Members with the current Travel Guidelines and instruction on completing and submitting the Travel Expense Reimbursement Form during the HPG Orientation. Travel is not covered for Planning Partners or guests, and the Division at its sole discretion may direct the Planning Coordinator to cover travel costs for key invited speakers.

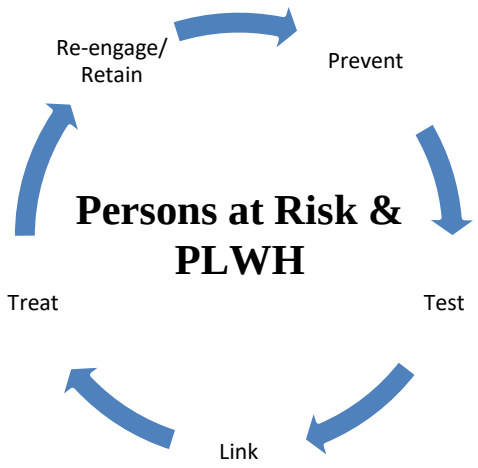
SECTION VIII: STAKEHOLDER ENGAGEMENT

8.1 STAKEHOLDER ENGAGEMENT PROTOCOL

The continuum of HIV services is at the core of integrating care and prevention in Pennsylvania. HRSA requires broad stakeholder involvement/feedback in comprehensive planning and needs assessment. In addition to this federally mandated planning body, key stakeholders are utilized in various ways (e.g., capacity building, focus groups, etc.) to ensure that everyone has an open and transparent process for providing input and feedback for planning.

The HIV Service Model (HSM), on the next page, has been developed to ensure key stakeholder engagement throughout the continuum of HIV services. The members of the HPG endorse this model as our focus for integrated planning. The model represents a clear continuum of HIV services through *Prevent-Test-Link-Treat-Re-engage/Retain* while centering around Persons at Risk & People Living with HIV.

The HIV Service Model (HSM)



The HPG members identified opportunities for key stakeholder engagement. The University of Pittsburgh HIV Prevention & Care Project developed the process below by integrating the HIV Service Model and expanding the opportunities for key stakeholder engagement. The result of this integrated collaboration is outlined below using the HIV Service Model to identify which key stakeholders add value to the engagement process during the life cycle of the continuum of HIV services.

Universal (relevant to all-points in figure above) Stakeholders

- Substance Abuse Providers
- Mental Health Care Providers
- TB programs
- Viral hepatitis programs
- STD programs
- Correctional Facilities (State and County and "the health care vendors for them")
- State Division of HIV Disease, PA Dept. of Health
- Academic communities
- PEHTI

Potential venues to access stakeholders:

A. Capacity building
B. SHIP Meetings
C. Regional Human Service Meetings
D. Philadelphia HIV Planning Committee
E. Regional Grantees
F. Conferences (Social Service Provider, Substance Abuse Providers, Living Well with a Disability Conference)

Prevent

- Universal stakeholders listed above (below figure)
- Members of high risk groups who are consumers of prevention and care services, including prevention for positives programs
- Members of high risk groups who are *not* consumers of prevention and care services
- Community based organizations servicing and outreaching high risk populations (e.g., LGBT bars and bathhouses, needle exchanges, venues where IDUs congregate, drug treatment), including online HIV outreach *
- Religious congregations with a focus on HIV *
- Providers to homeless and runaway populations such as homeless shelters and food banks with some focus on HIV (Homeless Action and PA Provider Network; Part of Housing Alliance of Pennsylvania) *
- Disability-related groups with some focus on HIV *

Potential venues to access stakeholders: Regional Grantees

Test

- Universal stakeholders (listed below figure)
- Groups with * above
- Members of high risk populations who have been tested, especially late testers
- Members of high risk populations who have not been tested
- Hospital departments providing HIV testing, community health centers, federally qualified health centers, other non-HIV-specific primary care providers ^
- County and State health department testing sites ^
- University and college health centers ^
- Planned Parenthood agencies that provide HIV testing ^
- Family focused programs that provide HIV testing ^

Potential venues to access stakeholders: PA Case Management

Link

- Universal stakeholders (listed below figure)
- All * and ^ above
- Members of high risk populations have been tested HIV+ and have been linked to care
- Members of high risk populations have been tested HIV+ and have *not* been linked to care
- Case-management programs

Potential venues to access stakeholders:

A. PA Case Management Coordination Project (HIV Positive Consumers, Part B Providers, Part B Case Managers)
B. Regional Grantees (HIV + Consumers)
C. Regional Consumer Groups (HIV + Consumer, Part C Advisory Councils, SPBP Advisory Council)

Treat

- Universal stakeholders (listed below figure)
- PLWH who are "loosely connected" to care
- PLWH who are "well connected" to care
- Hospital departments providing HIV testing, community health centers, federally qualified health centers, other non-HIV-specific primary care providers

Potential venues to access stakeholders:

A. PA Case Management Coordination Project (HIV Positive Consumers, Part B Providers, Part B Case Managers)
B. Regional Grantees (HIV + Consumers)
C. Regional Consumer Groups (HIV + Consumer, Part C Advisory Councils, SPBP Advisory Council)
D. HIV Qual (Part C)
E. QM All Parts Committee (Part C, Part D)

Re-engage/Retain

- PLWH who are "loosely connected" to care
- PLWH who are "well connected" to care
- PLWH who have dropped out of care
- Hospital departments providing HIV testing, community health centers, federally qualified health centers, other non-HIV-specific primary care providers
- County Housing continuums of Care
- SPNS CPI Project
- Universal stakeholders listed above (below figure)

Potential venues to access stakeholders:

A. PA Case Management Coordination Project (HIV Positive Consumers, Part B Providers, Part B Case Managers)
B. Regional Grantees (HIV + Consumers)
C. Regional Consumer Groups (HIV + Consumer, Part C Advisory Councils, SPBP Advisory Council)
D. HIV Qual (Part C)
E. QM All Parts Committee (Part C, Part D)

These opportunities will be leveraged to ensure parity, inclusion and representation (PIR). In addition and where appropriate, virtual meetings such as webinars or conference calls will be utilized to expand participation from a diverse group of consumers, providers and agencies serving PLWHA when face-to-face opportunities are not available. For example, HPG members may lead a discussion with all Ryan White Part C providers at their annual meeting. The Ryan White All Parts Summit, regional and/or section meetings all provide an opportunity for input and feedback. In addition, youth and consumer groups across the commonwealth meet at least semi-annually so that they have an equal opportunity for input and feedback. When and where appropriate it may be prudent to invite others into the planning process who represent either governmental or non-governmental (private sector) related services, such as: state and local education agencies, homeless shelters, LGBT leaders, representatives of business, labor, and faith communities.

SECTION IX: MEETINGS

9.1. FREQUENCY.

9.1.1. HIV Planning Group. The HPG will meet no less than four (4) times per calendar year.

9.1.2. Subcommittees. Each subcommittee should meet no less than four (4) times per calendar year and will deliver status updates to the full HPG. Subcommittees should expect to need some additional time in between full HPG meetings to complete some tasks.

9.1.3. Ad Hoc Subcommittees. Ad hoc subcommittees will meet as needed via conference calls or face-to-face times surrounding the HPG meetings, but likely will not have meeting time allocated during the HPG meetings. They will deliver status updates to the full HPG.

9.1.4. Work Groups. Work groups will meet as needed via conference calls or face-to-face times surrounding the HPG meetings, but will not have meeting time allocated during the HPG meetings.

9.1.5. Additional Meetings. The HPG may add additional in-person meetings to the schedule throughout a planning year if additional meetings are deemed necessary.

9.1.5.a. Pop-Up Stakeholder Meetings. The HPG may hold 1-2 additional townhall format meetings at various locations throughout the state during any planning year.

9.1.6. Web-Based Technology. Web-based meeting technology will be used between in-person meetings, if needed, including for additional subcommittee time. These web-based meetings cannot replace full-length HPG meetings and will not exceed two hours at a time.

9.2. QUORUM AND VOTING.

9.2.1 Quorum. A quorum is defined as more than one-half of the current HPG Community members. This quorum must be met to conduct official business of the HPG.

9.2.2 Voting. A quorum *(see above)* is required to vote on any motion or resolution. A simple majority of the Community members present is required to pass any motion or resolution. Proxy voting is not permitted. Absentee voting is not permitted, with the exception of the concurrence vote for approving or updating the IHPCP. However, distance voting procedures may be enacted jointly by the DOH Co-Chair and the Community Co-Chair on a case-by-case basis if timely resolution of HPG business is required to meet state or federal deadlines.

9.3. PUBLIC MEETINGS.

9.3.1. Publicizing Meetings. The HPG actively encourages community participation. Meetings are open to the public and meeting dates are advertised in the Pennsylvania Bulletin and on StopHIV.org, the HPG's statewide planning website.

9.3.2. Participation from Members of the Public. The views, perspectives, and needs of key stakeholders and all affected communities are actively solicited and included. Members of the public are welcome to attend and speak at the HPG meetings; advanced notice to the HPG Co-Chairs or support staff is preferred. Public participation will be accommodated to the extent it does not adversely affect the function of the HPG. While time may be limited to public participants wishing to speak, a public comment period is extended at each meeting after opening introductions.

9.4. MEETING PROCEDURES.

9.4.1. Meeting Check-In. Members and guests must sign the attendance sheet each day of the scheduled meetings. HPG members should also attempt to pick-up paperwork such as Travel Expense Reimbursement form, Travel Itinerary form, Minutes, Agendas, and other handouts before the beginning of each meeting, as distribution of these items during the meeting is often time consuming and can be disruptive.

9.4.2. Call To Order. The Community Co-Chair will call the meeting to order. At this time, the recording device, which records the proceedings of the meeting, will be turned on. Side conversation should be kept to a minimum. When HPG members are out of order or the noise level rises, the Community Co-Chair will use his or her discretion to determine whether or not the group must once again be called to order.

9.4.3. Review and Approval of Minutes. HPG members are responsible for reviewing the minutes prior to each meeting. At each HPG meeting, members will have an opportunity to request revisions to the minutes of the previous meeting. These changes will be noted in the record by the facilitator, who will ensure that any changes are reflected in the final record of the meeting. The HPG Community Co-Chair will ask the HPG for corrections. If none are presented, the minutes automatically stand approved; if corrections are requested, then a motion and vote to approve the minutes is required.

9.4.4. Review of Agenda. The HPG Co-Chairs will review the agenda prior to commencement of the meeting and discuss any changes with the HPG. The purpose of this review is to focus participants on the desired outcomes of the meeting.

9.4.5. Electronic Media Policy and Technology Use at the Table. Community Members and Planning Partners are encouraged to use discretion when using electronic devices at the table during HPG meetings. Cell phones and pages should be silenced. Use phones or media at breaks or lunch whenever possible. All calls should be taken outside of the meeting space. Phones for SMS text messaging, tablets and smaller laptops may be used at the table with discretion. Utmost respect should be considered for all presenters with our undivided attention and limited use of technology during presentations. Limit use of social media platforms to work or outreach during the meeting (this should be an urgent need). Search engines and criteria such as Google is welcome to enhance or advance the discussion of the HPG at the table. Members and Partners may draft personal notes on their personal electronic devices. File encryption is encouraged where server or cloud storage may be in use. Any distribution of personal notes or announcements to other stakeholders must be clearly labeled as "DRAFT". HPG resources such as presentations and official meeting minutes are available on www.stophiv.com. Members and Partners are encouraged to hold each other accountable to this policy; however, the co-chairs, at their discretion, may ask members to curtail excessive use of electronic media.

9.4.6. Facilitated Discussion. The University of Pittsburgh and the Co-Chairs will facilitate the HPG meetings adhering to the agenda and the work plan. All HPG members share responsibility for having productive meetings.

9.4.7. Parking Lot. A "Parking Lot" of ideas and topics should be maintained. This "Parking Lot" is to hold issues or items tabled during larger discussion due to time constraints, or items that require action later in the meeting. The Parking Lot will be reviewed at the conclusion of the meeting to ensure that all concerns have been or will be addressed.

9.4.8. Break Outs. Committee members will be asked to break out into small groups. Typically, these smaller groups are subcommittees. The Planning Coordinator or Co-Chair will provide room assignments.

9.4.9 Round Table Discussions. Committee members will be asked to reconvene after subcommittees meet to participate in round table discussions with the entire HPG membership. The purpose of these discussions is to summarize the work accomplished in subcommittees and share items of interest to the larger group to help facilitate an integrated approach for care and prevention. The entire HPG can then identify and/or address issues that may require further action or additional resources to fulfill the continuum of HIV services.

9.4.10. Technical Support. One staff person from the Department and one staff person from the contracted planning coordinator shall be assigned to provide technical support to each subcommittee.

9.4.11. Lunch. All HPG members, stakeholders, guests, and interested parties who RSVP'd to the Division of HIV Disease or HPCP will be invited to join that meeting's lunch. Lunch will also be provided to guests who have not RSVP'd as long as supplies are available.

9.4.12. Meeting Adjournment and Agenda Setting. The Community Co-Chair will adjourn meetings of the full HPG. After adjournment, the Steering Committee *(as defined in*

Section 5.2) will meet. The Steering Committee's tasks are to evaluate the meeting and identify the next steps in the planning process by updating the HPG work plan and setting agenda items for the next meeting. The agenda, once set, will be written and distributed to all HPG members at least three weeks prior to each scheduled meeting of the HPG. When supplemental meeting material is necessary, it will be distributed to members with the agenda. It is the responsibility of the member to review the agenda and supplemental material and bring them to the scheduled meeting (or ask that the Department knows of your need for printed copies). Standing items on the agenda include elements 9.4.3 – 9.4.5 above. In addition, if any ad hoc subcommittees have been created, a status report from that ad hoc subcommittee will be a standing item until the committee completes its work.

9.4.13. Submitting Travel and Reimbursement Paperwork. The Travel Itinerary form (this form indicates your plans to attend or not attend the next meeting) is available at HPG meetings and is also distributed to HPG members four weeks prior to the scheduled HPG meeting dates. HPG members are required to complete the Travel Itinerary form and return it to the Division of HIV Disease, no less than three weeks prior to the scheduled HPG meeting date. The Request for Travel Reimbursement form (this form accounts for all of your travel related to attending the meeting and provides the necessary documentation to receive your reimbursement) is distributed during the HPG meeting and should be completed and returned to the Division of HIV Disease staff at the conclusion of the HPG meeting or shortly thereafter.

9.4.14. Travel Reimbursement. The Request for Travel Expense Reimbursement form must be completed by each HPG member requesting reimbursement for expenses and submitted to the designated Division of HIV Disease staff. Reimbursement will be handled in a timely manner, usually within seven (7) weeks of the HPG meeting. Reimbursement will be provided at rates established by the Department. Should there be a problem with reimbursement, these concerns should be addressed with the Division of HIV Disease. Information on how to follow up on late reimbursement will be provided in the Travel Guidelines and the HPG Orientation.

9.5. MEETING MINUTES.

9.5.1. PA HIV Planning Group Meeting Minutes. The minutes of all HPG meetings will be audio-recorded by the contracted Planning Coordinator or Department staff. All formal HPG presentations are also video captured and made available for members to review and made available publicly on StopHIV.org with the Minutes Summary for each meeting. Minutes are presented in summary form and distributed to the Co-Chairs for approval and then to all HPG members at least two weeks prior to each scheduled meeting of the HPG. Members are responsible for reviewing these minutes prior to each meeting. At each meeting HPG members will have an opportunity to revise the minutes of the previous meeting. These changes will be noted in the record by the contracted Planning Coordinator, who will ensure that any changes are reflected in the final record of the meeting. The minutes are made available to the public as the meetings are open to the public and copies of the minutes are provided at the sign-in table and on StopHIV.org.

9.5.2. Steering Committee Meeting Minutes. The minutes of all HPG Steering Committee meetings will be transcribed by the contracted Planning Coordinator or Department staff. These minutes are reviewed by the Steering Committee members and included in the overall HPG meeting minutes distributed to the group prior to each meeting and approved at each meeting.

Because these minutes are included as a section of the HPG meeting minutes they are available to the public as copies are provided at the sign-in table.

9.5.3. Subcommittee, Ad Hoc Subcommittee, and Work Group Meeting Minutes. Each of these groups will select an individual to record minutes each time they convene to conduct business, whether in person, via teleconference, or other electronic means. The individual volunteering to take the minutes will agree to distribute those minutes within one week of the meeting to all members of the respective groups. These minutes are used to keep the groups updated on their progress and help any member who was not present for a meeting to understand the progress. If edits need to be made to these minutes, it is discussed at the next meeting and changed as necessary. There is no official approval process for these minutes and they are available to the public by request.

SECTION X: LEADERSHIP AND GOVERNANCE

10.1. PA HIV PLANNING GROUP CO-CHAIRS. Two Co-Chairs will serve as leaders of the HPG. One (1) Co-Chair is to be a representative of the PA Department of Health, Division of HIV Disease. One (1) Co-Chair is to be a community member elected from the voting membership of the HPG. These two Co-Chairs should work cooperatively to see that the planning process in the state is an equal effort of the Department and members of the HPG.

10.1.1. Department of Health Co-Chair. It is the responsibility of the Department of Health Co-Chair to make known the official positions and obligation of the Department. This Co-Chair must be an employee of the Department of Health, Division of HIV Disease. This individual is responsible for forwarding information relevant to the community planning process from the Department of Health to HPG members. It is also the responsibility of this individual to convey the concerns and requests of HPG members to Department officials. This individual is authorized to officially represent the Department and express Department positions on topics discussed at HPG meetings, the meetings of other organizations, and other functions. This individual is selected for this appointment by the Department administrators and may change at the discretion of such administrators.

10.1.2. Community Co-Chair. The Community Co-Chair is a member of the HPG elected by a majority of HPG voting members. The individual selected for this position should possess strong communication skills and have a thorough understanding of the group's function. The person in this position is to guide the members of the HPG through the planning process by assisting in developing and enforcing policies, which facilitate the community planning process. The Community Co-Chair will also assist in seeking input from HPG members to determine an agenda for each meeting, in coordinating subcommittee work and reports, in representing the HPG to the public, and in managing HPG conflict and dissent. This individual is elected to a two-year (2) term and can run for reelection as long as they are a member in good standing. The Community Co-Chair spends several hours per month outside of HPG meetings on HPG business. In addition to rigorous meeting planning and collaboration with the Division and HPCP, this may include HPG-related conferences, events, webinars, or conference calls.

10.1.3 Community Co-Chair Elect. The HPG will hold an election for the next Community Co-Chair one year before the end of the current Chair's term. The new Community Co-Chair will spend one year as the "Community Co-Chair Elect" shadowing the current Co-Chair before assuming their responsibilities. If the current Co-Chair runs for and wins re-election, no Community Co-Chair Elect is necessary. Responsibilities of the Community Co-Chair Elect include: learning the roles and responsibilities they will undertake as the future Co-Chair; filling in for the current Co-Chair if they are unable to attend an HPG meeting; serving as a member of the HPG's Steering Committee. This means that the member will serve one year as Community Co-Chair Elect *and* then two years Community Co-Chair (with a new election for the new Community Co-Chair Elect occurring at the beginning of the third year).

10.2. PLANNING COORDINATOR. The Department will select and retain a Planning Coordinator to assist the group in completing the community planning process. The current Planning Coordinator is the HIV Prevention and Care Project at the University of Pittsburgh.

10.3. SUBCOMMITTEE, AD HOC SUBCOMMITTEE, and WORK GROUP CHAIRS. At the first meeting of a Subcommittee, a chair should be selected by participants. Subcommittee members should nominate possible chairs and elect one (1) chair and one (1) co-chair to fulfill the duties of the chair in case of an absence. Ad hoc subcommittee and Work Group members should nominate possible chairs and elect one (1) chair. If only one individual accepts nomination, that individual will serve as the Ad Hoc subcommittee or Work Group chair. Subcommittee, Ad Hoc subcommittee, and Work Group chairs are responsible for convening the meetings. They are responsible for ensuring that their group accomplishes its work goals and reports activities to the full HPG. They provide status updates on their groups' work to the full HPG.

10.4. GOVERNING GROUND RULES. Members of the HPG developed the following Ground Rules. The HPG members and guests are to adhere to the following guidelines during meeting and group discussions:

10.4.1 Courtesy

- Show all participants common courtesy
- Respectful disagreement is acceptable
- Recognize and respect other's physical limitations and capacities
- Be on time and start on time
- Cell phones and pagers should be silenced
- Cross talking, or side-bar conversation is prohibited

10.4.2 Protocol

- One person speaks at a time, upon recognition by the Co-Chair or Facilitator of the discussion
- Speak for yourself without claiming to speak for others
- Speakers are asked to respect time, or express agreement without reiteration.
- Respectful disagreement is acceptable; interruptions are not.
- Discussions may be limited or deferred, due to time constraints or relevance, to a later agenda item.

10.5. CONFLICT RESOLUTION. Conflict is often part of working together as a group. Participation will be encouraged but ground rules will be enforced to direct a conflict toward a positive result.

10.6. CONFLICTS OF INTEREST. HPG members shall not knowingly take actions or make statements intended to influence the conduct of the public body in a way that might confer financial benefit on the member, family members, or on any other organization in which she/he is an employee or has a significant interest. Each new member will sign a conflict of interest statement upon acceptance. This statement will disclose any real or perceived conflict of interest that exists, or affirm that no such conflict does in fact exist. Any HPG members who also serve as a director, trustee, employee, volunteer, or might otherwise materially benefit from its association with any agency which may seek funds from the HPG is deemed to have an interest in said agency or agencies. If a conflict of interest is determined to exist, either through voluntary disclosure or other determination by the membership, that individual may be excluded from voting on that particular transaction. The recorded minutes for the meeting shall document such an action.

10.7. GRIEVANCE POLICY. Grievance procedures exist for the purpose of Priority Setting Dispute Resolution when HPG members or regional grantees dispute that the HPG did not follow its process for priority setting that may be perceived to influence the resource allocation percentage recommendations. This policy is on file and available by request from the Pennsylvania Department of Health at: PA DOH, 625 Forester St., Harrisburg, Pennsylvania 17120, or by calling 717-783-0572.

10.8. COMMITTEE ENDORSEMENTS. The consent of the HPG is required for the endorsement of any activity or statement by the HPG. The Co-Chairs are responsible for reviewing any statement or securing information about any activity that will require the HPG's endorsement. The Co-Chairs are responsible for presenting this information to the full HPG and for securing the consensus or approval of a majority of the HPG membership before endorsing a statement or activity.

10.9. OFFICIAL STATEMENTS. The consent of the HPG is required for the endorsement of any formal statement. The Community Co-Chair is responsible for coordinating the drafting of any formal statement that will require the HPG's endorsement. The Departmental Co-Chair is responsible for presenting this document to the full HPG and for securing the consensus or approval of a majority of the HPG membership before endorsing and releasing the formal statement.

10.10. MODIFICATION OF PROTOCOL. This protocol governing the HPG function may be modified as needed by a simple majority vote of the membership.