Meeting Agenda

HYBRID:
Wednesday, May 27th, 2026
2:30 p.m. – 4:30 p.m.

- ♦ Call to Order
- ♦ Welcome/Introductions
- ♦ Approval of Agenda
- ♦ Approval of Minutes (April 16th and April 22nd, 2026)
- ♦ Report of Co-Chairs
- ♦ Report of Staff
- ♦ Presentation Item
    - Feeding PA: SNAP Changes
- ♦ Discussion Item
    - Town Hall Results
- ♦ Other Business
- ♦ Announcements
- ♦ Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Comprehensive Planning Committee/Prevention Committee is June 24th, 2026 at 2:30 p.m. to 4:30 p.m.

Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107 (215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Comprehensive Planning Committee & Prevention Committee

HYBRID: Comprehensive Planning Committee
Meeting Minutes of
Thursday, April 16th, 2026
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: K. Carter, D. D'Alessandro (Co-Chair), N. Houston, S. Jacinto, C. Johnson, A. Leger, M. Mabou, P. Mukinay, J. Myahwegi, P. Neuman, A. Onorato

Excused: S. Wynne (Co-Chair)

Guests: Laura Silverman (DHH)

Staff: Tiffany Dominique, Elizabeth Fischer (Intern), Debbie Law, Sofia Moletteri, Kevin Trinh, Kristin Wilson (Intern)

Call to Order/Introductions: M. Mabou asked everyone to introduce themselves and called the meeting to order at 2:13 p.m.

Approval of Agenda:
M. Mabou referred to the April 2026 Comprehensive Planning Committee (CPC) agenda and asked for a motion to approve. **Motion:** K. Carter motioned; A. Onorato seconded to approve the April 2026 CPC agenda. A Zoom poll was launched. Members attending in person voted through a show of hands. **Motion passed:** 9 in favor. The April 2026 CPC agenda was approved.

Approval of Minutes (*March 19th, 2026*):
M. Mabou referred to the March 2026 CPC Meeting minutes. **Motion:** K. Carter motioned; A. Onorato seconded to approve the March 2026 CPC meeting minutes. A Zoom poll was launched. Members attending in person voted through a show of hands. **Motion passed:** 8 in favor, 1 abstained. The March 2026 CPC meeting minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
S. Moletteri said they were hosting a training on April 29th from 9am to 11am. The event would be focused on learning to interpret the finance spreadsheets used during the Allocations Process. Registration would close on April 22nd.

At this time, the HIV Integrated Planning Council (HIPC) was looking for a new co-chair. S. Moletteri said this was an opportune time, as most of the recommended members had become full fledged members. They welcomed any of the CPC members to feel free to nominate themselves for the position during the waiting period. They would elect the next HIPC co-chair in the May HIPC meeting. S. Moletteri then said they were also looking for co-chairs for the other committees. T. Dominique said they had recently sent out a survey to gauge interest in subcommittee membership. She asked the members to answer the survey. She reminded the

members that they could sit on multiple committees and were allowed to test drive a committee before they joined it.

Action Item:
-Finalizing Priorities-
The Priority Setting was a triennial procedure the CPC members performed. Each member ranked each service. While Priority Setting didn't affect where funding was allocated, it informed the HIPC members during the Allocations Process. The Condensed Priority Setting was an abbreviated version of the standard Priority Setting Process. This new process took place annually and transpired across two weeks rather than a few months taken by the standard Priority Setting Process. In the last CPC meeting, the committee members had conducted their Condensed Priority Setting. Members were asked to select three services they deemed were crucial.

S. Moletteri presented the committee members with a graph of the 2025 Priority Setting ranking. They said the rankings had largely stayed the same with the exception of the services they ranked up and deranked. Based on the Condensed Priority Setting, Food Bank Services had gone up in ranking to the second highest ranked while Mental Health Services had deranked from third highest service to the sixth. The AIDS Drug Assistance Program (ADAP) had increased in rank while Substance Abuse had deranked.

During the Condensed Priority Setting Process, the voting members had wanted to prioritize access to services and benefits. Voting members feared that the current political climate would hamper access and reduce benefits. A. Leger voiced that these services provided basic human needs and should be preserved. She referenced National HIV Behavioral Surveillance (NHBS) data saying stress was related to access to medication. M. Mabou agreed and said these basic needs were linked to other facets of their lives.

T. Dominique asked if the members were satisfied with the changes to the ranking including the services which deranked. D. D'Alessandro said services were being cut and they had to adapt. She reminded the other members of the possibility that their final award could be reduced. She said all the services were needed but some services were needed more than others. She said this ranking was more important than ever. K. Carter advised that voting in elections was the most significant thing they could do to reverse the cuts to benefits and services. He advocated not only voting but also registering others to vote. D. D'Alessandro mentioned an organization that would ask people if they had wanted to register to vote while they were getting a physical exam. S. Moletteri agreed that HIPC, as an organization, were bound by limits of their scope.

S. Moletteri called back to A. Leger's comment about medication and stress. They said it was interesting that the members had ranked Medication and Mental Health services higher in the ranking. K. Carter asked why they didn't just recycle their medication. D. D'Alessandro replied that it was a distribution issue. A. Leger added that it was also a liability issue. T. Dominique said distribution of medication was often under strict guidelines. Providers were often barred from giving free samples of medication or even having certain brands on their countertops as it would be seen as favoring one drugmaker over the other.

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C. Johnson discussed his concerns about the rising costs of medication. He mentioned that with SPBP being used as a last resort and dwindling public benefits, he was worried about how his clients would be able to access the medication they needed to survive. K. Carter echoed these sentiments and said they needed to share information if they were to cope with fewer resources.

Motion: A. Leger motioned, D'Dalessandro seconded to forward the Priority Setting Ranking list to the HIV Integrated Planning Council with the Comprehensive Planning Committee's recommendation for approval.

C. Johnson: In Favor
M. Mabou: In Favor
N. Houston: In Favor
P. Neuman: In Favor
S. Jacinto: In Favor
A. Onorato: In Favor
P. Mukinay: In Favor
K. Carter: In Favor
D. D'Alessandro: In Favor
A. Leger: In Favor

Motion Passed: 10 in favor. The motion to forward the Priority Setting Ranking to the HIV Integrated Planning Council was passed

After the vote, T. Dominique said they were holding a lottery for those who attended the meeting in-person. The winner of the lottery won a $25 gift card for any vendor in the Reading Terminal Market. K. Carter had won the lottery.

Presentation Item:

-Recommendations Based on the Town Halls-

K. Wilson was an intern from Temple University majoring in Public Health. She worked with the Office of HIV Planning (OHP) staff during the town hall events and created recommendations based on her experience and observations.

Four town hall events were hosted by the OHP staff for each region of the Eligible Metropolitan Area (EMA). Each event focused on receiving feedback from People With HIV (PWH) on how they used and learned about Ryan White (RW) services. The OHP staff wanted to learn where services could be improved and pinpoint existing service gaps.

K. Wilson described disparities in each region starting with the Philadelphia region. Medical Monitoring Project (MMP) and National HIV Behavioral Surveillance (NHBS) data highlighted Philadelphia's racial disparities in HIV diagnoses. Racial disparities were the highest among non-Hispanic Black residents and this was followed by Hispanic/Latinx residents. Housing and poverty remained key barriers to care. She said that housing instability was high among PWH. 31% of women with transexperience reported unstable housing. 65% of women with trans experience reported living below the federal poverty line. 45% of women with trans experience

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reported experiencing discrimination. K. Wilson said this demonstrated how social and structural factors could shape access to HIV care and health outcomes.

She explained that these factors influenced health outcomes for PWH. For example, case management allowed PWH's continued engagement in care and facilitates connection to essential resources. She said effective health intervention relied on robust system navigation and client understanding of health.

K. Wilson spoke about Housing, self-advocacy and how these factors affected health outcomes. She said housing instability lowered the rate of treatment adherence and viral suppression among PWH. She highlighted one study in San Francisco that found that PWH with stable housing had a viral suppression rate of 75%. PWH without stable housing had a lower suppression rate of 33%. She observed that the ability to self advocate for themselves was a pivotal factor in a client's experience within their healthcare. K. Carter commented that housing was invaluable for PWH using injectable treatment since they didn't need to worry about their medication being stolen or expiring from poor refrigeration. T. Dominique said San Francisco recognized that they had a housing crisis and that housing had affected numerous facets of a person's life. They had responded by asking for HRSA to send more funding for housing.

During the town hall events, participants were met with various methods meant to collect further care-related information. The first was a demographic survey to understand the pool of participants' age, gender, race/ethnicity, and other information. A second survey asked members about their most valued RW service and why they chose this service. The third survey asked participants how they used RW services. Lastly, participants were broken into groups where they were asked five questions with follow up on their individual needs and care.

About 42 total participants had attended the town halls. 25 were from Philadelphia 11 participants had attended the NJ town hall. Four participants had attended the PA town hall. Two people attended the town hall designated for individuals who were not able to physically attend the other town hall events in in-person. These two participants had participated in previous town halls and were not counted twice in the data analysis.

The participants in the town halls were between the ages of 29-76. Of the participants, 76.7% were over the age of 50. 56.6% of the participants had identified as African American. K. Wilson said most of the information she had presented had come from the Philadelphia town halls because that town hall had the most participants. D. D'Alessandro congratulated the OHP staff members for their recruitment efforts as the participants closely reflected the epidemic. T. Dominique said they would have likely had more participants for the PA town hall but adverse weather had forced to postpone the event to a later date.

K. Wilson highlighted three topics/themes based on her observations: Medical Case Management (MCM), Housing Stability, and Self Advocacy. Barriers to accessing MCM services included complex systems and gaps in coordination and communication. K. Wilson said many participants felt that the role of the case manager was unclear.

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She said 63.9% of participants used MCM services in the past year. They found that though most people had used a case manager, participants felt the service was situational. Some participants may feel that they do not need a case manager to meet their needs.

The second key theme was Housing Instability. 27% of participants used Housing assistance services this year. 22% of the participants needed the service but couldn't get it. K. Wilson concluded that there was a demand for the service but these needs were not being met. During the town hall, participants were given a survey to select one service they deemed as most important. Overall, Housing Services was the most selected service in the survey. Barriers to Housing Stability included limited access, lack of awareness for available resources and affordability. K. Wilson said that many participants had questions about housing during the town hall events. Participants wanted to know if they were eligible for certain programs and how to apply for these programs.

The third theme that K. Wilson had observed at the town hall was self-advocacy. Some participants wanted a case manager to advocate for themselves while others preferred to advocate for themselves. About 8.3% of participants indicated they never needed MCM services. K. Wilson said this had meant that engagement in care varied from person to person. Participants highlighted the need for empowerment, tailored support services, and supports for long-term engagement in care. K. Wilson said the ability to advocate for themselves and ask their case managers the right questions can lead to better engagement in care.

A. Leger and D. D'Alessandro both said that accessing case management and other resources can be difficult. Because of silos, learning about providers and which service they provided could prove to be challenging for the average consumer. T. Dominique said that this issue was often exacerbated by other issues outside of the case manager's control. For example, aging consumers may recall a time when they had more resources and programs. When these consumers reach out to their case managers, they may not know or be able to offer the client the resources they had in the past due to funding cuts. K. Carter asked what was the income and education level of the participants who stated they didn't need case management. S. Moletteri said the participants who said that felt they knew where to go to meet their needs. Some of these participants could either engage with case management for the first time or returned to MCM services if their health worsened. S. Moletteri said they couldn't form a correlation between education and income with MCM usage. T. Dominique added the conversation with statistics about the participants' income levels. About 18.9% of participants had a yearly income of less than $10,000. 19.9% of participants had an income of between $10,000 and $19,999. 10.8% of participants had an annual income between $20,000 and $29,999. 5.4% of participants had an annual income between $30,000 and $39,999. 5.4% of participants had an annual income between $40,000 and $49,999. 21% of participants had an annual income of $50,000 or more. 16% of participants elected not to disclose their income. 2.7% of participants were not sure how much annual income they had.

Equipped with the knowledge gained from her observation at the town hall events, K. Wilson had created three recommendations. The first recommendation asked HIPC and DHH to jointly review and assess DHH's MCM Coordination Project Training for case managers as outlined in the 2023-2024 Directives. K. Wilson hoped HIPC members would review the training to

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improve service navigation support, communication with clients, coordination across programs and consistent, client-centered care. She said clients should have access to a guide that defined the case manager's role. N. Houston, a case manager of 14 years, said she needed to explain to her clients her role every time she had a visit with her client. A. Leger said clients normally were only given expectations for themselves. K. Wilson said that because she didn't have access to the MCM training, she couldn't make a more precise recommendation. D. D'Dalessandro said DHH did have a training program that allowed providers to learn from other disciplines.

The second recommendation called for HIPC and DHH to create a clear, user-friendly housing resource guide for PWH. This housing guide could be used to determine eligibility. She recognized they didn't have the power to change eligibility requirements, but they can reduce confusion by helping clients understand the application steps and available services. P. Neuman said that at Cooper, who she represents, they had a client agreement that states the client and the program's rights and responsibilities. The agreement and Cooper brochure explained all services provided under RW services. M. Mabou suggested that the Office of Homeless Services should be involved in this resource since most housing applications had to go through them. K. Wilson said she had interviewed someone from the Office of Homeless Services. The person said that a client needed to be on the street before they were eligible for homeless services. T. Dominique talked about an article she had sent earlier from the Philadelphia Housing Authority (PHA) where it had explained that it was more affordable for the city to buy existing housing rather than construct new housing to meet the needs of those with unstable housing.

The third recommendation called for HIPC and DHH to develop and support initiatives that strengthened self-advocacy skills among PWH. The next steps for this recommendation was to create workshops, peer support groups and educational materials to support health literacy.

D. D'Alessandro said they should create opportunities for providers to work together across different disciplines. K. Carter said it was difficult for clients to understand which provider handled which service. A. Leger said this shouldn't be something the client should be worried about. She said services should be high quality and easy to understand and that clients should not need to know how the service was funded or about the different funding streams. She said all the services collaborating together should be seamless. K. Wilson said self-advocacy was only a temporary balm because services were not as efficient and straightforward as they could be.

K. Wilson concluded her presentation. She said the town halls highlighted some key challenges like navigating services, housing stability and the need for empowerment. She said future recommendations should focus on strengthening case management, improving housing access, and supporting self-advocacy. The goal of these recommendations was to improve access, engagement, and long-term HIV outcomes. She welcomed new recommendations and ideas to improve the quality of life for PWH.

Any Other Business:
None.

Announcements:
K. Carter announced that the Aging and Thriving Symposium would take place on May 5th.

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Adjournment:
D. D'Alessandro called for a motion to adjourn. **Motion:** D. D'Alessandro motioned, K. Carter seconded to adjourn the April CPC meeting. **Motion passed:** Meeting adjourned at 4:01 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:
- April 2026 CPC Agenda
- March 2026 CPC Meeting Minutes

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HYBRID: Prevention Committee
Meeting Minutes of
Wednesday, April 22th, 2026
2:30 p.m. - 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: J. Ealy (co-chair), J. Myahweg, A. Onorato, D. Surplus (co-chair)

Excused: J. Haskins

Guests: Dr. David Metzger (Presenter), W. Newman

Staff: Tiffany Dominique, Elizabeth Fischer (Intern), Debbie Law, Sofia Moletteri, Kevin Trinh, Kristin Wilson (Intern)

Call to Order/Introduction: J. Ealy asked for introductions and called the meeting to order at 2:39 p.m.

Approval of Agenda:
J. Ealy referred to the April 2026 Prevention Committee agenda and asked for a motion to approve. **Motion**: A. Onorato motioned; D. Surplus seconded to approve the April 2026 Prevention Committee agenda. Members voted vocally in the room and through Zoom. **Motion passed:** All in favor. The April 2026 Prevention Committee agenda was approved.

Approval of Minutes (*March 25th, 2026*):
J. Ealy referred to the March Prevention Committee Meeting minutes. **Motion**: D. Surplus motioned; J. Ealy seconded to approve the March 25th Prevention Committee meeting minutes. Members voted vocally in the room and through Zoom. **Motion Passed:** 3 in favor. The March 2026 Prevention Committee meeting minutes were approved.

Report of Co-chairs:
D. Surplus reminded everyone about the Spreadsheet training on April 29th from 9am-11am. Moving forward, each training event would be held in person on the 5th week of each month if applicable. The Office of HIV Planning staff wanted to host meetings on weeks the Council members were not scheduled to have a meeting.

Report of Staff:
T. Dominique said HIPC co-chair nominations were open for until May 14th. K. Trinh sent out an email requesting input for Section 4 of the Integrated Plan. Members had until March 24th to respond. T. Dominique asked members to check their emails for a similar document that the Office of HIV Planning (OHP) would be sending out on behalf of the Division of HIV Health (DHH) to discuss goals and objectives for the Integrated Plan. T. Dominique said Dr. Brady would be at the office May 14th to discuss the response and the following month there would be a vote for concurrence on it.

Presentation Items:
~Injection Drugs and HIV Transmission~
D. Surplus introduced and welcomed D. Metzger, who presented on injection drug use and HIV transmission. He began by sharing experiences from his earlier work with people who inject

drugs (PWID) and discussed the early emergence of HIV acquisition and its intersection with drug use in Philadelphia. D. Metzger introduced the project "The Rapid Initiation of Drug Treatment Engagement" that consisted of an advisory board with providers and PWID which was funded by HIV Prevention Trial Network which began in the 1990s.

He opened the presentation with an overview of HIV prevalence among PWID, emphasizing the need for sustained access to HIV testing and healthcare services. D. Metzger noted to ask questions throughout the presentation and offered to share the slides to the committee.

D. Metzger presented a graph titled *"Number of New HIV/AIDS Diagnoses Among IDUs in Philadelphia."* He discussed events along the timeline that affected the trends shown in the graph, including the implementation of the needle exchange program in Philadelphia under a previous mayoral administration, the introduction of SEP in 1990, and the introduction of Antiretroviral Therapy (ART). He noted that methadone became an important HIV harm reduction strategy. By 2014, the efforts were viewed as highly successful; however, prevention specialist grants became increasingly difficult to obtain. D. Metzger presented another graph titled *"Fatal Overdoses in Philadelphia County"*. D. Metzger explained that many overdose deaths were caused by combinations of drugs. The primary focus during this period shifted toward keeping people alive through overdose response efforts, while HIV prevention and treatment took a secondary role during the fentanyl epidemic and later the COVID-19 pandemic. He explained that COVID-19 significantly restricted HIV testing access. This was highlighted in another graph titled *"HIV Epidemic Curve Among PWID, 2018–2023"*. D. Metzger noted how new HIV cases attributed to injection drug use were reported less after COVID-19, which may have reflected changes in testing methods or inconsistent testing among high-risk populations. He concluded that the study he's presenting suggested that programs were not consistently reaching the people most at risk for HIV.

The presentation then shifted to the HPTN 094 Study, which tested the impact of providing free medications for opioid use disorder along with HIV testing using mobile units. The aim was to see if there was an impact on outcomes if the services were easily accessible. The study was conducted in Kensington and five additional cities: the Bronx, NY; Los Angeles, CA; Houston, TX; Washington, DC; and Philadelphia, PA.

J. Ealy asked if the care was through the University of Pennsylvania. D. Metzger responded that they used whatever was most convenient or available. They were selective with what services they referred participants to because they wanted services to be receptive to PWID.

D. Metzger then explained the study design, noting that all sites recruited participants through mobile units and used randomized assignments to determine if participants would receive services on the mobile unit or to get peer navigation and referral to community providers, not at the mobile unit. The study followed up with participants at 6 and 12 months. They parked the mobile unit on Kensington Avenue and recruited participants as they walked by. The Kensington site recruited more participants than any other site, which D. Metzger connected to the high rates of drug use and drug purchasing activity in the Kensington area.

The targeted population included individuals 18 years or older with opioid use disorder who agreed to treatment, demonstrated some level of risk behavior, and were living either with or

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without HIV. 831 individuals were screened and 447 individuals were enrolled in Philadelphia, which had the largest number of participants enrolled as compared to other cities. D. Metzger explained that many individuals were excluded because they weren't sharing needles. Recruitment and enrollment took place between June 2021 and September 2023, with Kensington Avenue serving as the primary recruitment site. D. Metzger noted that 10% of the participants were living with HIV. T. Dominique asked if the 10% enrolled with HIV were diagnosed at screening. D. Metzger confirmed it was 10% prevalence at the start of the study. He explained that most participants already knew their HIV status.

Demographic data showed that the average participant age was 38 years old. Participants were 62% men and 38% women. Approximately 77% identified as White, 19.5% as Black/African American, and 8.9% as Hispanic. Additionally, 77% of participants were unhoused. D. Metzger reflected that housing should be a major focus because adherence to treatment was extremely difficult without stable housing. D. Metzger discussed demographic differences in drug use patterns, noting that among many Black communities, smoking and snorting drugs were more common than injection use.

J. Ealy shared that, in his experience, needle aversion was common among people of color. D. Metzger agreed and stated that researchers must work carefully with participants to make them comfortable, particularly during blood draws. He referenced experiences from a study in Vietnam that highlighted similar concerns and hesitancy around blood collection. K. Trinh asked when the study in Vietnam took place. D. Metzger said it took place a year ago.

D. Metzger continued that approximately 88% of participants completed the 6-month follow-up, and 95% completed the 52-week follow-up. Drug screening data showed that 100% of participants tested positive for fentanyl at baseline, while only a few tested positive for heroin. D. Metzger discussed the historical heroin epidemic associated with Vietnam War veterans and contrasted it with the current fentanyl epidemic, which resulted in significantly higher fatality rates. He noted that the vast majority of participants tested positive for both opioids and stimulants simultaneously.

Regarding intervention outcomes, D. Metzger stated that the intervention did not significantly increase treatment engagement among participants living with HIV or those without HIV. T. Dominique asked whether participants attempted to stop using substances. D. Metzger responded that he believed most participants had attempted to stop, but that the prevalence of fentanyl use created significant barriers to successfully beginning treatment. Participants self-reported higher use of medications for opioid use disorder (MOUD) than what was reflected in supervision or monitoring data. Although it wasn't statistically significant, the study showed lower mortality rates during the trial period which could be worth further investigation.

D. Metzger explained there was a 3.5% incidence rate, indicating there were multiple new HIV cases identified during the study. He emphasized that this incidence rate was very high, and highlighted how Philadelphia was the only site to report new infections. S. Moletteri recalled that data from 2022 regarding HIV testing syringe exchange programs showed Philadelphia had one of the highest HIV incidence rates. D. Metzger agreed that Philadelphia had higher rates of overdose and HIV incidence within PWID nationally. He continued that the study recorded five participant deaths: three from overdose and two from other medical conditions. Additionally,

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51% of participants had at least one emergency room visit. Common medical issues included soft tissue necrosis (56%), cardiovascular issues (15.4%), overdose-related visits (6.1%), and trauma-related visits (7%).

T. Dominique asked if participants reported getting tested or being offered an HIV test at a hospital. D. Metzger explained that most emergency rooms do not regularly test for HIV, possibly due to the perception of the additional workload associated with managing positive diagnoses. He noted that the older people got, the more likely they were to end up in the hospital emphasizing a need for primary care and early detection of serious medical conditions and support for chronic medical conditions. S. Moletteri asked whether the study recorded how long participants had been using substances. D. Metzger stated that while he doesn't have an exact number, he would estimate that they'd been using substances since their teenage years.

D. Metzger concluded saying the intervention did not improve uptake of addiction treatment and that HIV continues to be transmitted at high rates among PWID in Philadelphia. He also highlighted the extremely high utilization of hospital and emergency healthcare services as well as the high mortality rate due to medical conditions within this population. K. Trinh asked if there were any additional questions. J. Ealy asked whether copies of the presentation slides could be shared. K. Trinh confirmed the slides would be uploaded to the website after the meeting.

~Overviewing Key Demographic, Socioeconomic, and Health-Related Factors of the EMA's General Population~

J. Ealy introduced the next presentation from E. Fischer, one of the interns at OHP, who presented her final project, "Epidemiologic Profile For the Philadelphia Eligible Metropolitan Area". E. Fischer began by providing a brief overview of the presentation and asked attendees to hold questions until the designated questions and comments slides located in the middle and at the end of the presentation.

E. Fischer presented an infographic highlighting key demographic and socioeconomic indicators within the general Philadelphia Eligible Metropolitan Area (EMA) population. She explained that the EMA consists of 9 counties including Philadelphia County, four New Jersey counties (Burlington, Camden, Gloucester, and Salem), and four suburban Pennsylvania counties (Bucks, Chester, Delaware, and Montgomery). She highlighted in 2024, the EMA had a population of 5.5 million people, the average household size was 2.5, the uninsured rate was 4.5%, the poverty rate was 10%, the unemployment rate was 5%, with 93% had at least a high school diploma, , 93% of households had internet access, and 9.8% used public transportation to get to work.

E. Fischer continued on the next infographic. She explained how Philadelphia residents had an average lower income compared to the NJ and PA counties, while Black/African American households had consistently lower incomes throughout the EMA. She added that Philadelphia county had the highest poverty rate in the EMA at 21.4% while Chester County had the lowest at 6%. Both Philadelphia (21.4%) and Salem (12.7%) counties had a poverty rate higher than the U.S. poverty rate (12.5%).

E. Fischer highlighted public assistance within the EMA, emphasizing how Philadelphia had a much higher percentage of public assistance income than the rest of the counties, showing that Philadelphia residents may need more public assistance. In terms of Social Security,

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Supplemental Income (SSI), and Retirement Income, suburban counties had higher rates of Social Security and Retirement Income which may indicate more stable or long-term working compared to Philadelphia, who had a higher rate of SSI which could indicate lower incomes or shorter-term work. She continued by showing a graph of the unemployment rate in each county where Philadelphia had the highest unemployment rate at 7.8% and Chester was the lowest at 3.2%. She also explained that as educational attainment increases, the poverty rate decreases. Women generally had higher poverty rates than men though 22% of men who had less than a high school degree were at or below the federal poverty level. She discussed how despite females having a higher education attainment than men, they still had higher poverty rates which could be due to gender pay wage gaps or childcare costs.

In terms of insurance coverage, E. Fischer noted how approximately 1 in 5 people in New Jersey and Pennsylvania use Medicaid for health insurance while approximately half of the population uses employment-based health insurance. She continued by highlighting people aged 19-64 were more likely to be uninsured in all EMA counties with Philadelphia having the highest uninsured rate for people 19-64 years old (9.6%). She explained that in all EMA regions, males had a higher uninsured rate than females with Philadelphia having the highest uninsured rate for both males and females at 7.2%.

E. Fischer stated the official definition of a "limited English speaking household" was one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well." Of the four New Jersey EMA counties, Camden, NJ had the highest percent of Limited English Speaking Households with 4.8%. Of the entire EMA, Philadelphia County had the highest percentage at 7%. E. Fischer stated this data implies that there may be a language barrier that could affect access and quality of care. She continued that while 80.6% of households in the Philadelphia EMA speak only English, 7.6% speak Spanish, either alone or alongside English. She said this was the second most common language in the EMA.

E. Fischer then compared the sexual education laws between New Jersey and Pennsylvania where New Jersey was required to teach comprehensive sexual education, but stress abstinence, and must include HIV and STI instruction, sexual orientation, gender identity, and consent, and the curriculum must be medically accurate. Of these same topics, Pennsylvania was only required to include HIV and STI instruction, and must stress abstinence. She emphasized that while New Jersey had seen success in advancing sexual education, Pennsylvania remained one of the few states that do not require comprehensive sexual education.

E. Fischer continued to explain sexual activity in Philadelphia high school students. She noted that as students progressed through high school, they were more likely to be sexually active, but were also more likely to engage in unprotected sex. She continued to explain how as students progress through high school, sexual activities increase. Students who ever had sexual intercourse went from 21% (9 grade) to nearly 50% (12 grade). A notable share of sexually active students engage in risky behaviors including not using condoms (17.1%). In terms of drug and alcohol use among Philadelphia high school students, she noted how over 1/5 of respondents reported they used marijuana at least once in the past month. Almost 16% of respondents reported using prescription medications without a prescription at least once in their life.

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E. Fischer completed the first half of the presentation and asked members if they had any questions or comments about any of the information presented. J. Ealy asked for elaboration on what it means for sexual education to be medically accurate. E. Fischer clarified that to be medically accurate, the information must be up-to-date and scientifically accurate. T. Dominique noted that although Pennsylvania doesn't require sexual education, Philadelphia County was more advanced in terms of their sexual education in comparison to the rest of the EMA.

E. Fischer introduced the next set of infographics that highlighted discussion items such as housing, transportation, food insecurity, and mental health. She started off by discussing housing. She presented the data collected in a Point in Time Count and noted that in Philadelphia, there was a 22.9% increase in people experiencing homelessness from 2022 to 2025.

She also noted that while most counties had a majority of owner-occupied housing, Philadelphia was nearly evenly split at 51.8% owner-occupied and 48.2% renter-occupied. E. Fischer compared the median value of owner occupied units by EMA county which showed urban and rural counties report lower value of owner-occupied units compared to suburban counties and highlighted that the median value of homes had increased in every county within the EMA from 2020 to 2024. Similarly, she compared the median monthly rent for occupied units paying rent by EMA county which showed the same trend where median rent had increased in every EMA county. She noted that the rent increase could be due to a variety of factors including high demand, higher landlord costs, and gentrification which limits affordable housing. E. Fischer then compared median household income to the rate of increase of home value and monthly rent for each county. She found that both rent and unit values were rising faster than household income making housing increasingly unaffordable for many households.

E. Fischer began discussing transportation explaining that the majority of commuters rely on private vehicles to get to work. She specifically noted that public transportation varies with the PA and NJ counties using 3% individually, but over 16% in Philadelphia. Additionally, she noted that modes of transportation differ between the EMA counties, which may show a difference in transportation access within the population. In terms of travel to work time, E. Fischer emphasized how Philadelphia county had the longest travel to work time at 31.7 minutes despite 78.3% of residents working within the county. She also found that New Jersey counties experience an average higher rate of individuals who work out of the state (13.9%) compared to Pennsylvania counties (6.6%). E. Fischer compared the means of transportation to work by workers' earnings which showed that in PA and NJ counties, individuals earning less than $15,000 predominantly used public transportation or taxis, biking, or walking. She found that over half of those working from home earn $65,000 or more and driving alone increases with income. These findings indicate that higher-income workers had more control over how they commute to work.

E. Fischer presented information on food insecurity. She highlighted 2025 SNAP eligibility changes to work requirements and citizenship which limit access to SNAP benefits. She defined food insecurity as the condition of limited or uncertain access to adequate food. She noted that while the data presented in this section reflect the most recent estimates, it was expected to increase the number of people experiencing food insecurity that do not qualify for benefits. She gave a basis that the United States had a food insecurity rate of 14.3%, an annual food budget shortfall of 32,156,122,000, and 44% of the food insecure population was above the SNAP

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threshold meaning they do not qualify for SNAP benefits. She noted that in New Jersey, the food insecurity rate was 11.7%, the annual food budget shortfall was 772,854,000 and 45% of the food insecure population was above the SNAP threshold. In Pennsylvania, the food insecurity rate was 13.2%, the annual food budget shortfall was 1,170,335,000, and 41% of the food insecure population was above the SNAP threshold. She highlighted in Pennsylvania, approximately 1 in 5 people in Philadelphia County were experiencing food insecurity. She also noted that Chester and Bucks County had 61% of people experiencing food insecurity who did not qualify for SNAP benefits.

E. Fischer shared insights on mental health demographics. She defined frequent mental distress as experiencing 14 or more days of mental distress per month. She noted that all New Jersey counties within the EMA had a higher percent of frequent mental distress compared to the state average. She highlighted that Philadelphia stands out as having nearly 1 in 5 adults who experience frequent mental distress. She noted that Salem (780:1), Gloucester (610:1), and Chester (320:1) counties had the three highest client burden per provider in the EMA. The ratio reflects the population to mental health providers where higher ratios indicate lower access to care since there were fewer providers available. This may lead to longer wait times, limited provider choice, and unmet mental health needs. She explained that residents in Philadelphia, Salem, and Delaware counties were reporting more mentally unhealthy days than both state averages.

Following the detailed presentation, E. Fischer concluded her infographics by highlighting key takeaways that highlighted disparities in transportation access, persistent food insecurity and SNAP eligibility gaps, and increased housing unaffordability driven by rising housing costs.

E. Fischer asked for questions or comments for members. K. Trinh asked if she collaborated with the other intern, K. Wilson, on the key takeaways. E. Fischer said that both used the townhall discussions to guide their projects since it highlighted what was important to the population. T. Dominique added that E. Fischer's project highlighted the general population while K. Wilson's project was specific for people living with HIV. She noted that both projects highlight how both populations were experiencing the same issues. T. Dominique added that the transportation a person uses to get to work was typically the same that you would get to your medical provider which means it takes away the amount of time to see a medical provider. S. Moletteri noted that rideshares were also higher for people who were making less than $35,000, so if they were running late they couldn't depend on their own car and found that data interesting. K. Wilson connected the increase in housing costs to her own recommendations for the EMA where she had seen increased housing costs directly impact people in the EMA.

E. Fischer asked the group a few evaluation questions to evaluate the project for her class. She asked "In what ways do you see yourself using the information that you learned in HIPC decision-making" and "How likely are you to use this knowledge moving forward?" J. Ealy responded that he would use the information presented to be more sensitive and create a questionnaire for patients to determine where they need support. D. Surplus added that she would reference the information when making decisions in HIPC.

E. Fischer asked "How clear and easy to understand were the infographics overall?" and "What aspects of the charts or the visualizations or design made the information easy or difficult to read

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and follow?" to gauge the quality of the presentation. J. Ealy responded that he appreciated information being pointed out by the presenter to help keep the audience visually engaged. K. Wilson noted that the visuals were engaging and enjoyed the colors used within the presentation. T. Dominique added that the presentation effectively captured a lot of information in a condensed way. J. Ealy emphasized the helpfulness of having access to the slides to go back and reference the information. T. Dominique informed the group that the infographics would be shared on the hivphilly social media pages.

Other Business:
J. Ealy shared that Merck had received FDA approval for a new treatment option. He noted that a presenter from the company may be interested in attending a future meeting to speak with the Prevention Committee.

Announcements:
K. Trinh announced OHP would be tabling at the Aging and Thriving symposium on May 5th. T. Dominique added OHP would be tabling at Mount Pisgah African Methodist Episcopal Church Community Wellness Day on Saturday, May 9, beginning at 11:00 a.m. A. Ornanto gave further explanation that it would include screening services, nutrition information, and a mobile unit doing HIV and STI testing. A. Ornanto would send out the finalized flyer.

Adjournment
J. Ealy called for a motion to adjourn. Motion: J. Ealy motioned, D. Surplus seconded to adjourn the April 2026 Prevention Committee meeting. Members voted vocally in the room and through Zoom. Motion passed: All in favor. The meeting adjourned at 4:18 p.m.

Respectfully submitted,
Elizabeth Fischer

Handouts distributed at the meeting:

- April 2026 Prevention Committee Agenda
- March 2026 Prevention Committee Meeting Minutes

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