Meeting Agenda

VIRTUAL:
Thursday, March 10, 2022
2:00 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(February 10, 2022)*
- Report of Co-Chairs
- Report of Staff
- Action Item
  - Recruitment Guidelines
- Committee Reports
  - Executive Committee
  - Finance Committee – *Alan Edelstein & David Gana*
  - Nominations Committee – *Juan Baez & Mike Cappuccilli*
  - Positive Committee – *Gracie Bornes & Kenya Moussa*
  - Comprehensive Planning Committee – *Gus Grannan*
  - Prevention Committee – *Lorett Matus & Clint Steib*
  - Ad-Hoc Recruitment Workgroup
- Other Business
- Announcements
- Adjournment

HIV Integrated Planning Council

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

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VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, February 10, 2022
2:00-4:30 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Juan Baez, Mike Cappuccilli, Keith Carter, Mark Coleman, Jose Demarco, Lupe Diaz (Co-Chair), Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan, Julie Hazzard, Sharee Heaven (Co-Chair), Janice Horan, Sterling Johnson, Gerry Keys, Kailah King-Collins, Marilyn Martinez, Lorett Matus, Kaleef Morse, Shane Nieves, Nhakia Outland, Sam Romero, Clint Steib, Desiree Surplus, Nicole Swinson, Evan Thornburg (Co-Chair)

Guests: Mike Frederick, Ameenah McCann-Woods (AACO), Nancy Oniovosa, Kim Thomas, Mikah Thomas, Javontae Williams (AACO), Shareen Wise

Excused: Debra D'Alessandro**,** Hemi Park

Staff: Beth Celeste, Julia Henrikson, Debbie Law, Mari Ross-Russell, Sofia Moletteri, Elijah Sumners

Call to Order: L. Diaz called the meeting to order at 2:04 p.m.

Approval of Agenda: L. Diaz presented the February 2022 HIPC agenda for approval. **Motion**: D. Gana motioned, K. Carter seconded to approve the February 2022 agenda. **Motion passed**: 16 in favor, 3 abstained, and 1 non-member.

Approval of Minutes *(January 13, 2022)*: L. Diaz presented the previous meeting's minutes for approval. **Motion**: D. Gana motioned to approve the minutes, A. Edelstein seconded to approve the January 2022 meeting minutes. **Motion passed**: 15 in favor and 5 abstained, and 3 non-members.

Report of Co-Chairs:

L. Diaz reminded the council that there was a policy in the by-laws regarding a leave of absence so it would not count toward missing meetings if they were sick or not doing well in any capacity.

Report of Staff:

M. Ross-Russell stated that the Office of HIV Planning has received push back from the Project Officer and their Supervisor to the point where she doesn't know how to respond. For example, we recently had our Finance Committee meeting, at which time we did not get any response from HRSA or our project officer, and/or their supervisor related to the monitoring the

administrative mechanism. Earlier this week, we received a response. And the reason that I am somewhat at a loss is that within the body of the response, it said that we should have language in there in our monitoring the administrative mechanism that specifically talks about when the recipient conforms contracts or gets the contract signed for Ryan White services. Within there we have a section called "contracting" and it says 90 days after receipt of the award. So to say that we don't have language is kind of confusing.

Where it says "Please ensure that this is in accordance with 45 CFR 75." That was actually a reference to the Office of Management and Budgets, cost principles, and audit principles for HHS awardees. That language was a reference to how the recipient would respond and certain circumstances or how the recipient must respond or what they must do because they have an application and or grants under HHS, it is fiscal. To put it on the Planning Council, was a bit strange, but, we do require that the recipient try to ensure that they have, letters of award conformed contracts within 90 days, which was in the monitoring language. They also said to us that we were asking for too much, which were what the bullet points were. To be clear, everything that was outlined in the monitoring the administrative mechanism was something that the planning body has been doing for 20 years, and has been writing about in the application for 20 years.

M. Ross-Russell continued, there was also some language where they talked about the fact that in the case of a partial award, that the recipient does not need to receive an approved allocation from the Planning Council, legislatively the language says that the Planning Council is responsible for allocations of awards, it does not say partial award, it does not say full award, it says awards. She was not sure what to say in order to try and satisfy this problem.

As it pertained to S. Moletteri's comments in regards to the recruitment guidelines, M. Ross-Russell stated that it was specifically stated in the recruitment plan that we were going to keep the language as far as population, somewhat vague. The reason for that was due to the fact that the people that we were going to recruit were going to change over time. If you were very specific and listed a group of populations, then what that meant was that every time you want to change or focus on another population, you have to go back and change the language. It is a plan, it is a guidance for how we were going to recruit people.

K. Carter stated that he believed the Planning Council should write a letter or grievance stating that this was just ridiculous, and it's wasting our time. P. Gorman stated OHP was at the mercy of whoever the consultants were that were coming to evaluate the site. The project officers rely heavily on those expert consultants to provide information or suggestions as to what the findings were and how the recipient may respond or provide recommendations as to what you can possibly do in order to address those particular findings. She said she understood K. Carter's sentiments, but this was HRSA's audit process.

M. Ross-Russell stated we were at a loss because we received the findings, we responded to the findings. This is the response to our response to the findings. P. Gorman suggested that she go

back to the project officer and say at this point, OHP needed some technical assistance as to how to address the findings. M. Ross-Russell stated that we have done three responses to the findings, the administrative mechanism. The creation of the form was based on initial findings, the recruitment process and coming up with guidance was based on their process. To put it into perspective, when we looked at this we saw what the other EMAs were doing across the country, before the monitoring the administrative mechanism was submitted. The 30, 60, and 90-day compliance, and including that to make sure the contracts were conformed, that language is already in the monitoring the administrative mechanism that we previously submitted, and this is the response to something that we previously submitted.

P. Gorman responded that typically it's communicating with your PO to find out exactly how they want it done. You clearly define your information in your responses to what you're doing, and it's not meeting up to what they want. That makes it really difficult because it sounds like they don't want it. They say they don't want to be prescriptive; however, if you keep coming back with a response, you need them to be more prescriptive.

K. Morse stated as a former Planning Council director, and government Co-Chair who survived your HRSA supervisor, he offered his assistance to help with this process. M. Ross-Russell thanked K. Morse and told K. Carter that the letter was at the discretion of the Planning Council if they wished to write it or if they wanted her to do so, but it would need to be signed by the Co-Chairs.

M. Martinez said that her organization went through a similar process in 2020 as a Ryan White recipient for Part C funding. She asked if there was a “Best Practices” to follow and she would greatly appreciate it. K. Carter asked did these project officers have lived experience and worked in this field before? K. Morse answered that the first piece to understand is Steve Young no longer works at HRSA. Steve Young used to be what Krissy Abrams is, this specific branch supervisor for the Northeast region, has been doing this to all of the planning councils across her jurisdiction. The third piece is you really don't get a chance to win against the HRSA folks unless you come with the legislation back at them. What's happening is that when you look at the Ryan White Legislation, and what the Planning Council was supposed to do, remember that the actual law has sunset. So the law is dead, we're on a resolution. So there's no new law to replace what's going on. There's bigger things going on, but he understood. It can be fixed, and he told M. Ross-Russell he was willing to help finish up the responses.

M. Ross-Russell said the other part of it was that the Planning Council has voted on the monitoring the administrative mechanism language, and she doesn't necessarily think that the language needed to change. It was just figuring out how best to deal with what it was that HRSA wanted. K. Morse responded to be prepared that the language may need to change.

S. Moletteri added that the project officer had concerns about the recruitment guidelines and because of these concerns the guideline language has been altered a bit. Instead of this being an action item, we're going to vote on finalizing the guidelines.

Discussion Items:

–MMP Presentation–

S. Wise presented the Medical Monitoring Project, which is a nationally representative, population-based surveillance system designed to learn more about the experiences and needs of people who were living with HIV. It's supported by several government agencies and conducted by state and local health departments along with the Centers for Disease Control and Prevention (CDC). It provides information about the behaviors, clinical outcomes, and quality of care for people with HIV (PWH). MMP provides high-priority national HIV prevention indicators, such as the proportion of PWH who experience stigma and homelessness. MMP data can also be used in making local and national policy decisions and in HIV funding and treatment services. In addition, MMP can answer important questions, such as: How many people living with HIV were
receiving medical care for HIV? How easy is it to access medical care, prevention, and support services? What were the met and unmet needs of people living with HIV? How is treatment affecting people living with HIV?

There were 23 jurisdictions and Philadelphia is one of them. The CDC staff draws the sample from the National HIV Surveillance System in order to take advantage of information reported by all US surveillance jurisdictions. CDC staff draws the sample from the National HIV Surveillance System in order to take advantage of information reported by all US surveillance jurisdictions.
All adults living with an HIV diagnosis were identified in the national case surveillance dataset
Data is then allocated to individual project areas MMP project areas pulls personally identifying information out of the local eHARS case surveillance database for use in locating and recruiting sampled persons.

S. Wise continued by stating they collect data from persons sample who were asked to participate in a detailed confidential health survey. Names were captured in the survey data. It takes roughly 45 to 60 minutes to complete. Of course, that depended on each individual person, it can go longer than 60 minutes, but not usually less than 45 minutes. It's completely voluntary, but they stress the importance of community participation while trying to recruit each sample person. Anyone can refuse to answer any questions that they want to. They also may retract consent at anytime during and after the survey. They also asked them to consent to a detailed medical record extraction. Lastly, for their participation they were rewarded a token of appreciation of $50 for participating and if they decide to retract consent, they can keep the $50.

S. Wise stated that the survey includes questions regarding participants medical past, use of medical and social services, sex practices, use of drugs and alcohol, reproductive history, ability to work and work history. The medical record of abstraction started from the survey completion from the date of survey completion to two years prior. For example, if a participant was

interviewed today, on February 10, 2022, the extraction date will start on February 10 2020, and will end on February 10, 2022. Information abstracted includes but is not limited to demographics, labs, medications, diagnosis, outpatient and patient encounters, STI testing, immunization and resistance sequencing.

Each jurisdiction sample size is based on their population. Philadelphia has a sample size of 400. For some comparison, Pennsylvania, their jurisdiction includes every single county in the state of Pennsylvania with the exclusion of Philadelphia, but their sample size is also 400. To satisfy the final data collection targets, we go by cycles in MMP. Each cycle starts on June 1 and ends on May 15. During that cycle, the target is to interview 50% of the eligible population or the eligible sample. Eligibility is determined by everybody that was pulled randomly from the National HIV surveillance system but some individuals will not always meet eligibility criteria, so throughout the cycle, the sample would become smaller and smaller. It has to be 50% of the final sample size out of the 50% of the population of the eligible sample that was surveyed. They have to complete a detailed medical record abstraction from that number from whatever the 50% was.

They determined eligibility with the minimum two-factor verification, but Philadelphia would typically use three, they have to be 18 years of age by sampling date, and the sample date was always December 31 of the year before the start of the data collection. Right now the MMP cycle year is 2021, so the sample date is December 31, 2020. With any sample here, the person has to be 18 years of age on that sample date. They also have to have lived at or had residency in one of the 23 MMP jurisdictions, and they also have to have HIV diagnosis on or before that sample.

S. Wise continued that a lot of the data collector's time was spent contacting sample persons and also researching ways to locate the sample person. In most of the contexts it was probably direct contacts, which could include telephone calls, cold calls, scheduled letters, email, text messages, and knowing the sample person in a public space or at the person's home. They also use Health Department supported databases like LexisNexis. Providers can disclose protected health information to public health, health authorities without individual authorization and all jurisdictions don't have service authority because it's something you have to apply for. Philadelphia does have this authority but some of the direct contact methods have been discontinued or postponed because of COVID-19. For direct contact we also make some indirectly so it could be through healthcare facilities or local health jurisdictions, case surveillance, service organizations, community-based organizations, and Health Department experts, like partner services located in certain medical associations. Associations and directors may support MMP by providing information about facilities providing HIV care, local project area, provider and community advisory boards could be instrumental in communicating with reluctant sample persons. Also, other MMP jurisdictions may contact participants on our behalf if we find out that they have moved or relocated to another place. A contact attempt can also be defined as having been able to get a final disposition for a person without contacting them, for example, if the person is deceased or incarcerated, but being incarcerated does not always mean that you can't interview the person, if there were in a local jail, sometimes, you can still obtain an interview depending on if there were staff in the local jail that is willing to assist you with

obtaining their interview.

Cross jurisdictional lead generation and recruitment. So with out of jurisdiction sample data, if the residency is determined to currently be from another jurisdiction during the sample period in and if the person wants to participate, but the current residency was not located in the MMP participating state, the data collector has to halt the recruitment and refer to the Council of State and Territorial Epidemiologists, the overall responsible party. You could find that you have to contact the state before you contact the person or you recruit the person.

Informed consent project areas must have a system in place to document consent. Consent can be oral, written, or over the phone and the consent form must be read in its entirety. Every interviewer should offer to provide a copy of consent to the participant, the participant must be informed that sensitive language that could disclose their status is located on the consent prior to mailing the copy. Data Collectors must be conscious of a respondents inability to consent to participate, but it does not require prospective participants to have the capacity to make every kind of decision because what they can't answer they just don't have to answer. Also consent to participate in the project required the participant to agree to both the survey and the medical record extraction. So if they consent to one and not the other, that was considered retracting consent, and then the interview has to be destroyed.

The medical record retrieval, following survey completion, is as follow. The data collector confirms a facility participant is obtained. As a medical care, surveillance authority can be used to obtain the participants record. But just to make the process a little easier and less time consuming, especially if it's a private provider, MMP asks for a release of information just to make a more seamless transition.

The facilities that understand sponsor authority, and understand that we don't need ROI (release of information), they may still request correspondence on city letterhead stating what records were needed and the participants identifying info so they can make sure we're asking for the correct persons records. If the person is out of the jurisdiction, surveillance authority cannot be used, and we have to obtain ROI from the participant. They would still have to confirm with the facility that the participant was receiving their medical care. And we always have to use a trackable mail service like UPS or FedEx.

S. Wise stated that they have to track all the information and the Health Department also has to send all the data to the CDC. In house they have something called the tracking module. It's an application that captures all the work that the data collectors were doing, interviews, all the contacts successful or unsuccessful, the medical records, the statuses, whether you could obtain it or not all the lead generations for every single sample person. Additionally, non-personally identifiable data is entered in this application would be routinely synced to the DCC. From the Data Coordinating Center, we send all the encrypted information to the CDC, so that was how they get all the information. All the data that MMP has collected and sent to CDC does not contain any personal identifying information from MMP.

P. Gorman asked if there was another project for youth since this data was for 18 and older? S. Wise answered that when the person was considered a youth or a minor, that sometimes it's a really hard project to conduct because there were different rules and regulations for them. The main problem was the consent factor, it's hard to determine what age, when the person was considered a youth, they could consent to something like this. J. Williams followed up that the Health Department does not do any similar project with people under 18. However, the Dexus Project has a lower age, perhaps in the medical monitoring project where it starts at 18 because they were able to give consent, and then you can access their medical records without a parental signature.

–OHP Budget Review–

A. Edelstein reported that this came about, as a result of the site visit that was held, and an item that was noted that we needed to do a more formal review of the budget for the Office of HIV Planning and also to monitor the expenditures during the year and it was decided that that task would be delegated to the Finance Committee. In the last meeting the Finance Committee reviewed the year-to-date expenditures. It says expenditures to date, 3/1/2021 through 11/30/2021, which would be nine months which would be three quarters of the year or 75%. When you look at the percentage of the total if you were staying on track at nine months through the year, you would be seeing 75%. And you can see like we're a little bit under that. If you look at the direct expenses, OHP was at 61.9%. The salaries and fringe benefits, this was for all the staff, so the total expense date has $228,000, which is about 69.3% of the total.

A. Edelstein continued in the budget narrative it read that the responsibility of reviewing the support budget on a quarterly basis was given to the Finance Committee, by the Executive Committee and agreed upon by the Planning Council. The Public Health Management Corporation acts as the fiscal agent for the Office of HIV planning, who act as support staff to HIPC the segregation of responsibilities is ensured through the following steps. Segregation of responsibilities is an accounting principle, which refers to the process by which payments were approved and then payments were made. The office manager processed a Payment Authorization, the Director would review and sign the authorization. The checks would be processed and distributed through the accounting department of PHMC, and signed by the CEO of PHMC Richard Cohen. Monthly invoices were then submitted by PHMC to the recipient for payment, and to OHP as support documentation, any reimbursement for expenditures by the OHP director would be reviewed and authorized by the recipient, AACO. This type of expenditure cannot be authorized by the OHP Director, copies of payment or authorizations were maintained for a period of no less than seven years.

The expenditures through November 30th, were $308,060, the projected expenditure should have been $373,034, which would be based on 75% of the budget. Currently, there was approximately $64,974 underspending, it was anticipated that a portion of this would be used because of costs associated with the PLWH service evaluation survey in the fourth quarter. The lease for space

increased effective 1/1/22 to $18 per square foot from $16. This was still below the current market rate for the area, which was roughly between $22 to $24 a square foot. The change will also affect the underspending in the fourth quarter. The expense items, personnel was impacted by the departure of the senior health planner as well as position shifts and hiring of a new community planning Support Coordinator in July. So this was why OHP was somewhat below budget in spending, for personnel because of those changes in staff. Operating costs were affected by the office closure as a result of the pandemic, and switched to virtual meetings versus in person.

Utilities were under budget in terms of spending because the office does not require usual heating and cooling or electrical output for computers and printers and copiers, so we save some money there. Communications, phones and internet were fully operational, therefore the costs have not changed significantly. So even if there weren't people in the building, or a lot of people in the building, you need to maintain their services. Postage was preloaded and did not require additional payment, this would change with the survey. The cost for postage paid mailers and return envelopes was expected to amount to about $7,000 based on historic expenditures, the survey tool is 10 pages and it's expected that approximately 2,500 packets will be created to get a 20% sample of the epidemic. Courier service has not been used, but again this would change with the delivery of surveys to providers.

A. Edelstein continued by stating that the costs incurred by office and meeting supplies were mostly related to PPE supplies, and virtual meeting structure has decreased the need for basic supplies. Leased equipment included a copier and the postage machine. Due to the virtual meeting environment, there has been very little printing completed. Equipment. This expense is mostly for the software license and subscription costs which was paid on an annual basis including SPSS. Those expenses were for the entire 12-month period and they've been paid. Expense items under "Other" included the security system, exterminator, and office cleaning and maintenance and only the cost for the security system were incurred because of the pandemic.

–Recruitment Guidelines–

S. Moletteri began by reiterating that the Project Officer had concerns about the recruitment guidelines that were presented at last month's meeting. In the beginning of the guidelines there were three concerns that were addressed. First, the Project Officer said, "please clarify if Black, Hispanic and multi race individuals will be included under population specific outreach", which was what this recruitment plan was about. In regards to objective 1.1, the Project Officer asked why is aging the focus when the reflectiveness shows that people under 39 were underrepresented in the planning council. As a reminder, we do have the youth portion within the recruitment plan. We also talked about recruiting those who were aging with HIV in the New Jersey, and PA counties.

The third concern from the Project Officer was "please clarify that the workgroup will strategize efforts to fill required membership categories and each demographic goal and include a generic goal and objective to fill the vacancies." Those were the three concerns which we worked our

hardest to work into the recruitment plan in the beginning, and then there's a fourth comment: goals within the guidelines will change as the epidemic changes since the ultimate goal of these guidelines is to strategize efforts to fill required membership categories and reach demographic goals.

S. Moletteri reiterated that the Project Officer asked to give a generic goal of what the Recruitment Guidelines was supposed to be, which was reaching demographic goals. The three goals were to focus on recruiting people living with HIV within New Jersey and PA counties, young men who have sex with men, and Transwomen. M. Ross-Russell added that the Project Officer's comments could mean that there were other populations that probably needed to be added and/or to include a generic goal so that it would cover any additional populations because there were specific populations which have been identified.

K. Carter asked if according to the Project Officer's comments that in order to satisfy demographic representation for example one could not be listed as both formerly incarcerated and HIV positive, they would have to satisfy one of the categories. M. Ross-Russell responded affirmatively and stated that was related to the program terms report, where all of the member representation was listed. The member representation was also supposed to be consistent with the various service provider categories, and provider categories that were listed in the legislative language. The issue that the Project Officer had regarding the program terms report was that initially, there was somebody who represented recently released and/or incarcerated, but that was a provider. That provider has since either resigned or been removed from the planning council, so because they only allowed OHP to identify membership based on a single day and time during the course of the 365 days out of the year, we had to change our membership representation. While you could have had a person living with HIV who was previously incarcerated represent that category, it would have meant that that individual could not represent unaligned people living with HIV.

K. Morse asked if there was guidance around how long this recruitment plan should be from HRSA because it seems like it's very long and very detailed. M. Ross-Russell answered that it seemed like if we use brevity as the basis for our decision and give them something which was short, we got a complaint. If we give them something that was detailed, it's too detailed, and we told them too much. K. Carter added that the recruitment guidelines were created based on a six-week class S. Moleteri, M. Cappuccilli, and he took and they had to present a final recruitment plan through Planning CHATT.

D. Law stated that the categories that were being discussed that K. Carter brought up was representation of expertise, which was for 15 categories such as social service providers, substance abuse users, incarcerated PLWH, that's different from demographic representation, that's a separate list that we look at. For the purpose of addressing what K. Carter was saying, of not being able to represent incarcerated, or unaligned consumers, those were actually two separate things.

K. Carter asked if we looked at our current Planning Council membership could we check off each one of the boxes to make sure of proper representation? D. Law answered on a membership application, there were four different areas or parts that you check off. That was separate from when you check off "which area of expertise can you bring to the table" That's two different columns. What we were saying was you cannot represent two areas of expertise. We ask what your primary and your secondary was, that's different from your demographics being Black, Hispanic, or your age.

Action Items:

–Level Funding Budget–

A. Edelstein presented the level funding budget and stated that this item was reviewed last week in the Finance Committee. He was bringing it forward as a motion from the Finance Committee, with the recommendation that it be approved by the entire Planning Council. The key point that he wanted to make at the outset is that what the Finance Committee were asking everyone to approve is, basically to approve decisions, which we previously made as a Planning Council in July. We were going to be receiving a partial allocation from the feds for funding our services, because the federal government has yet to pass a budget for the full year. They will pass what's called a "continuing resolution" which would fund some portion of the year and then at some time, down the road, they will pass the budget. We will get the final numbers first with the allocation going through the recipient.

Basically, what was being asked of the Planning Council was to approve a budget, which was based on this year's fiscal calendar that ends at the end of this month.

Motion: Approve a partial budget allocation based on the level funding budget, which was approved last summer when we made our plans. That budget would be in effect temporarily until the final allocation amount becomes known, at which point the Finance Committee would come back with the proposal for the final amount as to how that should be allocated.

Juan Baez– In Favor
Mike Cappuccill– In Favor
Keith Carter– In Favor
Jose Demarco– Abstain
Lupe Diaz – Abstain
Alan Edelstein– In Favor
David Gana– In Favor
Pamela Gorman– In Favor
Gus Grannan– In Favor
Julie Hazzard– In Favor
Sterling Johnson– Abstain
Gerry Keys– In Favor

Kailah King-Collins
Marilyn Martinez– In Favor
Lorett Matus– In Favor
Kaleef Morse– In Favor
Shane Nieves – Abstain
Nhakia Outland– In Favor
Erica Rand– In Favor
Sam Romero– In Favor
Clint Steib–In Favor
Desiree Surplus– In Favor
Evan Thornburg – Abstain
Mike Frederick– No Answer

17 in favor, 5 abstain

Committee Reports:

–Executive Committee–

No Report.

–Finance Committee–

No Report.

–Nominations Committee–

Mike reported that the committee reviewed the attendance policy and discussion surrounding Trauma-informed care. How and if we do that would be determined. D. Law reported on the orientation, and they discussed the "buddy system" and ways to improve that moving forward.

–Positive Committee–

S. Moletteri reported that the Poz Committee will meet on February 14th at 2pm.

–Comprehensive Planning Committee–

G. Grannan reported that the last meeting was focused on priority setting and its purpose was to set up overarching goals for the year.

–Prevention Committee–

Julia reported that there was a presentation led by AACO where they talked about some of their milestones from 2021, like formalizing a community mobilization as a distinctive service category, establishing the PrEP update and AACO prevention update. Additionally, priorities for 2022 like continuing their EHE efforts and revamping Philly Keep on Loving and the creation of AACO's first Strategic Prevention plan. The next meeting would be the 23rd at 2:30 p.m.

–Ad-Hoc Recruitment Workgroup–

No further report.

Any Other Business:

None.

Announcements:

K. Carter reported that April 20, during the day, April 21, and evening there would be a meeting for the Reunion Project and S. Moleterri was given the materials to disseminate to HIPC.

Adjournment:

L. Diaz asked for a motion to adjourn. K. Carter motioned to adjourn, C. Steib seconded. Meeting was adjourned at 4:14 pm.

Respectfully Submitted,

Elijah Sumners, staff