MEETING AGENDA

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

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(January 13, 2022)*
- Report of Co-Chairs
- Report of Staff
- Discussion Item
  - MMP Presentation
  - OHP Budget Review
- Action Item
  - Level Funding Budget Review
  - Recruitment Guidelines
- Committee Reports
  - Executive Committee
  - Finance Committee – *Alan Edelstein & David Gana*
  - Nominations Committee – *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, January 13, 2021
2:00-4:30 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Mike Cappuccilli, Lupe Diaz (Co-Chair), Debra D'Alessandro, Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan, Julie Hazzard, Sharee Heaven (Co-Chair), Janice Horan, Gerry Keys, Kailah King-Collins, Lorett Matus, Shane Nieves, Hemi Park, Sam Romero, Blake Rowley, Clint Steib, Desiree Surplus, Evan Thornburg (Co-Chair), Adam Williams

Guests: Ameenah McCann-Woods (AACO), Anna Thomas-Ferraoli (AACO), Olivia Kirby, Mikah Thomas (AACO)

Excused: Juan Baez

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 2:08 p.m.

Approval of Agenda: L. Diaz presented the January 2022 HIPC agenda for approval. K. Carter motioned to approve the amended agenda. **Motion**: K. Carter motioned, M. Cappuccilli seconded to approve the amended January 2022 agenda. **Motion passed**: 14 in favor and 3 abstained.

Approval of Minutes *(December 9, 2021)*: L. Diaz presented the previous meeting's minutes for approval. **Motion**: G. Keys motioned to approve the agenda with amendment, A. Edelstein seconded to approve the amended December 2021 meeting minutes. **Motion passed**: 16 in favor and 3 abstained.

Report of Co-Chairs:

S. Heaven reported that a HIV Housing Advisory Committee meeting was scheduled for Tuesday, January 18th at 2 pm, but it was postponed until Tuesday, March 15th at 2pm. There would be an email reminder sent out for those expected to attend the meeting. She continued that there would also be staff changes in DHCD in the next couple months. Additionally, the Phase Four Rental Assistance Program has ended and that the City has requested funds to serve applicants that were in the pipeline that may not have been able to be served because of the cut off. She does not believe there would be a Phase Five Rental Assistance Program.

Report of Staff:

M. Ross-Russell reported that the work for the Community Survey was ongoing and hoped that individuals who were a part of the Planning Council, and those who represent organizations would help OHP once everything was settled. She would let members know when packets were completed and OHP would contact providers for their dissemination as well as contacting other Ryan White funded organizations to see if they were also willing to participate. S. Moletteri reported that D. Law sent out information regarding new member orientation and for new members to respond to the Doodle Poll if it was not already completed. The email also has information on resources for HIPC, summary of Robert's Rules, acronyms, etc. to help the transition into the Planning Council.

Discussion Items:

–Updates on EHE Activities–

A. Thomas-Ferraoili presented the EHE update on behalf of AACO. As of December there was new HIV surveillance data. The goal would be to introduce the current AACO EHE Coordination Team and give the Planning Council a brief update about the epidemiology of HIV in Philadelphia. Additionally, the Federal EHE initiative and EHE in Philadelphia, and then discuss a bit about what AACO has been doing as it relates to each of the pillars. Finally, a discussion about how community partners can contribute to ending the HIV epidemic in Philadelphia.

A. Thomas-Ferraoili presented the EHE Coordination Team, which was funded under various sources and were on various teams within AACO. Javontae Williams is the Senior Coordinator for HIV Prevention Services, Drexel Shaw is the CDC EHE Coordinator, Brian Hernandez is the Prevention Program Associate, Olivia Kirby is the HRSA EHE Coordinator, Tanner Nassau is the EHE Evaluator, Mars Potros is the EHE Epidemiologist, Mikah Thomas is the Community Engagement and Communications Specialist, Evan Thornburg is Health Equity Special Advisor, and Anna Thomas-Ferraioli is EHE Advisor.

M. Thomas introduced themselves to the Planning Council as the newest member of the EHE Coordination team and stated their goal in this role was to integrate more of the underrepresented, marginalized, and highly-impacted community members to make sure they receive the resources and make sure that HIPC worked within organizations to yield the best outcomes.

A. Thomas-Ferraoili continued that as of December, there was a new HIV Surveillance Report. There was a data lag, so the reports typically come out about a year after reporting was complete, so this was the information for 2020. There were 18,621 people living with HIV in Philadelphia, 332 people were newly diagnosed with HIV in 2020, which was down from 446 people in 2019. This was good, but it was unclear that this represented a true decrease in incidence of HIV. This was due to a decrease in HIV testing volume in early 2020, along with the shutdown due to

COVID-19. Testing did not fully rebound during the year, so there was lower testing volume for the entirety of 2020. Among people living with HIV in 2020, the most affected populations were men at 72%. People who were Black, Non-Hispanic ethnicity at 63.7%, 54.8% of individuals were 50 and older, and 38.9% MSM.

In 2020, there were 36 million new diagnosed cases of HIV among people who inject drugs. This does include MSM who inject drugs. For the Federal ending the HIV epidemic program, the goal was a 75% reduction in new HIV infections in five years. A 75% reduction by 2025 and a 90% reduction in 10 years by 2030. The way that they propose we do that was by diagnosing all people with HIV as early as possible, treating the infection rapidly, and effectively preventing people at risk for HIV. By using multiple prevention interventions including PrEP to respond rapidly in order to detect and respond to growing HIV clusters to prevent new infections and to support the HIV workforce.

A. Thomas-Ferraoili stated that Philadelphia was one of the Phase One jurisdictions, which meant that it was one of the priority jurisdictions with more than 50% of new HIV diagnoses in 2016 and 2017. In the United States, there were 38 counties and Philadelphia was among them. So on December 1, 2020 AACO released the HIV epidemic Community Plan. Ending the HIV epidemic in Philadelphia is a community strategic plan aimed to reduce 75% of new infections by 2025 and 90% by 2030, same as the objectives.

A. Thomas-Ferraoili presented the EHE goals for Philadelphia and stated that most people living with HIV in Philadelphia do know they're HIV positive, but as of 2020 11.5% did not know their status, which meant there was a gap in access to and provision of testing. The goal was to reduce new infections from 470 in 2017, down to 118 in 2026, and then 47 in 2030. This would mean that the epidemic would no longer be growing in Philadelphia if we met those numbers. So in 2025 95% of people newly diagnosed with HIV would need to have a medical appointment within 30 days of their diagnoses. By 2025, 95% of people living with HIV, need to be on treatment and virally suppressed. Those are two strategies we would need to complete to meet this goal. This was also directly pulled from the 2020 surveillance report.

The Philadelphia Community EHE Plan was a five year strategic plan and it contains four pillars for the local jurisdiction as well as one that is unique to Philadelphia. It focused on diagnosing all Philadelphians with HIV as early as possible, treating people living with HIV quickly and effectively, preventing new transmissions by promoting PrEP, PEP, and syringe service programs responding quickly to HIV outbreaks. Pillar zero, which was unique to Philadelphia, was really about overarching approaches based on health equity, and Radical Customer Service. Additionally, Pillar Zero was really a structural pillar. It was meant to acknowledge the ways in which our system must be more equitable, in order for us to end the epidemic, and we had several strategies that were identified in the original plan, including providing radical customer service, reducing HIV stigma, providing safe and secure housing, and really focused on addressing the system rather than the individuals in the past there have been a lot of focus on

individual behavior, and what was wrong with a client and are a patient that made them vulnerable to HIV or not achieving viral load suppression.

AACO has developed a standardized Health Equity Assessment tool, conducted assessments at EHE-funded sites, and completed Health Equity Plans based on the assessment findings. AACO has further defined Radical Customer Service and applied the concept to program design and implementation across the EHE programs. At the root of radical customer service was the idea that programs would be client-centered and would adjust their structures to meet people where they were. Lastly, developed a Health Literacy and Comprehension guide for use by providers.

The First Pillar for both the National and local to Philadelphia was “Diagnose” and by 2025 97% of people living with HIV in Philadelphia know their status. There were some barriers mentioned here and some gaps. These were the activities that have been done thus far through EHE. There has been expansion of the HIV self-test kit program that's really focused on normalizing, destigmatizing, and expanding access to HIV testing. Community-based status neutral testing continued, with a focus on funding grass-roots community-based organizations in Philadelphia to test for HIV with a focus in specific communities and expanded capacity in strategic locations serving priority populations for low barrier HIV testing including walk-in options. Finally, there's the low threshold sexual health services. These services have been funded. These are to expand access to sexual health services for priority populations and geographic areas.

The second pillar was “Treat.” The end goal was by 2025, 92% of people living with HIV would achieve viral suppression. This was important for the health of the individual living with HIV because there were better health outcomes associated with being virally suppressed, and then preventing onward transmission of HIV. As we know, “undetectable equals untransmittable,” so if a person has achieved viral load suppression, if their viral load is undetectable, they cannot pass HIV to a sexual partner. AACO funded five agencies to conduct engagement and reengagement activities; there would be a sixth agency funded before the program year’s out. The Sana Clinic has opened at Prevention Point Philadelphia, which was a low threshold multi-service setting for people who inject drugs that provided HIV care; that was opened in July of 2021. Then the Philadelphia Regional EHE collaborative was launched. Our next meeting of the immediate ART Working Group, which was the first working group of the collaborative, will be on January 19th.

The third pillar is “Prevent,” so by 2025 the goal is that 50% of people with a PrEP indication will be prescribed PrEP and that 100% of people seeking nPEP will be prescribed the treatment. There were several needs and gaps related to getting prevention services to individuals. Low-Threshold Sexual Health Sites (L-SHS), a network of clinics to provide HIV, STI and HCV testing, PrEP, nPEP, and linkage to HIV, STI and HCV treatment, nPEP Center of Excellence, A jurisdiction-wide nPEP 24/7 call center, Two Brick-and-mortar clinical sites that provide low-threshold access to nPEP to the public, TelePrEP Services, RFP released to establish, operate and provide telemedicine for HIV prevention. Though we observed an increase that was reported in 2016.

The fourth pillar "Respond" focused on outbreak response related to surge in HIV cases among certain sub-populations. In Philadelphia, we have an ongoing outbreak among people who inject drugs, though we observed an increase that was reported in 2016, where there was a big increase in cases we are seeing lower numbers, but this was still an ongoing outbreak among people who inject drugs in Philadelphia. As part of our response, we investigated and responded to all related HIV cases to stop chains of transmission. We have initiated an outbreak response plan and we have focused on making systemic changes based on the data.

In 2021, we updated the outbreak response plan and it was approved by the CDC. A Field Service Program has been established within AACO that focuses on HIV care linkage and re-engagement with a specific focus on cases associated with outbreaks and clusters. And then there's the Nexus program in which a multidisciplinary team reviews incidences of HIV acquisition and focuses on response to improve outcomes.

She presented the objectives for 2022. They were to enhance community and stakeholder awareness of EHE activities and strategies, supporting EHE-funded programs as they move into implementation by providing technical assistance and evaluating using implementation science and making work plan adjustments. Lastly, support immediate ART implementation across all Philadelphia HIV care providers, not just those that were EHE funded.

G. Grannan asked if we could get the number of tests administered by month from January 2020 through the present? A. Thomas-Ferraoili responded that they were not available at the time of the presentation, but the numbers for 2020 were in the surveillance report, and she would note this request for monthly testing numbers and report back. S. Johnson asked to clarify that testing was down? A. Thomas-Ferraoili answered yes, testing was down, which could also explain the decrease in newly diagnosed HIV infections. K. Carter asked if it was possible to provide the link to the Radical Customer Service guidance as well as the Health Equity Policy as that was mentioned during the presentation? A. Thomas-Ferraoili answered that they were working on getting these things posted to AACO's website, so when they were posted, a link would be provided. D. D'Allessandro noted some jurisdictions considered "workforce development" as part of pillar five, does Philadelphia? A. Thomas-Ferraoili answered that it was not in the Community Plan as a separate pillar, but it was an activity in the EHE Community Plan, and it was something that AACO did have incorporated within our activities, but AACO didn't report it separately.

J. Demarco asked how the Omicron COVID-19 variant was being addressed in HIV testing services? A. Thomas-Ferraoili answered that there have been some operations disrupted at sites as they relate to staffing, but reassured that there has not been any intentional scaling down or reduction of services related to COVID-19. G. Keys stated that public health centers have stayed open since the beginning of the pandemic and have continued to do HIV testing. She continued that they were open, but people stayed home because COVID-19. Also, health centers did have to limit the amount of people that could be in a building at one time, but they never stopped

testing. The social workers do a lot of HIV testing in the health center. L. Diaz agreed and relayed that her center was noticing as the numbers were increasing for people to get tested, more of their staff were being exposed to COVID-19.

B. Rowley asked what was the time to treat a patient in 2020 and has that begun to change? A. Thomas-Ferraoili answered that she was in the process of requesting the average time data for the initiation of HIV treatment, from diagnosis to treatment and hoped to have the data soon.

–Ad-Hoc Recruitment Workgroup Guidelines–

S. Moletteri presented the guidelines to the full planning committee. She read the overview "HIPC will establish an ad-hoc workgroup to strategize recruitment efforts and reach demographic goals, reporting back to the full Planning Council with a finalized plan by January 2022." That was the language that began the Ad-Hoc Recruitment Guidelines and formed the Ad-Hoc Recruitment workgroup. The Ad-Hoc Recruitment Workgroup would follow up with HIPC to report recruitment progress on a quarterly basis. The recruitment guidelines were a living document because population and representation would change as epidemiological information changed and HIPC membership changed. The Recruitment guidelines goals were made up of three goals, each goal being a specific population. The first goal was people living with HIV within New Jersey and PA counties, the second was young men who have sex with men, and the third were transgender women. The main goal with the recruitment efforts was to make sure that everyone has a seat at the table.

M. Cappuccilli stated the overall goal of this plan, which all EMAs share, was to recruit and retain membership. All EMAs have the same challenge with this, as we learned, with our experience talking to them, the Philadelphia EMA was somewhat unique, in that it encompassed nine counties, two states, urban, suburban and rural communities. So even with a great variety of resources, there is also a great challenge for this particular EMA. COVID-19 and virtual meetings just added another barrier to recruitment and retention. The first goal of three was to recruit more people within the New Jersey and PA counties. Each of these goals has, along with them objectives and then strategies. The first objective, which isn't necessarily specific to New Jersey and PA counties, but is a particular challenge in those regions, was to address the digital divide for aging potential members within the counties as a barrier to participation and recruitment. He reiterated that all the strategies and materials were potentially applicable to Philadelphia as well. The first strategy in this first goal was to disseminate Digital Divide resources. He thanked the Positive Committee, which created a one page handout which was already on the website and would be available for distribution. AACO would distribute this handout through case managers, and also in directors meetings, which we have quarterly through AACO.

M. Cappuccilli continued that the challenge was to identify and reach our case managers in New Jersey and suburban regions of Pennsylvania. The feedback mechanism would be to reach out after these were distributed to get feedback from case managers to report back to the Office of

HIV Planning. Again, this would be an ongoing process because of turnover. We had discussed the option of distributing tablets or other equipment through the Office of HIV Planning, but that was not possible. These other resources would hopefully help our members who are having challenges. M. Cappuccilli stated the second strategy and our first goal was to increase meeting participation. The Ad-Hoc Recruitment Workgroup was in the process of coming up with vouchers or gift cards that would be made available to our members. We discussed some options with vouchers, and that was still in the process and hasn't been decided yet.

M. Cappuccilli stated that transportation to meetings was not an issue, we were looking at other ways to award people that were actually participating in meetings. Dunkin Donuts gift cards were discussed, other options have been discussed, vouchers and gift cards were in process. The Positive Committee was currently drafting a letter to past Positive Committee participants inviting them back to attend meetings and to offer feedback. It was really important that we have full participation and full feedback from our Positive Committee because it's particularly important that they were a part of this process. Our follow up would be once we distribute vouchers and gift cards, through the positive committee and other members of HIPC, we would be able to track the use of those. Also, we would be able to track the distribution of the Positive Committee letter.
K. Carter stated that the Positive Committee was currently rewriting the letter because some people may not want to have a letter from the Office of HIV Planning or the Positive Committee, and there was language included that may not be safe for some individuals. M. Cappuccilli thanked K. Carter for the update.

M. Cappuccilli continued to the next objective in the first goal of reaching out to New Jersey and in the suburbs. To increase awareness of the existence of the Planning Council and the importance of HIV services. The first strategy and this objective would be to expand advertising, and we discussed different ways of doing this. The potential for putting advertisements on buses and on PATCO. we determined that the cost of doing that versus the effect would not be worth it. It was too prohibitive, so the Office of HIV Planning would create a press release to offer information on the Planning Council that was in progress. his will be distributed to newspapers, newsletters, to be determined. Also, the press release would be on the website once it receives approval from the City's Media Office. Everything that gets written in terms of a press release has to go through the City. That was all in process.

M. Cappuccilli stated the second strategy was to use all members of the Planning Council to leverage their connections. In this regard, there were a couple of handouts to present. One was a recruitment script that we created that our volunteer members can use if they were talking to our member organizations in the PA counties and New Jersey, that would give out a point by point description of what the Planning Council was as well as the benefits and advantages of membership to the Planning Council. Another other strategy was to create population specific materials in the form of flyers and posters, using some online digital tools like Canva to target very specific populations. This could be changed in a number of different ways based on our EMA-wide epidemiological data, to distribute in various locations also will be available on our

website. M. Cappuccilli stated that the group looked at it to discuss language and how it could be changed based on the population that was targeted. The follow up would be volunteers who distribute these and would report back to the office of HIV planning on outcomes.

D. Gana asked if we could make sure that funding was non-agency specific? A. Edelstein clarified that it might refer to not having dollars to support the effort flow through different agencies. D. Gana agreed and stated he did not want somebody joining from an agency thinking they were going to be able to get the money specifically for their agency. M. Cappuccilli agreed and stated that members on the Planning Council represent everyone and all agencies on the Planning Council, not just where they come from.

K. Carter stated that goal two of the Ad-Hoc Recruitment Workgroup was recruitment of young men who have sex with men, or Queer youth in general. For goal two, there were three objectives. Objective one was to create an impactful online presence. Our second goal would be to advertise HIPC to a young men who have sex with men and other queer youth, and to ensure that HIPC was approachable for youth. So for our first objective, objective 2.1 was to create a more impactful online presence. Strategy 2.1.1 which was to enhance social media platforms just says specifically target Men who have sex with men, so what we want to do would be to create a population specific, simple information graphics. He stated that J. Henrikson would be responsible for posting on social media and she would utilize the EHE plan and EPI Profile information to curate the messaging to specific populations.
K. Carter continued that members who work directly with youth could leverage that network to help develop content and feedback. Additionally, there was currently a list of about 180 Youth Organizations between New Jersey and Pennsylvania that was created to help identify youth in the EMA who could be interested in joining HIPC. He also presented the social media recruitment template where there would be a campaign and the purpose would be to see what kind of social media tool would be used, who was going to be responsible for posting this, how often they're going to post it, etc. The next strategy 2.1.2 would be to “Put a face” to HIPC, which would begin with interview style video to ask questions like “What made you join HIPC?” “Why do you want to be a part of something like HIPC?” in order to humanize the people behind the work done by the Planning Council. HIPC will develop questions for the interview-style video and members can volunteer/ to participate in the video; members will share the video via social media OHP will create agreements for participation and film the interview-style video; the video will be posted to the HIVPhilly.org website and shared on OHP social media accounts.

K. Carter stated that HIPC was going to start livestreaming meetings, and that will give folks an opportunity to familiarize themselves with the work being completed by the Planning Council. This would also give them a chance to sit in the comfort of their own homes with their friends to familiarize themselves with the process. K. Carter continued that strategy 2.2.1 was “focus on population-specific messages and provider connections.” This would be achieved through the creation of a three fold pamphlet, which will have a QR code on it, and that QR code will direct individuals to the OHP website. From there people could get information on how to join, when committees meet, and familiarize themselves with the website. Additionally, we have to

prioritize face-to-face interactions and we can be real with folks and they could see that HIPC is willing to come into their community spaces. Additionally, tabling at events like Outfest or Pride.

K. Carter stated that the final objective 2.3 was "Ensure HIPC is approachable for youth" with the goal of eventually developing a youth council. This could allow them the ability to have their own voice and report back to the full planning council. Additionally, if youth were interested in joining the HIPC could create a mentorship program so they can sit with somebody who has a little more experience with the planning council to help guide them and hopefully create a pipeline of youth to join as full members. However, we identify one of the biggest challenges with youth recruitment and other marginalized populations was that HIPC does not have the ability to compensate people for their participation. That detail was still forthcoming.

L. Diaz presented the Goal 3: Recruit Trans Women and objective 3.1 Advertise HIPC to Trans Women. She stated that the Ad-Hoc Recruitment Workgroup wanted to create population specific materials including shareable infographics. In addition, where to go to share this information, so that it could be advertised to Trans Women that HIPC was an available resource to them. One of the goals was that while we were trying to advertise and help bring in Transwomen to sit at the table, we needed to know how we could do that. L. Diaz continued that a strategy was to identify community leaders who are Trans Women who were willing to participate within the HIPC process.

S. Nieves asked for the previous goal for youth recruitment, what was the age range for youth? S. Moletteri answered that the range would be 18-24 was the goal. S. Nieves asked if recruitment was focusing on Transwomen exclusively? Or would recruitment consider opening that up to anyone who doesn't fit the traditional gender binary? Or are you looking to really hone in on Transwomen? L. Diaz answered that recruitment was firm on getting more Transwomen involved because that was the demographic that we were low on at the moment. However, we would love anyone within the scope of Trans Non-Binary because they were not as represented on the Council, so anyone within that spectrum would be a great addition.

S. Moletteri stated that HIPC was not voting on these guidelines this meeting to make them official but there would be a 30-day comment period, so they would send the guidelines to the Council and if there were any comments or concerns to respond to their email. M. Cappuccilli stated that the goal was to give feedback on this plan on a quarterly basis going forward.

Action Items:

–Reallocation Request–

A. Edelstein presented the reallocation request to the full council. Throughout the Ryan White contract year, the Recipient closely monitors Subrecipient spending, recaptures underspent funds and reallocates underspending regionally or EMA wide with the HIV Integrated Planning Council's approval as necessary. Customarily, the Recipient's fiduciaries PHMC and UAC

experience delays in billing and processing of invoices. Larger institutions such as hospitals and universities inherently have cumbersome fiscal processes and experience delays in submitting invoices as well. The end of the 2021-22 contract year is looming (February 28, 2022). The administrative mechanism employed by the HIV Integrated Planning Council is effective in mitigating underspending at the conclusion of every contract year and assists the Recipient in its endeavor to finalize and close contracts. Acting proactively the Recipient is requesting permission to reallocate any remaining underspending to the following direct service categories: Emergency Financial Assistance, Food Bank/Home Delivered Meals, Oral Health Care, Medical Transportation Services.

A. Edelstein stated that this request was presented to the Finance Committee at their last meeting and the members voted to approve the request and bring it to the full Planning Council with the recommendation that the full council vote to approve the request.

K. Carter- In Favor
M. Cappuccilli- In Favor
L. Diaz -- Abstain
D. D'Alessandro–In Favor
A. Edelstein– In Favor
D. Gana– In Favor
P. Gorman– In Favor
G. Grannan- In Favor
J. Hazzard– In Favor
S. Heaven– Abstain
S. Johnson – In Favor
G. Keys– In Favor
K. King-Collins– No answer
L. Matus– In Favor
S. Nieves– Abstain
H. Park – No answer
S. Romero– In Favor
B. Rowley – In Favor
C. Steib– In Favor
D. Surplus– In favor
E. Thornburg–Abstain
A. Williams–In Favor

The motion was approved: 15 in favor, 4 abstained

–Mission Statement–

S. Moletteri previously presented the mission statement for comment. There were no additional changes issued during the 30 day comment period. The HIV Integrated Planning Council (HIPC)

works to ensure that all people living with HIV (PLWH) have fair, equitable, and appropriate access to all services within the Philadelphia EMA. HIPC focuses on the continuous improvement in service system standards and functions to maximize the quality of life for PLWH. We do so by: Promoting diversity and inclusivity through listening to individual needs; Maximizing meaningful involvement of PLWH on the Council through active recruitment and by providing an additional, designated space for PLWH to meet with each other; Diminishing barriers to care and promoting dignity by following client-centered approaches; Ensuring that PLWH and service providers work together and have open discussions around all levels of design, delivery, and evaluation of services; Upholding and advocating for the autonomy and agency of PLWH.

K. Carter motioned to approve the new mission statement language as is presented by S. Moletteri, A. Williams seconded the motion.

K. Carter- In Favor
M. Cappuccilli- In Favor
L. Diaz -- Abstain
D. D'Alessandro–In Favor
A. Edelstein– In Favor
D. Gana– In Favor
P. Gorman– In Favor
G. Grannan- In favor
J. Hazzard– In Favor
S. Heaven– Abstain
G. Keys – In favor
K. King-Collins– No answer
L. Matus– In Favor
S. Nieves– In Favor
H. Park – No answer
S. Romero – In Favor
B. Rowley – In Favor
C. Steib– In Favor
D. Surplus– In favor
E. Thornburg – Abstain
A. Williams – In favor
S. Johnson – In Favor
J. Demarco – In Favor

The motion passed: 18 in favor, 2 abstain

Committee Reports:

–Executive Committee–

No Report.

–Finance Committee–

No Report.

–Nominations Committee–

No Report.

–Positive Committee–

S. Moletteri reported that the Positive Committee met Monday and continued discussion of writing the letter to past members.

–Comprehensive Planning Committee–

CPC will meet next Thursday, January 20th.

–Prevention Committee–

Prevention will meet on Wednesday, January 26th.

–Ad-Hoc Recruitment Workgroup–

No further report.

Any Other Business:

None.

Announcements:

None.

Adjournment:

S. Heaven asked for a motion to adjourn. K. Carter motioned to adjourn, C. Steib seconded.

Respectfully Submitted,

Elijah Sumners, staff