Ryan White Part A Planning Council (RWPC) of the Philadelphia EMA
Meeting Minutes
Thursday, February 9, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Katelyn Baron, Henry Bennett, Michael Cappuccilli, Karen Coleman, Mark Coleman, Alan Edelstein, David Gana, Pamela Gorman, Sharee Heaven, Peter Houle, Gerry Keys, Sayuri Lio, Nicole Miller, Nuit Shein, Adam Thompson, Leroy Way

Excused: Tre Alexander, Juan Baez, Ralph Bradley, Bikim Brown, Kevin Burns, Edward Campbell, Keith Carter, Cheryl Dennis, Lupe Diaz, Tessa Fox, Christina Hoegel, Andrena Ingram, Abraham Mejia, Christine Quimby, Ann Ricksecker, Joseph Roderick, Samuel Romero, Carlos Sanchez, Steven Saunders, Kyle Tucker, Lorrita Wellington, Melvin White, Deanne Wingate

Guests: Clint Steib, James Breinig, Chris Chu, Ricardo Colon, Gus Grannan, Kathleen Brady

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

Call to Order: K. Baron called the meeting to order at 2:00p.m.

Welcome/Introductions/Moment of Silence K. Baron welcomed RWPC members and guests. Those present then introduced themselves.

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

Recap of Previous Meeting: K. Baron reported that at their last meeting the Planning Council discussed membership appointment requirements and heard an update on the consumer survey. Subcommittee co-chairs also presented their standard reports.

Approval of Minutes (*January 12, 2017*): K. Baron presented the minutes for approval. **Motion:** A. Edelstein moved, M. Cappuccilli seconded to approve the January 12, 2017 minutes. **Motion passed**: All in favor.

Report of Co-Chair: None.

Report of Staff: N. Johns stated that she'd printed and distributed preliminary results for the consumer survey. She said 307 responses to the survey had been received. She stated that more surveys had been sent out recently, so more would most likely be received in the future. She noted that education level of respondents was varied. She stated that 29% had graduated from high school, and 20% had attended some college. She noted that respondents had been asked about internet access on the consumer survey for the first time. She stated that 59% of respondents said they had their own computer or smartphone, and 16% said they had a place to go to access the internet. She stated that these results had not yet been compared by geography or income. She added that people had also been asked about their employment status for the first time. She stated that each county was proportionally represented in its proportion of respondents.

N. Johns noted that 25 of 307 respondents were diagnosed with HIV in 2016, and one respondent had been diagnosed in 2017. She reported that 40 people had said they were diagnosed in the last 5 years. She stated that 80% said they got medical care within 30 days of their diagnosis, and 83% reported that their viral loads were undetectable. She noted that respondents were asked if they needed HIV care and didn't

get it in the last 12 months, and 9% had said yes. She stated that 82% of people were satisfied with their case managers, and many people had written praise in the comments for the question. She noted that the survey also asked about sex partners: if they were on PrEP, HIV positive, or taking medication. She stated that 5% said their partners were on PrEP, 13% said their partners were positive and taking medication, and 2% said their partners were positive and not taking medication.

She said that another question had been added that asked if respondents had been incarcerated since their diagnosis, and 20% responded that they had. She added that questions had been added about medical and mental health comorbidities. She noted that many respondents were over 50, so many listed comorbidities like diabetes and high blood pressure. She said that 50% of respondents had been diagnosed with depression, 42% with anxiety, 19% with bipolar disorder, 9% with post-traumatic stress disorder (PTSD), and 10% with substance use disorder. K. Brady asked if there was an option for none of the above, and N. Johns replied that there was. She explained that 30% said none of the above and 6% did not answer, for a total of 38% that did not answer positively for any of the diagnoses.

N. Johns stated that 29% of people stated that they had trouble getting to medical appointments because of issues with transportation, which were also explored through a recent Needs Assessment Committee transportation survey. C. Steib asked if there were statistics on the age groups that took the survey. N. Johns replied that most respondents were over 50. She stated that newly diagnosed respondents varied in age. M. Cappuccilli asked what the response rate was for the survey. N. Johns stated that there had been 307 responses out of 2850 surveys distributed, and 34 online surveys had also been completed. She said that an ad for the online survey was being placed in Philadelphia Gay News (PGN) in print and online.

Public Comment: None.

Action Items:

- **Partial Grant Award Allocations**

A. Edelstein said that the recipient had received a notice of a partial grant award for 70% of the current year's Formula funding. He stated that the RWPC needed to approve a spending plan for that partial allocation. N. Shein added that 40% of Minority AIDS Initiatve (MAI) funding had also been received. A. Edelstein added that the notice of the final award total was pending.

A. Edelstein pointed the group to the spending plan adopted at last year's allocations meeting. He said that an allocation had been adopted for level funding, based on a 100% award. He noted that $160,000 had been allocated at level funding to health insurance premium/cost-sharing assistance. He stated that research was currently being conducted about how to support the program in the Philadelphia EMA. He explained that the AIDS Activities Coordinating Office (AACO) had presented on their resource, and they found that providing the service in the Philadelphia EMA would require around $1.6 million. He said that many other states funded their health insurance premium/cost-sharing assistance programs at the state level (through Part B and ADAP), according to the AACO presentation. He explained that the Comprehensive Planning Committee (CPC) intended to contact the state, asking if the PA Department of Health could provide support for the program in some way. He explained that the Commonwealth of Pennsylvania got rebates from pharmaceutical companies, which could potentially be used to fund health insurance premium/cost-sharing assistance. He noted that the Finance Committee had voted to recommend the RWPC keep the $160,000 in the budget, pending the response from the PA DOH.

G. Grannan noted that pharmaceutical rebates sometimes went directly to providers, without the knowledge of the PA DOH. He asked if there was a control mechanism for how rebates were used. A. Edelstein said that the PA DOH would have to make this decision. He added that the amount of money available through rebates was not known to the RWPC. He explained that the conversation with the PA

DOH following their receipt of the CPC's letter would hopefully reveal more about how much money would be available to support health insurance premium/cost-sharing assistance, and from which sources.

A. Thompson said that clinics could open up 340B pharmacies. He stated that these pharmacies allowed the clinics to access rebates. He noted that money coming into Ryan White programs as a result of program service delivery had to be put back into the program. He explained that providers were already required to do this. He said that all clinics used these funds differently, but many Federally Qualified Health Centers (FQHCs) were able to continue operating due to 340B funds. He explained that the CPC's letter was intended to open basic communication with the PA DOH about what funds were available.

Motion: The Finance Committee moved that the RWPC approve the allocation for the 70% award of the Part A formula dollars and the 40% award of the MAI dollars according to the level funding plan that was adopted in last summer's allocations meetings. **Motion passed**: 14 in favor, 0 opposed, 1 abstained.

- **Reallocation Request**

A. Edelstein said that the Finance Committee had 2 action items that were initiated by the recipient. He stated that the reallocation request was for the current year, ending on February 28th. He said that it was unknown how much underspending there would be at the end of the year, and this wouldn't be clear until the spring or summer. He explained that invoices were sometimes delayed from large institutions. He said that the Planning Council needed to take action before the end of the year to approve a reallocation request.

A. Edelstein directed the group to the 7th paragraph of the recipient's reallocation request handout (*see-attached sheet*). He said that the recipient asked to reallocate underspent funds to services that directly benefit consumers, like medications, food, and transportation. He stated that the Finance Committee had voted to recommend that the RWPC approve the request.

Motion: The Finance Committee moved to approve the recipient's reallocation request. **Motion passed**: 13 in favor, 2 abstained, 0 opposed

Special Presentation:

- **Epidemiological Presentation** – *Kathleen Brady, AACO*

K. Brady began her presentation by reviewing the HIV care continuum. She noted that people with HIV ranged from not aware of their infection to fully engaged in HIV care. She reviewed CDC HIV Continuum Measures, which aligned with the national goals for 2020. She noted that information on the national goals was available on aids.gov.

K. Brady began reviewing prevalence rates of diagnosed HIV, according to CDC national data. She explained how prevalence was calculated. She said NJ had significant lag time of 1-2 years for lab reports. She displayed a bar graph with estimated numbers of people who were aware of their HIV infection. She stated that 87% of people with HIV were estimated to be aware of their HIV infection, so 13% were estimated to be unaware. She noted that this number was declining significantly. She stated that men were less likely to be aware of their HIV status than women. She explained that the estimates were made using information on when people were diagnosed the stage of their infection at diagnosis to estimate who was unaware.

K. Brady presented a graph of national estimated awareness of HIV status by age group. She stated that less than half of people from 13-24 were likely to be aware of their status, with significant increases by age.

K. Brady reviewed estimates of people unaware of their HIV status by select demographic groups in Philadelphia in 2014. She said that Philadelphia estimated a greater proportion of men than women who were unaware of their status. She said that Black people were also most unlikely to know their status compared to other races, and a relatively equal proportion of heterosexuals and MSM were unaware of their status, while injection drug users (IDU) had an estimated 0% unaware. She said the overall unaware rate in Philadelphia was estimated to be 7%.

G. Grannan asked if the numbers were based on test results. K. Brady stated that the estimates were based on statistical programming, using estimates of who had been diagnosed with HIV. G. Grannan asked if there was any way of knowing at what point in the infection people were getting their diagnosis. K. Brady stated that it was known when people had a previous negative HIV test result. She said that the likelihood of recent seroconversion could possibly be estimated based on this information. She added that new tests could detect acute HIV infections, meaning cases where clients had been exposed to HIV within the last few weeks. She stated that anyone with an acute HIV infection or a negative test within the last 6 months was classified as stage 0, which meant they were recently infected. She noted that the database didn't automatically record who was a stage 0, but this would change in the near future. She stated that the model estimated that there would be around 40 HIV infections this year, which was between 5-10% of new diagnoses.

M. Cappuccilli asked if urban areas or rural areas tended to have a higher percentage of people unaware of their status. K. Brady reported that the CDC said that people in metropolitan areas tended to have lower rates of people unaware of their status due to higher rates of testing.

K. Brady reviewed statistics on concurrent HIV/AIDS diagnoses. She noted that the purple line graph indicated the EMA total for concurrent diagnoses. She said that this number was decreasing, and now stood at 23.5%. She stated that the PA counties had the highest rates of concurrent HIV/AIDS diagnosis, with NJ second, and Philadelphia the lowest. She stated that the trends in NJ and Philadelphia were a decrease in concurrent infection, but this trend wasn't being seen in the PA counties.

K. Brady reviewed demographic data on concurrent HIV/AIDS infection for the NJ and PA suburban counties. She noted that, based on the numbers, people were getting diagnosed earlier and earlier. She added that local statistics were better than national numbers. She noted that in 2015, men and women were equally likely to have concurrent HIV/AIDS diagnosis. She noted that some demographic categories had very small samples. She stated that Black people were most likely to be concurrently diagnosed with HIV/AIDS, with White people second and Latinos third.

K. Brady noted that concurrent HIV/AIDS diagnoses increased with age. She suggested that the trend was a result of a failure to engage people in routine testing. She said that this trend had been consistent throughout the years.

K. Brady discussed linkage to care. She explained the way that indicators were calculated. She reviewed a bar graph of national rates of linkage to care. She noted that 74.5% of people diagnosed with HIV were linked to care within a month, with a small difference between women and men. She stated that the next bar graph broke out linkage to care rates by mode of HIV transmission. She pointed out that linkage was fairly consistent across risk groups. She moved forward to Philadelphia-specific indicators. She stated that Philadelphia still used 90-day linkage data, though the graph included data for linkage in 30 days as well. She stated that linkage to care in 2015 was at 91% in 90 days, and 81% within 30 days. She noted that both these numbers represented improvements. She stated that globally, there was a goal of 90-90-90: 90% diagnosed, 90% linked to care, and 90% virally suppressed. She said the indicator for this measure was 90 days.

K. Brady moved on to indicators on retention in care. She reviewed the numerator and denominator used to calculate the data. She also explained the numerator and denominator for viral suppression. She continued to a bar graph representing retention in care and viral suppression by sex on a national level. She stated that more women than men tended to be retained in care, but fewer were virally suppressed. She reported that 56.5% of people with an HIV diagnosis were retained in care and 54.7% were virally suppressed. N. Shein asked where the data was collected. K. Brady explained that it was gathered from 32 states and Washington, D.C., and more were being added on an ongoing basis. She said that PA was not included in the data, due to lack of mandatory CD4 and viral load reporting at a state level.

K. Brady said that the next graph broke down retention in care and viral suppression by method of transmission, which was highest among MSM who inject drugs and lowest among non-MSM people who inject drugs. She moved forward to Philadelphia-specific statistics. She said that, overall, rates of retention in care and viral suppression were increasing. She said that, in 2015, 93% of people estimated to have HIV in Philadelphia were diagnosed, 91% were linked to care, 49% were in care, and 52% were virally suppressed. She noted that the number of people who were virally suppressed was higher because some virally suppressed people did not visit the doctor as often, so they did not meet the retention measure. A. Thompson noted that the public health retention measure only required 1 visit per year for virally suppressed people. K. Brady asserted that people who were retained and not virally suppressed probably needed intervention as well, but HRSA used only retention as an indicator of unmet need.

K. Brady stated that the charts on the next slide directly compared prevalence-based continuum numbers for the US and Philadelphia. N. Shein pointed out that Philadelphia's statistics were better than the national statistics. K. Brady pointed out that the national statistics were for 2013 and the Philadelphia statistics were for 2015.

K. Brady reviewed a graph of newly-diagnosed HIV cases, deaths, and living HIV cases by year in Philadelphia from 2008-2015. She said that fewer people were diagnosed with HIV and fewer people were dying in recent years. She noted that some people were healthy and moved in and out of Philadelphia.

K. Brady said the next slide gave the rates of adults and adolescents living with diagnosed HIV infection by area of residence by year end 2014. She pointed out geographic trends in HIV prevalence.

K. Brady showed a diagram of rate of PLWHA per 100,000 of population in the EMA. She said information was available at the county level but not by zip code.

K. Brady showed a diagram of numbers of PLWHA in Philadelphia by census tract.

K. Brady compared HIV prevalence in the US versus the Philadelphia EMA. She said the statistics broke down rates by location, race, gender, age, and mode of transmission. She noted that, in the Philadelphia EMA, there were 26,807 PLWH as of 12/2015. She stated that 57.9% of these people were Black, 15% were Latino, and 22.8% were White. She added that 70.9% were male. She continued that 48.8% were over or equal to 50, and 24.6% were 40-49. She noted that 35.5% were MSM, 21.3% were IDU, and 34.8% were heterosexual. She said that the majority of cases were among Black people, regardless of risk.

K. Brady compared these rates with HIV prevalence in the US. She stated that there were 955,081 PLWH in the US as of 12/2014. Out of these, 42.4% were Black, 20.8% Latino, and 31.4% White. She said that 75.6% were male. She continued that 44.9% were currently 50 or over, and 27.6% were 40-49. She continued that 53.3% were MSM, 13.7% were IDU, and 25.8% were heterosexual. She added that the highest rates of HIV were in the Northeast US.

K. Brady reviewed HIV prevalence rates by race and sex in Philadelphia. She stated that nearly 3% of Black men in Philadelphia were living with HIV, 2.3% of Hispanic males, 1.1% of Black women, 1.1% of White males, 0.9% of Hispanic females, and 0.2% of White women. She noted that the overall prevalence in Philadelphia was 1.3%, and over 1% represented generalized epidemic level. She stated that everyone in areas with a generalized HIV epidemic should be screened for HIV.

K. Brady reviewed the proportion of residents diagnosed and living with HIV by race/ethnicity and sex in 2015, broken down for Philadelphia and the suburban counties. She noted that there were large disparities in prevalence between urban and suburban counties.

K. Brady reviewed HIV prevalence per 100,000 people by race and transmission group in Philadelphia. She stated that the highest rates were among Black individuals (regardless of risk category). She said almost 30% of Black MSM and 17% of White MSM were infected and diagnosed in Philadelphia.

K. Brady reviewed a graph of HIV diagnoses. She continued to a map of new diagnoses in the US. She stated that PA and NJ were considered relatively high morbidity areas. She also reviewed maps of HIV diagnoses by census tract in Philadelphia and by county in the EMA. She pointed out the areas of Philadelphia that had high and low diagnosis rates. She stated that the next slide had data from 2014 and had not been updated.

K. Brady gave the 2015 data for Philadelphia of people who were newly diagnosed with HIV by age at diagnosis. N. Johns asked if the percentage of newly-diagnosed people by age had changed over the years. She noted that a majority of new diagnoses occurred among 20-29 year olds. She said that many newly diagnosed people were 20-24 or 17-19. She stated that the numbers of diagnoses in 40-49 year olds were decreasing, and the new diagnoses among 30-39 year olds were slightly increasing.

K. Brady pointed out that a majority of diagnoses occurred among African Americans in Philadelphia. She said that the numbers of new diagnoses among White people and Latinos were similar in Philadelphia, but there was a much higher percentage of Latinos in Philadelphia (meaning the rates of HIV in that population were higher).

K. Brady reviewed a chart of newly diagnosed HIV by mode of transmission. She stated that the rates of new HIV diagnoses among MSM were relatively stable, though they were falling for other modes of transmission. She noted that there was crossover in heterosexual and IDU populations. N. Shein pointed out that the differences in rates could be related to percentage of people with HIV in different populations. N. Johns asked if there were differences in testing rates among different risk groups. She asked if MSM or youth were more likely to be tested. K. Brady stated that she believed there were high rates of testing in these populations. She pointed out that most new diagnoses were among young Black MSM.

K. Brady moved onto charts of new HIV diagnoses in the Philadelphia EMA broken down by race, age, and mode of transmission. She stated that the highest proportion of HIV among MSM was in Philadelphia. A. Edelstein noted that many people in the PA counties were not diagnosed until they became symptomatic.

K. Brady moved on to incidence. She reviewed the data sources for the information, which estimated the recentness of HIV infection. She said that estimates of incidence were developed based on this information. She said that based on those estimates, 299 new HIV infections occurred in 2014 in adults and adolescents, which represented a significant reduction since 2012. She noted that HIV incidence trends by demographics were decreasing substantially since about 2011.

K. Brady reviewed estimated incidence by risk populations. She said about 0.6% of MSM were diagnosed HIV positive in 2014, which was much lower than prior years. She noted that the CDC incidence program was only in effect for 2 more years.

K. Brady reviewed data on special populations. She stated that the data included included annual retention, annual viral suppression, and durable viral suppression for Ryan White and non-Ryan White clients. She stated that the statistics included people who were alive in 2010, Philadelphia residents, and people who lived in Philadelphia in 2010-2014. She stated that annual retention in care was measured from 2011-2014, viral suppression was based on the end of each year, and durable viral suppression continued over a period of time. She noted that there were major differences in the indicators. She stated that people in the Ryan White system were more likely to achieve retention and durable viral suppression than those who weren't. A. Thompson asked for more information on the retention measures. He asked if there was a stable retention rate, or it declined over time. K. Brady replied that retention in care over time was not tracked, but could be measured.

K. Brady reviewed a graph of care continuum numbers for special populations including MSM of color, African American men, youth 13-24, African American women, and transgender people. She stated that the bar graphs compared the continuum data points for special populations, and also included statistics for all PLWHA for comparison. She noted that, for MSM of color and African American men in particular, there was a big drop-off from people linked to care to people retained in care. She noted that many youth were not diagnosed. She stated that, among African American women, there was a trend similar to all PLWHA – there was a drop-off between prescribed ART and virally suppressed, the same trend that could be seen for transgender individuals, which may indicate issues with adhering to ART. N. Shein pointed out that many transgender people regularly engaged with medical care.

K. Brady stated that a provider meeting had been held last week about HIV/Hepatitis C co-infection. She noted that a Special Projects of National Significance (SPNS) grant had been received to study HIV/Hepatitis C coinfection. She stated that 18.6% of PLWH in the EMA and 17.5% in Philadelphia were HCV coinfected. She stated that HCV testing rates were high among people with HIV. She stated that the percentage of PLWH with Hepatitis C was highest among Black people. She added that there was not much difference between coinfection rates between men and women. She noted that many people who were coinfected were over 50. She said that a large percentage of PLWH who were coinfected also injected drugs at some point in their lives. She noted that the estimated Hepatitis C prevalence among PLWH was highest among Hispanic and multiracial people compared to other races, slightly higher for men than women, and also highest among PWID. She noted that baby boomers had the higher rates of coinfection.

G. Grannan asked if there was any data on rates of Hepatitis C coinfection among transgender people. K. Brady stated that there was some data for coinfection among transgender people, though sample sizes were small. She said that this year's surveillance report had a table for PLWHA by their current gender. She stated that a position statement was being prepared to recommend data collection standards for transgender people nationally. She stated that coinfection rates required coordination with Hepatitis C surveillance data. She noted that this data was not complete, and was matched on name and dates of birth. She said that Social Security numbers and birthdates were often not available.

A. Thompson suggested looking at retention rates as a measure of success. He asked if data was available for disparities between different risk groups. K. Brady said she'd ask for this information. A. Thompson stated that AACO staff had a disparity calculator, and asked if the data had been plugged into it. K. Brady stated that disparities were looked at on a varying basis, about once a year. A. Thompson said that disparities were sometimes larger than they appeared.

Action Item:

- **Health Insurance Premium/Cost-Sharing Assistance (HIPCSA) Letter**

K. Baron stated that the group would be reviewing a draft of a letter by A. Thompson to the state regarding HIPCSA. A. Thompson said he'd accepted comments on the letter. He noted that the CPC had discussed what the RWPC could do with the allocation for HIPCSA. He reiterated that the $160,000 allocation was not enough to support a full HIPCSA program. He noted that there were no other regions in the US that funded HIPCSA at an EMA or city level. He stated that HRSA representatives had confirmed this. He stated that PA was one of the only states that didn't have a statewide HIPCSA program. He said the committee had discussed different potential ways of using the funding allocated for HIPCSA. He noted that they'd decided it was necessary to communicate with the PA DOH about the pharmaceutical rebate dollars and other funding sources that could be used to support the program. He said that some other regions in PA were providing HIPCSA on a small scale through their Part B contracts. He stated that these small models couldn't be replicated on the large scale necessary to provide the service in the Philadelphia EMA.

A. Thompson noted that the current structure of the PA HPG made it difficult to communicate with them about implementing a HIPCSA program. He stated that Part A representation in the state HPG was small. He said that the CPC had decided to write a letter to the PA DOH about the Philadelphia EMA's desire to start a HIPCSA program, noting that most regions of the US had these programs, and identifying a disparity compared to NJ, which was implementing HIPCSA. He stated that the letter was intended to begin a communication process with the PA DOH. He asked the Planning Council to review the letter, which would then be returned to the CPC for a vote.

A. Edelstein stated that the RWPC could make a motion to submit the letter. He said that the Planning Council co-chairs could be signatories to the letter. A. Thompson explained that he'd like to give Planning Council members more time to make comments before submitting the letter to the PA DOH. He asked who the letter would be addressed to. He noted that the PA HPG did not have clearly identified leadership. A. Edelstein noted that there was a governmental agency responsible for administering Part B, and B. Morgan stated that a new division director had been appointed. A. Thompson said he was accepting input on who to address and copy the letter to. M. Cappuccilli asked how to submit edits. A. Thompson said he'd create a document and send out a copy tomorrow to solicit feedback. He asked for comments to be submitted by next Thursday. K. Baron said the letter would be put to a vote in March. J. Hayes said she'd forward the draft letter to the entire Planning Council.

Finance Committee – *A. Edelstein, Co-Chair*
No report.

Needs Assessment – *G. Keys, Co-Chair*
G. Keys stated that the Needs Assessment Committee had met with the CPC last month. She added that the CPC would meet next week.

Comprehensive Planning Committee – *A. Thompson, Co-Chair*
No report.

Positive Committee – *K. Carter, Co-Chair*
D. Gana said the Positive Committee would be meeting next Monday.

Nominations Committee – *M. Cappuccilli, Co-Chair*
M. Cappuccilli stated that the committee had not met today because only a small amount of people were able to attend. He asked RWPC members who were available to stay and help with application review. Volunteers for the task raised their hands. He thanked N. Johns for helping the group recruit new

members. He stated that the group was awaiting tax certification forms from current members of the RWPC.

Old Business: None.

New Business: None.

Announcements: M. Coleman stated that February was Heart Awareness Month. D. Gana announced that, on February 25th, the LGBT Elder Initiative (LGBTEI) was hosting a program at St. Luke's Church on 13th Street. He said that registration was available online for the event, which ran from 11-2pm. He added that the South Philly Co-Op was having a happy hour tonight. He asked anyone interested to speak with him after the meeting.

Adjournment: **Motion**: L. Way made, G. Keys seconded a motion to adjourn the meeting at 4:00p.m. **Motion passed**: All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- January 12, 2017 Meeting Minutes
- Recipient Third Quarter Report on Underspending, Reallocation Request, & Notice of Grant Award
- Philadelphia EMA 2017-2018 Allocations Spreadsheets
- CPC Letter to the State (Not scanned)
- OHP Calendar