Comprehensive Planning Committee/Prevention Committee
Meeting Minutes of
Thursday, September 27th, 2023
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, Gerry Keys, Gus Grannan (Co-chair), Lorett Matus, DJ Jack, Clint Steib (Co-chair), Desiree Surplus (Co-chair), AJ Scruggs, Erica Rand, Pamela Gorman

Excused: Debra D'Alessandro (Co-chair)

Guest: Laura Silverman, Emily McNamara, Blake Rowley, William Peterson

Staff: Tiffany Dominique, Debbie Law, Sofia Moletteri, Mari Ross-Russell, Kevin Trinh

Call to Order: C. Steib called the meeting to order at 2:35 p.m.

Introductions: C. Steib asked everyone to introduce themselves.

Approval of Agenda:
C. Steib referred to the September 2023 Comprehensive Planning Committee/Prevention Committee agenda and asked for a motion to approve. **Motion:** G. Keys motioned; K. Carter seconded to approve the September 2023 Comprehensive Planning Committee/Prevention Committee agenda via a Zoom poll **Motion passed:** 6 in favor, 1 abstaining. The September 2023 Comprehensive Planning Committee/Prevention Committee agenda was approved.

Approval of Minutes (*June 28th, 2023 and August 17, 2023*):
C. Steib referred to the August 2023 Comprehensive Planning Committee and June 2023 Prevention Committee minutes. **Motion:** K. Carter motioned; P. Gorman seconded to approve the August 2023 Comprehensive Planning and the June Prevention Committee meeting minutes via a Zoom poll. **Motion passed:** 7 in favor, 3 abstaining. The August 2023 Comprehensive Planning and June 2023 Prevention Committee Minutes were approved.

Report of Co-chairs:
C. Steib, the co-chair of the Prevention Committee, welcomed D. Surplus as the new co-chair of the Prevention Committee and announced he was looking for someone to take his place as co-chair.

Report of Staff:
M. Ross-Russell notified the committee members that the Department of HIV Health (DHH) would be holding a presentation on the progress of the implementation of the Integrated Plan. She also reminded the committee of the HIPC's responsibility to review the service standards.

The service standards encompass both the service definitions and the requirements each provider needed to fulfill if they wanted to be funded by DHH. The role of the HIV Integrated Planning Council (HIPC), in cooperation with DHH, was to provide input on how the standards were implemented into services. The Health Resources and Services Administration (HRSA) and the Centers for Disease Control (CDC) created these service definitions. She mentioned that they would need to decide whether they required a workgroup. The decision about whether a workgroup was necessary would be made at the November HIPC meeting. The meeting would also determine whether the workgroup would be overseen by HIPC or if the responsibility could be taken on by the CPC.

G. Grannan asked if the federal agencies had their standards posted online for public review. M. Ross-Russell confirmed that the Monitoring Standards, the Ryan White Part A Manual, and the 2023 Allocations Service Categories Booklet were available online. M. Ross-Russell anticipated that they would have a site visit next April. E. Rand asked about the intent of the workgroup. M. Ross-Russell replied that the workgroup's purpose was to collaborate with the recipient, DHH, to provide input and finalize the standards. E. Rand asked if this applied to prevention services or all standards of care. M. Ross-Russell answered that it only applied to Ryan White Part A services. K. Carter asked if there were changes to the service categories. K. Carter asked if they were reviewing the standards to ensure they were using person-centered language. M. Ross-Russell recalled that they reviewed the roles and responsibilities of the client and provider, including expectations for how providers and clients should treat each other during medical visits. These were not always included in the service definitions provided by HRSA. The level of additional detail for each service category could be determined by HIPC members and the recipient. M. Ross-Russell stated that the language had already been decided based on factors such as federal requirements, federal definitions, and HRSA expectations regarding how the service needed to be delivered.

C. Steib inquired whether there were questions about the service categories on the Consumer Survey and asked if they could include them in the survey to help people outside the HIPC understand the services. M. Ross-Russell said they could do that. K. Carter asked if the service definitions had to be based on documented needs. M. Ross-Russell said they did not. She explained that service definitions generally represented their expectations for the providers. K. Carter noted that this was similar to business standard operating procedures. M. Ross-Russell agreed with K. Carter's understanding.

M. Ross-Russell anticipated that the recipient would have a presentation at the November HIPC meeting about the service standards and expectations. From there, HIPC would decide whether CPC would oversee the workgroup to examine the service definitions and when this process would begin. K. Carter asked how they had handled this issue in the past. M. Ross-Russell believed it was standard procedure to allow the CPC or a needs assessment committee to oversee the workgroup.

Presentation:
–National HIV and Aging Survey–

S. Moletteri and K. Carter would jointly be giving a presentation on the State of Aging with HIV National Survey from HealthHIV. S. Moletteri stated that she would be sharing facts and information while K. Carter provided his expertise on the topic. S. Moletteri said all findings or conclusions, unless stated otherwise, would be the findings of HealthHIV.

HealthHIV is a national nonprofit that works with organizations, communities, and providers. The purpose of HealthHIV is to advance HIV care, STI care, Hepatitis C care, queer health, and harm reduction through capacity building, training, and advocacy. The survey is part of HIVHealth's 'state of' series of surveys. The State of Aging with HIV is in its 3rd iteration. The first Aging with HIV survey was conducted in 2019, the second iteration was postponed to 2021 due to COVID-19, and the third iteration was completed in 2022. The survey contains 151 open and closed questions. The survey was distributed between late October 2022 and January 2023. S. Moletteri said their survey recruitment was performed online through their Constituent Relationship Management (CRM). 673 eligible respondents answered the survey. The survey demographics captured people living with HIV who were 50 years or older and people who were living with HIV for 15 years or more. S. Moletteri noted that there was significant overlap in the two populations. K. Carter was displeased that the methodology for the survey was difficult to find. He wanted to know more about how survey participants were recruited.

S. Moletteri explained that the demographics of survey participants were majority White, gay-identifying cisgender men. 66% of this demographic had at least one post-secondary degree. 62% of the survey participants were White. 27% of participants were Black. 14% identified themselves as Hispanic/Latinx. 7% of participants reported being multiracial. K. Carter expressed disappointment that the survey did not recruit more non-White participants, feeling that this skewed the results. He emphasized that each population had its own unique challenges, and the survey needed representation from every population to provide an accurate picture of the demographics.

The survey found that people living with HIV for more than 15 years were more established with income and education. S. Moletteri shared the income distribution of the participants. Over 25% of the participants made over $65,000. Nearly 50% of participants made less than $32,000, and nearly 25% made less than $17,000. More than 54% of participants did not have a retirement plan. S. Moletteri concluded that the general theme represented in the data was that people aging with HIV were generally worried about retirement and long-term care.

Survey participants were asked to describe their experience of aging with HIV in one word. Most participants answered 'challenging', followed by 'difficult' and 'complicated.' These words were gathered in a word cloud. S. Moletteri noted words such as 'manageable,' 'hopeful,' and 'grateful.' She concluded that the word cloud indicated participants may have difficulty navigating care. Inspired by the national survey, S. Moletteri noted that T. Dominique had created a cloud regarding barriers to care within the HIPC's 2022 Consumer Survey. The most frequent word in relation to barriers to care was 'transportation.' S. Moletteri said using word clouds or other ways to display qualitative data could inform their future work. T. Dominique clarified that the responses were taken from all respondents of the Consumer Survey, not just those who were 50 years or older.

Returning to the national survey from HealthHIV, S. Moletteri reported that the survey had 4 key findings. The first was multimorbidity and polypharmacy as near-universal issues. Two in three respondents reported at least two comorbidities, and three in four reported taking at least two daily medications. Mental illness was another issue and was on the rise. 64% of respondents reported mental health concerns, compared to less than 40% of respondents the previous year. Minimal retirement savings was the third issue. Half of the respondents had no financial retirement plan, and 4 in 5 respondents had not saved enough for long-term care or supportive home care. The survey found that many respondents shared a strong sentiment that older adults with HIV (OPWH) were often forgotten and left out of the conversation around HIV care. K. Carter reminded the committee that they had many resources to help OPWH. He stressed that they should promote the usage of these tools and resources in preventative care to better manage comorbidities. He also stressed the importance of helping young adults plan ahead financially for their future, particularly regarding long-term care insurance.

T. Dominique asked if the survey had examined the impact of respondents aged 50 or older who were diagnosed early in their life. K. Carter said he believed that most respondents were diagnosed at a late stage while they were 50 years or older. S. Moletteri noted that the survey may not have covered this topic, but she offered to make a note of it and explore more information in the survey. K. Carter emphasized that adults were not getting tested enough, and the CDC's recommendations for older adults were insufficient, as older adults were still sexually active. S. Moletteri provided data in the next slide to support K. Carter's assertions. The survey found that 53% of respondents were sexually active in the last year. Respondents felt that there was a general assumption that older adults were asexual, which contributed to late-stage HIV diagnoses and a general lack of prevention services.

S. Moletteri read that 62% of respondents reported living with at least two comorbidities. She noted that comorbidities were less common for older adults with private health insurance. The survey asked respondents how they would rate their health compared to those who weren't living with HIV. 36.1% of respondents stated they felt good. The survey asked respondents how they would rate their physical health, with 50.2% of respondents rating their physical health as 'good.' Respondents were also asked about their level of frailty. 28% of respondents reported frailty, and 12.7% said they needed assistance with activities of daily living. S. Moletteri read that Comprehensive Geriatric Assessments (CGA) and Frailty Index (FI) screenings were recommended for People With HIV starting at 50 years old, but few providers have incorporated this into their standard practice. K. Carter reminded the committee that preventative healthcare was crucial, as many comorbidities compounded with age and added complexity to the healthcare system.

The survey recorded information about mental health and social support. 63.6% of respondents reported having a mental health condition, including depression and anxiety. 80% of respondents reported experiencing 'a lot of stress' or 'moderate stress' within the last six months. Depression was one of the strongest indicators of poor antiretroviral therapy (ART) adherence. Older adults were less likely to seek mental healthcare.

The next slide presented a list of comorbidities and their frequencies within the population of respondents. S. Moletteri reminded the committee that they could review the presentation at their leisure after downloading it from the Office of HIV Planning website. K. Carter stressed that as adults age, the number of issues adds up, making it crucial for older adults to find new providers who can support them effectively. Many older respondents reported a lack of social support, despite 66% reporting participation in community groups. 39% of respondents stated that they did not have anyone who could take care of them when they were sick or in case of an emergency. Respondents expressed a need for a stronger connection to the community to prevent social isolation, as many feared that illness would lead to isolation. Others noticed their peers' tendency to stay at home in isolation rather than coexisting with others.

S. Moletteri then presented the committees with their own data on Comorbidities and Mental Health. She said the information was obtained from the Consumer Survey of respondents aged 50 or older. Like the HealthHIV survey, depression was one of the chief mental health issues that older adults faced. S. Moletteri moved to the next slide, which compared substance use between older adults with HIV and older adults without HIV. The data showed that older adults with HIV had a tendency to use substances more often, with more than a quarter of respondents reporting being in recovery from substance abuse. G. Grannan asked S. Moletteri if there was a definition for recovery in the data. S. Moletteri clarified that there was no specific definition provided. K. Carter acknowledged that they didn't have access to the questions for the HealthHIV survey and agreed to look into this issue. S. Moletteri suggested addressing this question in their next survey and asked how they would handle it in their next Consumer Survey. G. Grannan provided a broad definition of recovery, emphasizing it as any positive change as deemed by the individual, rather than enforcing abstinence and 12-step programs.

S. Moletteri reviewed the slide on Housing and Long-term care, revealing that 81% of respondents reported not having enough savings for assisted living. K. Carter noted the contrast between the United States and other countries, where older adults are often taken care of and placed at the center of the family. He mentioned that increasing taxes make it difficult for older adults to stay in the same location, and G. Grannan inquired about tax freezes for older adults. K. Carter explained that his parents still had to pay property and school taxes, and renting caused even more stress since rent increases can necessitate frequent moves. S. Moletteri continued with the report on the HealthHIV survey, stating that 37% of respondents engaged in exercise. 19% of respondents reported limitations in their ability to perform physical activity. She then noted that 23% of respondents had difficulty paying for food in the last six months, which was reflected in their Consumer Survey where the cost of food had been reported to have increased. 20% of respondents were concerned about having enough to eat or where their next meal would come from, with 20% regularly working with a nutritionist or dietitian or planning to see one. Additionally, 1.6% of respondents reported facing transphobia, and another 1.6% of respondents reported facing racism.

S. Moletteri continued with the survey data on coordinated care. Survey respondents were asked whether their providers coordinated or communicated with each other about their care and prevention needs. 66% of respondents reported that their providers did not do this. Discrimination was identified as a barrier to care, with 36% of respondents reporting that they

experienced stigma within care settings. 20% of respondents stated they experienced ageism, which could best be described as “feeling forgotten” or left behind in care settings. She mentioned that 8% of respondents also reported facing sexism, 1.8% experienced racism, and 1.8% experienced transphobia.

K. Carter stressed the importance of pharmacists in the care continuum due to their knowledge of medication interactions. S. Moletteri moved on to the final portion of her report. She reminded the committees that the conclusions were not her own but were the conclusions of HealthHIV. The first conclusion was the need to build a competent workforce of HIV gerontologists to address the multifaceted issues confronting people living with HIV (PLWH) as they grew older. The second conclusion was the need for efficient coordination of care between healthcare providers to ensure that OPWH received the comprehensive support they needed. The third conclusion was the need to address the social determinants of health to improve health outcomes, as health extends beyond clinical settings. The last conclusion was to ensure access to safe and stable housing as needed, as fixed incomes and housing emergencies escalate for OPWH. 94% of respondents agreed, emphasizing the need for more community representation on boards that develop treatment guidelines.

–Prevention Committee Workplan–

T. Dominique would be hosting the next presentation where they would be brainstorming for the Prevention Planning Year. She reminded the committee that DHH would be presenting at the next HIPC meeting on the Diagnose and Prevent pillars of the Integrated Plan. She said they would be speaking about these two pillars in this presentation. She reminded the committees that the Integrated Plan was a living document and items were subject to change. T. Dominique asked the committees to ponder questions they would like to ask DHH in the upcoming meeting as well as the gaps in service that they could have DHH consider. She had wanted the committees to remember the prevention concerns that they had thought of at the beginning of the year and see if the Integrated Plan addresses any of these concerns.

The first goal was to diagnose 95% of persons living with HIV by 2026. The first objective for this goal was to promote routine opt-out HIV screenings and diagnostic testing in at least 50 healthcare and other institutional settings. The first strategy to accomplish this goal was to expand opt-out testing in the Philadelphia Department of Public Health DHH emergency departments. The second strategy was to continue opt-out testing in the Philadelphia Department of Prisons. The third strategy was to increase efforts to educate medical providers about conducting opt-out HIV testing. The fourth strategy was to educate clinical providers on bio-social HIV clinical settings where opt-out testing was not achievable. The fifth strategy was to promote opt-out HIV testing for all Philadelphia Department of Public Health DHH-funded providers. The prevention concern the Prevention Committee had brainstormed from a previous meeting was meeting marginalized members of the community where they access services.

The second objective of goal 1 was to maintain HIV testing services in non-clinical settings using rapid point-of-care testing or 4th generation laboratory testing. The first key strategy to achieve this objective was to increase a status-neutral approach in priority populations. The second key strategy was to support HIV self-testing through a telehealth program. The third key

strategy was to build capacity for non-clinical HIV testing. Regarding this topic, the Prevention Committee had concerns that consumers were unable to navigate through healthcare systems and follow up on prevention services.

Objective 3 of goal 1 was to implement Novel HIV testing initiatives. The first key strategy was to implement routine opt-out testing at intake to substance use Tx facilities. The second key strategy to achieve this goal was to promote testing in primary care facilities. The third key strategy in this objective was to implement testing in pharmacies in priority zip codes. The last key strategy in this objective was to support capacity building in novel settings. T. Dominique said she did not find a response from the Prevention Concerns Survey that lined up with this objective.

T. Dominique then moved to the Prevention goals. The first goal was to use biomedical interventions to reduce new HIV diagnoses by 75%. The first objective for this goal was to have 50% of people with a PrEP indication be prescribed PrEP. The first strategy was to expand the current network of low-threshold sexual wellness clinics to provide HIV, STI, and HCV testing, PrEP, PEP, and linkage to HIV, STI, and HCV treatment in Philadelphia. The second strategy was to expand PrEP access and provider capacity through low-threshold implementation models such as same-day PrEP, telePrEP, nurse-extended PrEP, pharmacy-administered PrEP, and PrEP in drug treatment centers and behavioral health programs. The third key strategy was to pursue new PrEP partnerships with the PA and NJ Department of Health. The fourth key strategy was to expand financial support for PrEP-related routine laboratory work through provider and home-collected specimens and adherence services. T. Dominique said one of the concerns from the Prevention Concerns Survey that was related to this topic was that members wanted to offer injectable PrEP immediately and offer incentives for return visits. Respondents to the Prevention Concerns Survey wanted to provide sex education in schools. The fifth strategy was to continue to provide ongoing technical assistance for the implementation of PrEP. The sixth key strategy was to expand DHH's capacity to evaluate PrEP uptake. The seventh key strategy was to increase knowledge of PrEP among the most impacted populations through communication and outreach. The eighth key strategy was to increase the number of providers trained to prescribe PrEP. Provider training to improve PrEP uptake was one of the concerns that respondents on the Prevention Concerns Survey had said was important to them. They also wanted to grant greater access to PrEP and PrEP uptake. The ninth key strategy was to develop collaborations with providers to expand PrEP screening to people who inject drugs. The tenth key strategy was to support research by expanding PrEP access and uptake among underserved populations. The eleventh key strategy was to collaborate with the PA Department of Health to support the PrEP Initiative. The twelve key strategy was to increase uptake of ART as a method of prevention.

The second Prevent objective of goal 1 was to ensure access to nonoccupational post-exposure prophylaxis (nPEP or PEP). To accomplish this objective, the Integrated Plan sought to establish a centralized mechanism to distribute PEP through a PEP Center of Excellence. The second key strategy was to establish a new PEP partnership with the PA and New Jersey Department of Health. The third key strategy was to develop an initiative to address gaps in the provision of PEP, including capacity, education, and resources. T. Dominique said this part of the Integrated

Plan had addressed concerns in the Prevention Concerns Survey regarding primary care physicians (PCP) either being hesitant or refusing to prescribe PrEP.

T. Dominique then reviewed the third Prevent objective of goal 1. The objective was to support perinatal HIV prevention services for pregnant individuals. The first key strategy was to provide specialized case management for pregnant persons living with HIV. The second key strategy for this objective was to develop PrEP navigation support for pregnant HIV-negative women at risk of HIV acquisition. The third key strategy aimed to conduct case surveillance for women diagnosed with HIV and their infants. The fourth strategy was to conduct perinatal HIV exposure reporting.

The second goal of the Prevent pillar was to increase the number of access points for evidence-based harm reduction services. The objective was to expand access to harm reduction supplies through novel approaches. The first key strategy was to implement harm reduction vending machine intervention at pilot sites. The second key strategy was to ensure the availability of syringes at pharmacies by maintaining the PA Department of Health standing order. The third key strategy for this objective was to provide organizational development and capacity building to expand local partnerships and establish new organizations providing Syrine Service Programs (SSP) services and new locations of service based on need and HIV public health data. The Prevention Concern Survey response that closely aligned with this topic was providing stable housing, low barrier services, transportation and providers who were not stigmatized views against people who used drugs.

K. Carter asked if they could provide PrEP for women who were pregnant and how they could support those women. B. Rowley replied that doctors would prescribe PrEP to pregnant women. He said they should make a distinction between the types of PrEP because each drug type had a different effect. T. Dominique thanked B. Rowley for his answer. She then challenged the committee members to create questions on the same level as K. Carter's questions for the meeting with DHH.

T. Dominique continued onto the second objective of the second Prevent goal. The objective was to expand access to syringe service programs. To achieve this goal, one of the key strategies was to enhance linkage to substance use disorder treatment in SSPs. The goal was to implement improvement plans as needed. It would provide more equitable SSP services geographically in Philadelphia and advocate for the implementation of SSPs in the counties in the jurisdiction out of Philadelphia and in New Jersey counties in the EMA. T. Dominique noted that respondents to the Prevention Concerns Survey were concerned that there would be much political opposition to increased harm reduction promotion and use. T. Dominique said they must be mindful of where they could promote public health while recognizing the limitations they had as HIPC members. Respondents were also concerned about the stigma surrounding interventions around drug use and sex work.

K. Carter asked the committee if there were safe consumption sites in Camden, New Jersey. G. Grannan said there were two safe consumption sites within NYC that he had been to, though he was unsure of the exact locations because he was unfamiliar with New York. He stated he had

heard people wanted a safe consumption location built near the airport. G. Grannan believed such a location would only benefit the pilots at the airport. He said people working in social services needed to react less incredulously to political actors. K. Carter wondered when policymakers would understand that preventative care would save the city funding that otherwise would be spent on the death of someone. G. Grannan said that such cost-saving economics held little sway in the current political climate. T. Dominique said G. Grannan's remark about the airport safe consumption location being only useful for airplane pilots could be phrased as a question he could ask DHH for more information about in the upcoming meeting. T. Dominique remembered that the vending machine providing Narcan was still a pilot program and said that they could ask questions about the vending machine's impact on the community. K. Carter asked where the vending machine was. T. Dominique said she only knew the location of the vending machine that was outside Lucien Blackwell Library. T. Dominique said there should be more than one vending machine but the machine was near the library and was the only one where she witnessed it in person. T. Dominique said there was a lack of overdose prevention centers and places where syringe exchange can occur so the homeless would not need to share needles. She said they needed to think of how their prevention year would be shaped.

The third goal under the Prevent Pillar was to reduce disparities in HIV-related prevention services in priority populations. The key strategies to achieve the objective were to continue reporting data by demographics and risk groups in the DHH Surveillance Report and to maintain a bi-annual update of the End the HIV Epidemic (EHE) dashboard which included HIV care metrics by demographics and risk groups. The key strategy also included measuring the men who had sex with men (MSM) and trans individuals who had sex with men perspectives on HIV testing and PrEP access to monitor disparities in access to testing/PrEP among these groups. The key strategies would attempt to address the concerns from the Prevention Concerns Survey. One of the responses from the survey was that trans men were not generally brought to the table to talk about their own, personal concerns and risk factors. Another response from the survey was there was a bias regarding how trans men/ trans masculine persons engage with partners sexually. Respondents also said there was very little information regarding drug use, homelessness, and other things that people living with HIV experience. T. Dominique said she had included the responses from the survey to spur ideas for the upcoming DHH meeting.

The second objective of the third Prevent goal was centered around increasing and supporting health promotion activities for HIV prevention in communities where HIV was most heavily concentrated. The key strategies would be to continue the distribution of condoms in the jurisdiction and to support media campaigns that advance HIV prevention and health promotion behaviors. The Integrated Plan would also encourage the provision of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, people with intellectual disabilities, and people experiencing homelessness. T. Dominique said this part of the plan had reminded her of the concerns from the survey that they had missed messaging and prevention campaigns targeting people who were assigned female at birth. T. Dominique noted that survey respondents were also concerned about the lack of health literacy in sexual and reproductive health aid in prevention. The lack of sexual education has shown a spike in STI and HIV rates nationally. The survey respondents were also concerned about the lack of awareness of prevention services in Philadelphia.

T. Dominique concluded her presentation and asked if there were any questions. K. Carter asked about the teen pregnancy rate in Philadelphia. T. Dominique said she did not know the exact number and she said she would give K. Carter the answer in the next meeting. K. Carter asked if they knew how many teens had access to PrEP. T. Dominique said C. Steib and D. Jack likely had some anecdotal information from their clinic to answer that question. She said B. Rowley and pharmaceutical companies may also have the answer. However, she personally did not know the answer to K. Carter's question. T. Dominique said she could save this question so she could research the answer later. K. Carter said they should target school districts in their health promotion campaigns because teens were sexually active and he wanted to protect them from HIV transmission. T. Dominique said there were health resource centers that had helped youth with pregnancy issues, but she was unsure whether or not they provided information on PrEP. K. Carter said there was much discussion about how to prevent someone from becoming pregnant but there was not much discussion about how to prevent young men from contracting HIV. A. Scruggs said they needed to bring sexual health education to schools because schools did not have this program anymore. He said they needed to streamline the program and make it accessible for the youth in Philadelphia. C. Steib asked if the presentation would be on the Office of HIV Planning website. T. Dominique said she could ask S. Moletteri to upload the presentation to the website.

Discussion Item:
-Allocations Parking Lot-
The committee decided to table the topic until the next meeting

Other Business:
T. Dominique recalled that they were discussing moving towards hybrid meetings in the previous HIPC meeting.

T. Dominique said the Prevention Committee did not have meetings in November and December due to the holiday schedule. She asked the committees if they would like to continue this tradition or if were they willing to have a combined meeting with the Comprehensive Planning Committee (CPC). T. Dominique asked the co-chairs of the Prevention Committee and the CPC for their input on the issue. C. Steib said they had still the month of October to discuss and confirm their decision. On a personal level, he said he favored combining both meetings. G. Grannan said he was in favor of combining the meetings and he was willing to discuss the topic during the month of October. G. Grannan asked if they were going to have a co-chair meeting before the aforementioned meetings. T. Dominique said the Prevention co-chair meetings generally happened on the first Friday of the month. She said she was willing to speak with all the co-chairs to find the best possible decision. D. Surplus and L. Matus were in favor of the plan.

Announcements:
K. Carter announced there would be an event on October 6th called Connecting the Dots. The event would be centered on HIV and mental health. He said he knew the event was being hosted by the University of Pennsylvania and he encouraged all the members to attend the event. S.

Surplus asked K. Carter to send her more information on the event. K. Carter announced Jefferson Hospital would also be launching their LGBTQ+ clinic that week or the next week.

C. Steib reminded the committee members that the AIDS Walk would take place on October 15th.

E. Rand said that there was a fundraising event hosted by the Mazzoni Center on October 6th from 7 p.m. to 10 p.m.

Adjournment:
C. Steib called for a motion to adjourn. **Motion:** K. Carter motioned, and E. Rand seconded to adjourn the Comprehensive Planning Committee/Prevention Committee meeting. **Motion passed:** Meeting adjourned at 4:33 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2023 Meeting Agenda
- June 2023 Prevention Committee Meeting Minutes
- August 2023 Comprehensive Planning Meeting Minutes