Meeting Agenda

HYBRID:
Wednesday, June 24th, 2026
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes (May 27th, 2026)
- Report of Co-Chairs
- Report of Staff
- Discussion Items
  - Future Projects for Prevention Committee
  - Directives and Allocations Prep
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Comprehensive Planning Committee/Prevention Committee is TBD.

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Comprehensive Planning Committee & Prevention Committee

HYBRID: Comprehensive Planning Committee/Prevention Committee
Meeting Minutes of
Wednesday, May 27th, 2026
2:30 p.m. - 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia, PA 19107

Present: K. Carter, D. D'Alessandro (co-chair), J. Ealy (co-chair), J. Haskins, A. Leger, P. Mukinay, J. Myahwegi, K. Williams

Excused: E. Harbaugh, N. Houston, D. Surplus (co-chair)

Guests: Ryan Prater (Feeding PA), Lauren Duff (Feeding PA), L. Silverman (DHH)

Staff: Elizabeth Fischer, Debbie Law, Sofia Moletteri, Kevin Trinh, Kristin Wilson

Call to Order/Introduction: J. Ealy called the meeting to order at 2:37 p.m.

Approval of Agenda:
J. Ealy referred to the May 2026 Comprehensive Planning Committee (CPC)/Prevention Committee agenda and asked for a motion to approve. **Motion**: D. D'Alessandro motioned; A. Leger seconded to approve the April 2026 Prevention Committee agenda. Members voted vocally in the room and through Zoom. **Motion passed:** All in favor. The May 2026 Prevention Committee agenda was approved.

Approval of Minutes (*April 16th* and *April 22nd, 2026*):
J. Ealy referred to the April 2026 CPC Meeting minutes. **Motion**: A. Leger motioned; P. Mukinay seconded to approve the April CPC meeting minutes. Members voted vocally in the room and through Zoom. **Motion Passed:** All in favor. The April 2026 CPC meeting minutes were approved.

J. Ealy referred to the April 2026 Prevention Meeting minutes. S. Moletteri called for an amendment on the minutes to correct the spelling of J. Myahwegi under "Present". **Motion**: J. Myahwegi motioned; J. Ealy seconded to approve the amended April Prevention meeting minutes. Members voted vocally in the room and through Zoom. **Motion Passed:** All in favor. The amended April 2026 Prevention meeting minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
K. Trinh said there would be a combined CPC and Prevention meeting in June. S. Moletteri said the meetings were combined due to a demanding schedule for the vote on concurrence of the Integrated Plans for Philadelphia, Pennsylvania, and New Jersey. Furthermore, S. Moletteri said that HIPC may use the June 18th meeting date to complete other tasks.

J. Ealy congratulated E. Fischer and K. Wilson on joining the Office of HIV Planning (OHP) as staff members after completing their internships.

K. Trinh said the June CPC/Prevention Committee meeting would feature a presentation from Merck, which would showcase their new HIV treatment, IDVYNSO. J. Ealy asked if the Merck representative was following through with the presentation. K. Trinh said Merck was reviewing the decision for the presentation.

S. Moletteri said OHP tabled at the Aging and Thriving Symposium and successfully engaged people. OHP made connections with the Commission on Aging and looked into housing resources within the city and counties. S. Moletteri said OHP would be tabling at the HIV Education Summit, hosted by Philadelphia FIGHT on June 12th. The theme of the HIV Education Summit event would be mental health and wellness. S. Moletteri said the information would be sent out in the newsletter. K.Trinh said OHP would be tabling at the Temple Black Men's Wellness event on June 6th. D. D'Alessandro asked if OHP had previously tabled at Pride events, and if they would do so in June. S. Moletteri said we had tabled at Pride events in the past, and they were open to suggestions and opportunities to table in the future. D. D'Alessandro asked if they had funding allocated to pay vendor fees. S. Moletteri said there was not always a fee to table, but if there was a fee, OHP typically partnered with another organization to have a joint table.

J. Ealy asked for other staff updates. K. Trinh said the Orientation was on June 4th. D. Law added that the orientation would be in person on June 4th from 11 a.m. to 2 p.m. Lunch would be provided, and members were asked to reply to D.Law's email with their lunch choices. D. Law said the Finance Committee would meet following the orientation. She confirmed email reminders would be sent out the following week. D. Law welcomed co-chairs to be at orientation between 12:30 and 1:00 p.m. to introduce their committee and share their experience. D. D'Alessandro and J. Ealy said they would be at orientation for the last hour. S. Moletteri said the Finance Committee would review the Allocation and Budget for Minority AIDs Initiative (MAI) and Monitoring the Administrative Mechanism. S. Moletteri said this was an annual process for the council to ensure all the contracts have been completed promptly. The Planning Council reviewed whether the allocations and the directives created last year were followed. She said this would be a good introductory meeting for members to learn how the Finance Committee functioned.

Presentation Item:
~Feeding PA: SNAP Changes~
J. Ealy introduced the presenters, R. Prater and L. Duff. L. Duff was the Chief Public Affairs Officer with Feeding Pennsylvania. She worked on policy, communications, marketing, and development as well as the organization's statewide data project. R. Prater introduced himself as the Director of Public Policy at Feeding Pennsylvania. He oversaw the organization's state and federal advocacy, government relations, and contact with legislators in Harrisburg and D.C. R. Prater managed many programs, including tax credit programs that supported food banks and pantries, programs that worked with farmers to buy food from Pennsylvania farmers to give out at food banks, and most notably, the Supplemental Nutrition Assistance Program (SNAP).

L. Duff explained that Feeding PA helped food banks secure resources and operate more effectively. She described the Pennsylvania Agricultural Surplus System, which allowed food banks to purchase fresh produce from PA farmers. She explained that the program increased

access to fresh food for people experiencing food insecurity. They advocated for policies that get more food to more Pennsylvanians. They raised public awareness of food insecurity across the state.

L. Duff played a video that detailed the structure and mission of Feeding PA. The video highlighted how the organization supported the state's charitable food system by securing funding, sharing resources, raising public awareness, and advocating for policies to address the root causes of food insecurity.

The Feeding PA network consisted of 9 food banks and 2,750 food pantries (including school pantries, soup kitchens, etc). L. Duff said 1 in 8 Pennsylvanians experienced food insecurity, including 1 in 6 children. The rate had increased by 40% during the two years leading up to 2023. She explained that demand for food bank services had driven greater limitations to SNAP access. This increase ranged from 20% to 64%. L. Duff said for every 1 meal a food pantry provides, SNAP provides 9, highlighting the critical need for SNAP.

L. Duff said the Feeding PA network supplied 237 million pounds of food each year, served 800,000 households each month, and had 60,000 volunteers each year.

L. Duff explained that food insecurity affects communities by impacting their physical health, mental health, educational attainment, and society as a whole. She said in terms of physical health, food insecurity puts people at higher risk for a wide range of diseases and chronic conditions, including obesity, diabetes, and heart conditions. Food insecurity also impacted mental health through increased stress and was a major risk factor for childhood depression, anxiety, and behavioral and developmental conditions. In terms of educational attainment, L. Duff noted that students had a harder time learning while hungry or stressed about food. People with food insecurity would likely require more expensive medical interventions and these interventions taxed societal economic productivity. Furthermore, food insecurity had long-term effects, even after achieving food stability.

R. Prater gave background on SNAP (formerly food stamps), the nation's largest anti-hunger program. He explained that Feeding PA called themselves the Emergency Food Network, meaning they work hand-in-hand with SNAP. He said that for many, SNAP benefits do not adequately meet their needs. He said the average national benefit was $6 per day, but for the elderly population, the average was only $23 per month. He explained how people would receive their SNAP benefits at the beginning of the month, but as that funding runs out, they resort to using food pantries. This emphasized the need for SNAP, food pantries, and food banks. He continued that there were 1.7 million Pennsylvanians currently enrolled, compared to 2 million last April. He said nationally, there were 42 million people enrolled last year compared to 38 million currently enrolled. R. Prater explained that the decrease in enrollment was due to difficulty applying and keeping benefits, as well as the stigma of using public assistance programs.

D. D'Alessandro said it's a very founded fear for immigrants due to lookbacks on public assistance when assessing someone's citizenship application. R. Prater agreed that this was something they saw at food pantries, where people go to pick up food for individuals who don't

feel safe leaving their home. S. Moletteri asked if the presenters considered food pantries to be lower-barriered for food access. R. Prater said food pantries were considered the lowest barrier for food access, but there were still some government programs and food banks that required income, county, and household documentation. S. Moletteri asked if the food pantries serve individuals more than once per month. L. Duff explained that policies vary by pantry. Some offer only one distribution per month, while others generally limit service to once monthly, but may assist individuals who return within the same month. In those cases, individuals may receive a reduced benefit but were typically not turned away empty-handed. L. Duff said the average visit per month was about 1.36, showing most people were only coming when they needed to. J. Myahwegi asked how Feeding America analyzed the gaps between food access and food excess to reduce waste. R. Prater answered that there were several programs that were designed to reduce food waste and recycle it back into the Charitable Food Network. He explained that the Charitable Food Network would buy fresh produce below market price if the produce wasn't shelf-perfect. L. Duff explained that there were retail recovery programs where grocery stores would work with food banks to give extra food to the food banks. The Mid-Atlantic Cooperative was an example of one way Feeding America was investing in the food going to where it was needed the most. L. Duff gave an example that if one food bank gets a large donation that they won't utilize fully, the food would be redistributed to food banks all across the region.

R. Prater continued that the One, Big, Beautiful Bill Act (BBB), also known as H.R.1, was passed by Congress and signed into law on July 4, 2025. Using the 'reconciliation' process, spending changes were made across many programs. Examples include SNAP, Medicaid, taxes, student loans, farm support, and more. The implementation timelines vary by program, with parts starting as early as July 4, 2025, and others as late as 2027.

These changes included limited future updates and limited increases to the SNAP benefit amount. There were changes to immigrant eligibility and other benefit calculations, which made it harder for legal immigrants to access the program. These changes eliminated SNAP-Ed, a program used to help food banks educate individuals on healthy eating and food preparation. H.R. 1 changed state cost-sharing, meaning states were required to pay for a portion of SNAP benefits and also changed work requirements and time limits for recipients. L. Duff added that the Food Security Supplement was eliminated, which was the survey that showed the food insecurity rate. The last survey came out this year. L. Duff said Feeding PA was working with Feeding America to create a new survey through the Behavioral Risk Factor Surveillance System (BRFSS) to have a measurement to compare trends.

R. Prater continued explaining the SNAP work requirement changes, which he said would impact Philadelphia residents the most. Before H.R. 1, there were general work requirements for ages 16-59 years old. All SNAP recipients without exemptions were required to work if able. In the 1990s, they added Able-Bodied Adults Without Dependents (ABAWD) work requirements for ages 18-54. These benefits were time-limited to 3 months in a 3-year period if not exempt. He said work requirements were proven to be ineffective at increasing work. He said Feeding PA prefers to call them time limits or paperwork requirements. He explained that 35% of SNAP recipients were under 18, 25% of recipients were over 55, and 11% of people aged 18-54 have a disability.

R. Prater described the work requirement changes in H.R. 1. As of September 1st, the geographic waiver, which waived work requirements for counties with high unemployment, was eliminated, which meant Philadelphia was subject to ABAWD rules for the first time ever. In November, the ABAWD definition was expanded to increase the age range to 65, include parents of kids 14+, and eliminate exemptions for people experiencing homelessness, veterans, and former foster youth.

R. Prater explained that new screenings for new requirements would occur at the client's next renewal. Recipients would be either exempt (safe until next renewal), compliant (meeting requirements, but must report changes), or noncompliant/time-limited (limited to 3 months of benefits). L. Duff added that SNAP recipients should register any change of address to the post office and the Department of Human Services so the renewal letters would be sent to the correct address.

R. Prater listed the exemptions which included individuals who were age 65 or older; had a dependent in the household under age 14; were receiving or had applied for unemployment compensation; were receiving a disability benefit; had a medical condition that limited their ability to work; were participating in a substance use disorder, mental health, or vocational rehab program; were pregnant; were enrolled in school or job training at least half-time; were caring for a person with a disability or an older adult in the household; or were working at least 30 hours per week or earning at least 217.50 per week.

R. Prater said to prove the exemption, no additional paperwork was needed if the client was under 18 or 65+ years old or receiving disability benefits. If the client earned over 217.5 dollars per week, use paystubs. To file for an exemption due to medical conditions, R. Prater suggested submitting a provider-signed PA 1921 form. All other exemptions need to be verified "if questionable."

R. Prater continued to explain how to comply if the client wasn't exempt. Ways to comply included working 20 hours per week (or 80 hours a month), participating in an employment and training program for 20 hours per week, or participating in community service or volunteering (hours required varies). He explained that if a client was not exempt or complying, they were limited to 3 months of SNAP benefits in a 3-year period.

R. Prater said the initial estimates indicated 144,000 individuals would be subject to new work requirements. He noted that since July, 2025, the number of people who have fallen off SNAP benefits had already exceeded that estimate. The presenter said people would continue to fall off until November, which was a full year after the new requirements were set. This puts more demand on food pantries and does not help with food insecurity. R. Prater noted that the SNAP caseload was down more than 200,000 (10%) since July 2025 and states were implementing new technology like case trackers, consent-based verification, or document legibility. He said there has been an inaccurate narrative around 'waste, fraud, and abuse', which would continue to grow in the curren political climate right now. He noted that there were very strict requirements and barriers to receiving SNAP benefits. A. Leger asked if the implemented new technology improved efficiency or raised concerns. R. Prater responded that the technology was intended to streamline the program, improve communication with clients, and reduce administrative burdens

on caseworkers. However, he noted that there were privacy concerns and stated that the changes also add additional requirements and steps for clients to complete in order to receive benefits. Overall, he described the changes as having both benefits and drawbacks. L. Duff added that the additional requirements were created by the legislation itself, not the technology. She stated that the Department of Human Services was working to make the process as streamlined as possible to help individuals meet requirements and maintain access to benefits. She also noted that the technological updates were intended to reduce administrative errors and support the state's ability to continue administering SNAP.

R. Prater shared a graph from the Center on Budget and Policy Priorities that showed each state and the impact of the SNAP changes. He said SNAP enrollment was dropping every month and every state across the country has been impacted. R. Prater concluded by asking for organizations to partner with Feeding PA to raise public awareness, help SNAP recipients comply with work requirements, and to advocate with local, state, and federal elected officials.

R. Prater opened the presentation to allow for questions. J. Ealy asked why policymakers were attempting to remove people from SNAP benefits. L. Duff said she thought that hunger was a policy choice that society was making. She encouraged the audience to share resources with people who would be impacted. She highlighted how Feeding PA wanted to share experiences to humanize SNAP benefits. D. D'Alessandro, speaking as a private citizen and not for her agency, shared that National Public Radio (NPR) recently had a story that shared first-person experiences that focused on impacts in red states. She said there was a perception that benefits primarily serve low-income Black residents in urban areas and were associated with fraud and waste. She added that the reality was that the majority of recipients in Pennsylvania and other states were low-income white individuals, reflecting the larger number of low-income white individuals compared to low-income Black individuals nationally. L. Duff said in PA, the highest food insecurity rates were in rural areas. A. Leger asked if there was a need for more volunteers in food banks or pantries. R. Prater said there was a need for more volunteers everywhere, which could also suffice for work requirements. He would have to check for more information within the organization.

Discussion Item:
~Town Hall Recommendations~
In the last CPC meeting, K. Wilson presented three recommendations derived from the town halls. These three recommendations included medical case management training, housing assistance, and self-advocacy.

K. Wilson said the medical case management recommendation looked into the DHH's training program for medical case managers. This recommendation was developed as a response to a recurring theme at the town hall events. Many clients lacked a clear understanding of the role of the medical case manager and how to effectively utilize the service. S. Moletteri said these discussions were echoed in the Poz Committee, where members discussed the roles and responsibilities of both client and case manager. D. D'Alessandro said DHH has a standardized curriculum for medical case managers, as well as standard deliverables that the case management agencies were required to deliver. K. Wilson highlighted the struggle someone would face trying to find information when they don't have a background in the field. A. Leger clarified that the

recommendation was to have an easily accessible public document that highlighted information such as medical case manager training, requirements, and responsibilities.

S. Moletteri said the purpose of this conversation was to craft verbiage and ideas of directives for the allocations process. She mentioned a directive from last year that HIPC crafted regarding medical case management training that would ensure the case managers and providers were properly trained in relevant areas. J. Ealy noted that entry-level staff sometimes don't have basic HIV knowledge, and this issue could stem from the training they received from their employer. S. Moletteri said reception and intake staff typically had different training than other medical staff. D. D'Alessandro said the Health Federation delivers thorough trainings on behalf of DHH, highlighting that people must ask them for the information. S. Moletteri said that they would be receiving a full report back of what those trainings were. She said the trainings were standardized to some degree, but was tailored to the organization. S. Moletteri also noted that medical case managers have ongoing training throughout their careers. S. Moletteri said she could gather a summary and disseminate it. K. Wilson said that the recommendation was for the client, someone with no experience in organizations or with providers. S. Moletteri emphasized that this directive would identify gaps within the provided trainings.

K. Carter asked D. D'Alessandro if the case managers were expected to get a certain grade or if the curriculum was pass/fail. D. D'Alessandro highlighted that she was not the direct staff that oversees this area, but said the trainings were very interactive, but did not have a grade system. She noted that it was the supervisor's responsibility to make sure there was competency within the case manager. K. Carter asked if there was a mock training where a new case manager was paired with an experienced case manager to practice skills before taking on clients. D. D'Alessandro said only an agency can answer that question because the training varies by agency. She did note that there was nothing in her experience that was a mock trial type training. D. D'Alessandro reiterated that to find out more information, someone would have to directly ask DHH. She noted that to her, an infographic that highlighted the services and what to expect would be most helpful for the general population, especially if it was on an accessible site such as Philly Keep on Loving. She said DHH has very clear standards of what it means to be a Ryan White funded medical case management for people with HIV. A. Leger said even if the organizations can't provide a detailed curriculum, it would be beneficial for them to provide information about the minimum qualifications or certifications to ensure transparency and to build trust with clients. D. D'Alessandro agreed that it would be beneficial if DHH released a list that detailed the topics that were covered in the curriculum. S. Moletteri said optional and required topics could be interesting to have available.

S. Moletteri emphasized that the conversation was to craft verbiage for the allocations process. She highlighted that directives to DHH can be about specific subpopulations, specific geographic areas, how services should be provided, and the type of organizations that receive funding. S. Moletteri said she was writing down everyone's comments on the topics to help with the allocations process.

When talking about medical case management, S. Moletteri highlighted that in the last committee meeting, they talked about how clients need a clear, consistent explanation of what case managers do because case management systems may feel confusing, siloed, and hard to

navigate, and clients often don't know which provider handles which service. K. Wilson gave an example of a client not knowing if it was the case manager or their own responsibility to renew a medical card. J. Ealy mentioned that in his experience, there was always a lack of clarity of the expectations of the client and what the employee was hired to do. He highlighted how it might not be clear to the medical case manager if certain actions were part of their job. He also questioned the impact of what the medical case manager's caseload looked like and how overwhelming the job was. K. Wilson noted that despite the medical case manager having a big caseload, the client still needed the service. S. Moletteri said there could be a contract laid out to keep expectations clear. J. Ealy agreed with K. Carter's statement that clients have varied needs. A. Leger agreed that all clients were different and said the type of services received from a medical case manager changes depending on the acuity level of the client. So, those who have higher needs or have more complex circumstances would have different standards than a client who does not need that support.

In terms of appointment attendance, A. Leger noted that most case managers were staff at clinical sites, but the bulk of case management was done through organizations that employ case managers, such as Bebashi and Action Wellness. She said that since the COVID-19 pandemic, appointment frequency has declined, and there were many more appointments that were virtual, which might be easier for clients to access, but harder for case managers to access.

A. Leger also said that although caseloads were currently high, the staffing problem was exacerbated at every level, not just at the case manager level. She said that many of the issues might not be deriving from bad intentions, but instead staffing and funding issues. K. Carter mentioned that maybe the number of MCM might need an assistant to help with paperwork. J. Ealy said in his experience, having someone sit in the appointment has worked well for patient coordination. A. Leger said that there was a lack of understanding and education for community members and clients about the different types of case managers they may be seeing, which shows a lack of standardization and communication about what role people serve. S. Moletteri said that members have reported having seamless or enjoyable experiences with their medical provider, so an assessment that determines if the client needs extra support could be beneficial.

S. Moletteri highlighted that this recommendation requests clarity when it comes to the responsibilities of each party. She said that through this conversation and previous committee conversations, it seems that a recommendation was to create a simple "What Does Your Case Manager Do vs What You Do As a Client" guide. A. Leger added that including a glossary of words that clients might encounter would be helpful. S. Moletteri said DHH might have to look into some of these topics further before they report back to make sure they were providing the council with correct and comprehensive information. A. Leger asked if having the information was the goal or if the process was the goal. S. Moletteri said the goal was to request that information and compile it comprehensively to make it accessible. S. Moletteri said more information would be helpful to see what the council can do as a directive in the future. K. Wilson said this was not a complete directive but just a recommendation based on conversations from the town halls.

A. Leger said many other jurisdictions have online manuals that include the standards for each of the service categories. She said she believes DHH has a specific set of standards for each service

category, even though it might not be easily accessible. She said there was a need to understand what those standards were for priority setting and allocations. S. Moletteri agreed that it was important for priority settings and allocations because the council should know what they are putting funds toward. K. Carter said we need a summary of what each agency specializes in. S. Moletteri gave an example that the HRSA policy differs from how the council funded substance use services. She said the council learned that a lot of the substance use services funds went towards drug tests.

S. Moletteri shared several potential directives that emerged from the conversation, including developing DHH infographics that highlight Medical Case Management eligibility criteria; exploring Medical Case Management curriculum and training opportunities while maintaining transparency; clarifying the annual visit requirement; defining the distinct responsibilities of case managers and clients; creating a glossary of key terms; and establishing a specific set of standards for services and agencies. D. D'Alessandro added that the DHH infographic could include a section outlining what clients can expect from their Medical Case Manager.

S. Moletteri said in terms of housing services, there was a need for a clear, user-friendly housing resource guide. She said this would be complicated because there are many different eligibility requirements for each program and Ryan White Part A was a payer of last resort. She said other barriers were long wait times and a lack of a comprehensive list outlining what housing programs organizations have. She said OHP was trying to get someone from the City to present in Poz Committee to talk about housing resources for the Commission of Aging for people who are over 55 years old. S. Moletteri's presentation also highlighted how clients want help understanding eligibility requirements, application process, and what programs actually exist to clear confusion. A. Leger suggested reaching out to agencies funded for housing services to find pre-existing resources. She suggested looking into www.findhelp.org (Previously Aunt Bertha), which was an online system used to streamline all the resources across the country. S. Moletteri said we don't have the capacity to make that type of resource, but highlighted the importance of bringing in providers and clients who can share information and resources with the council.

S. Moletteri explained that the last recommendation focused on self-advocacy and empowerment. She highlighted talking points from the last meeting, which included clients wanting support to advocate more effectively for themselves in healthcare settings and a need for health literacy support and clearer guidance on how to navigate care. Members suggested having more educational materials, workshops, and peer support groups needed for education and resource sharing. A. Leger said there could be an opportunity to connect the Medical Case Management and self-advocacy recommendations. She highlighted that a lot of the information made public would empower clients to understand the care system to advocate for themselves and the services they need. K. Wilson agreed that connecting the two would empower clients to advocate for their health. A. Leger said she doesn't find empowerment and self-advocacy to be a core component of case management services because they prioritize linkage to care. She added that it was a funding concern for many case management roles because they get funding based on the number of clients they're providing services to. She explained, in her experience, that there are often no conversations about termination because the goal of case management isn't to graduate clients from the system, but instead keep the ongoing need. S. Moletteri said that HIPC could create a glossary or educational material internally, then have DHH distribute it to case

managers. She said if that's something the council was interested in, it could be a task of a committee, such as CPC. A. Leger suggested the council could research other jurisdictions' resources. J. Ealy agreed that we could find resources to help with the process. A. Leger noted that the Maternal and Child Family Health created a guide on behavioral mental health from pregnancy, with plans to update the guide frequently. She suggested reaching out to them to see whether their methodology was successful and, in the future, mirroring it for our project. K. Carter said medical case managers should empower clients to be involved. S. Moletteri said case managers empowering clients was similar to the recommendation to ensure clients have adequate services. A. Leger clarified that there was no ulterior motive to the case management funding and system, but there was no incentive to graduate clients.

Other Business:
None.

Announcements:
K. Carter said June was AIDS Education Month. J. Haskins said June 5th marks the flag rising for Pride Month at City Hall and June 7th was the Pride Parade on the parkway. S. Moletteri asked if there was a fee for the Pride Parade. J. Haskins said it costs $10. J. Ealy said May 28th was International Masturbation Day and May was National Masturbation Month.

Adjournment
J. Ealy called for a motion to adjourn. Motion: J. Ealy motioned, A. Leger seconded to adjourn the May 2026 CPC/Prevention Committee meeting. Members voted vocally in the room and through Zoom. Motion passed: All in favor. The meeting adjourned at 4:48 p.m.

Respectfully submitted,
Elizabeth Fischer

Handouts distributed at the meeting:

- May 2026 CPC/Prevention Committee Agenda
- April 2026 Prevention Committee Meeting Minutes
- April 2026 CPC Meeting Minutes