Prevention Committee
Meeting Minutes of
Wednesday, April 26th, 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, Gus Grannan, Diamond Jackson, Erica Rand, Client Steib, Desiree Surplus, Adam Williams

Excused: Lorett Matus

Staff: Tiffany Dominique, Sofia Moletetteri, Mari Ross-Russell, Kevin Trinh

Call to Order/Introductions: C. Steib asked everyone to introduce themselves and called the meeting to order at 2:33 p.m.

Approval of Agenda:

C. Steib referred to the April 2023 Prevention Committee agenda and asked for a motion to approve. **Motion:** K. Carter motioned; A. Williams seconded to approve the April Prevention Committee agenda via Zoom poll. **Motion passed:** 6 in favor, 1 abstaining. The April 2023 agenda were approved.

Approval of Minutes (*March 22nd, 2023*):

C. Steib referred to the March 2023 Prevention Committee minutes. **Motion:** K. Carter motioned; G. Grannan seconded to approve the March 2023 Prevention Committee meeting minutes and agenda via a Zoom poll. **Motion passed: 5** in favor 2 abstaining. The March 2023 Minutes were approved.

Report of Co-chairs

None.

Report of Staff

T. Dominique said she had sent the Prevention Committee an email requesting a one-on-one meeting to do a check-in.

Discussion Item:

-Integrated Plan-

T. Dominique said they would review the diagnosis and prevention goals of the Integrated Plan. She reviewed the actions taken in the diagnosis part of the plan, which was on page 34 of the Integrated Plan.

The actions taken under the diagnosis section of the Integrated Plan looked to provide accessible sexual health services, focusing on overall sexual wellness to decrease stigma around HIV testing. The plan proposed appointing clinical advisors to detail public health detailing to increase opt-out testing, repeating testing, and biosocial screening where opt-out testing isn't available. The plan also intended to implement HIV testing in select pharmacies and include expanded hours and more availability for testing in zip codes with higher incidence rates of HIV. To encourage testing, the Department of Health aimed to maintain HIV testing at no cost. Additionally, they hoped to continue HIV self-testing programs and launch an HIV testing media campaign to destigmatize HIV testing. The Integrated Plan would maintain the Philly Keep on Loving (PKOL) website, which would provide information on HIV testing.

T. Dominique reviewed the action steps of the prevention goal in the Integrated Plan. The plan included the establishment of a Center of Excellence in Philadelphia, providing 24/7 access to nonoccupational post-exposure prophylaxis (NPEP). DHH also launched a TelePrEP program on the PKOL website. The plan would appoint a clinical advisor to do public health detailing for PrEP provision. The plan launched PKOL and a TelePrEP media campaign to de-stigmatize PrEP. The Department of Public Health collaborated with key stakeholders to make PrEP and PEP more accessible and available.

G. Grannan asked who was the target demographic of these action steps. T. Dominique responded that the target under the diagnosis and prevention section of the Integrated Plan had targeted people who injected drugs, black men who had sex with men (MSM), women, and high-risk youth. G. Grannan agreed that these were target demographics, but he suggested they still needed to reach out to clinicians and health providers who may be skeptical of PrEP. G. Grannan emphasized that clinicians and other health providers should be taught the value of PrEP, both in their education and job training, without putting their professional futures at risk.He said many clinicians were not responsible for their attitudes towards PrEP because of the educational background in which they were trained. He said that many of the committee's activities had focused on patients' understanding of PrEP. He suggested raising awareness about PrEP among both the general population and healthcare providers.

A. Williams asked G. Grannan if the point he had discussed were previously covered in the Philadelphia Ending the HIV Epidemic (EHE) Plan under the workforce development pillar. T. Dominique clarified that the EHE Plan was different from the Integrated Plan, though the two plans had worked together in tandem. T. Dominique said that if the committee had found a deficiency or an issue, they could send a directive to the recipient from the HIV Integrated Planning Council (HIPC). The recipient may not be able to resolve the issue, but they would need to address the concerns put forward. T. Dominique mentioned if the Prevention Committee had felt clinicians did not receive education about PrEP, they could bring the issue to the recipient through HIPC. M. Ross-Russell explained that directives were part of the allocations process and acted as both requests and recommendations they could send to the Department of HIV Health.

K. Carter asked if it was necessary to educate both providers within and outside the Ryan White system about PrEP. M. Ross-Russell clarified that the concerns G. Grannan had about clinician knowledge of PrEP had affected all clinicians whether they were in the Ryan White System or not. T. Dominique said though they may advocate for more PrEP education in clinician training, clinicians and the medical school institution had the final decision on whether to elect coursework related to PrEP. K. Carter said clinicians did not have enough incentives to learn about PrEP. He said they did not know which practitioners had prescribed PrEP until they had advised patients to ask their primary providers about PrEP.

M. Ross-Russell asked the committee to describe the patient experience when they ask for PrEP. T. Dominique said the PrEP process would be dependent on the provider. M. Ross-Russell said that it was important that the process to receive PrEP was transparent and accessible. She said the access to the information could prompt potential persons exposed to HIV to request PrEP. G. Grannan said that some providers followed the best practices and some that did not. He said there needed a way for patients to report stigma against PrEP without punishing the clinicians for one response. G. Grannan said they should discuss with the health provider if PrEP stigma was found. He said that patients were entitled to expect engaging care such as the Mazzoni Center or their primary care provider.

C. Steib asked to return to the Prevent action steps slide. He said the action step regarding appointing a clinical advisor had been completed by the Department of HIV Health (DHH). He said DHH had hired a clinical advisor to present information about PrEP and HIV to health providers. C. Steib explained that the word “detailing” had originated in pharmaceutical companies where representatives would visit health providers to persuade them about the benefits of a new drug. He recommended that they invite the clinical advisor to speak to the HIPC or the Prevention Committee. He said they could gauge DHH’s progress toward educating providers about PrEP and and request a list of clinicians who were prescribing PrEP.

T. Dominique paused for questions before moving on to the objectives and key activities and strategies of the diagnosis section of the Integrated Plan. The first goal was to diagnose 95% of persons living with HIV by 2026. The first objective was to expand opt-out HIV screenings and diagnostic testing in at least 50 healthcare and other institutional settings. The key strategies and activities were to expand opt-out testing in DHH-funded emergency departments, increase efforts to educate medical providers about conducting opt-out HIV testing, educate clinical providers on bio-social HIV screening in clinical settings, and promote opt-out HIV testing for all DHH-funded providers.

The second objective was to maintain HIV testing services in non-clinical settings using rapid point-of-care testing or 4th generation laboratory testing. The key strategies and activities were to increase status-neutral testing in priority populations, support HIV self-testing through telehealth programs, and build capacity for non-clinical HIV testing.

The third objective was to implement routine opt-out testing at intake to substance use treatment facilities. The key strategies and activities were to implement routine opt-out testing at intake to

substance use treatment facilities, promote testing in primary care settings, implement testing in pharmacies in priority zip codes, and support capacity building in novel settings.
T. Dominique said the goals and timeline for the Integrated Plan differed from the EHE Plan. She said they had received an update from A. Thomas-Ferraioli in the April 13,th, 2023 HIPC meeting where they had received more information about the timeline and goals. For example, the Integrated Plan aimed to diagnose 95% of people living with HIV by 2026 instead of 2026 as mentioned in the EHE Plan. T. Dominique said that DHH had provided a way to view their goals to reach a diagnosis 95% of people with HIV on their dashboard.

The second goal was to eliminate disparities in non-clinical HIV testing. The first objective was to increase the number of partners to address syndemics to reduce new HIV diagnoses. The first key activity was to implement HIV/Viral Hepatitis Service integration. The second key activity was to collaborate with substance use facilities. The third key strategy was to work with the Pennsylvania and New Jersey Departments of Health to address interrelated factors exacerbating HIV.

The second objective was to enhance health equity efforts through policy and process improvements. DHH looked to implement and coordinate health equity efforts with the Pennsylvania and New Jersey Departments of Health. They also aimed to extend current health equity efforts to DHH-funded prevention providers.

The third objective was to evaluate HIV testing programs to address disparities in priority populations on an annual basis. The first key activity for this objective was to use public health data to identify disparities in non-clinical HIV diagnosis. The second activity was to provide feedback to funded providers. The third activity was to implement Continuous Quality Improvement (CQI) to address disparities.

Goal 2 of the integrated Plan listed the partners and potential funding sources.The partners involved with the Integrated Plan were the Philadelphia Office of HIV Planning (OHP), Philadelphia Department of Public Health Division of Disease Control (PDPH DDC), Ryan White (RW) funded clinical providers, health care facilities, community-based providers, Philadelphia County Prison Health Services, non-clinical testing sites, hospital emergency departments, sexual wellness clinics, and the Pennsylvania and New Jersey Departments of Health.

The potential funding sources included the CDC HIV Prevention and Surveillance Prevention Cooperative Agreement, the Pennsylvania Department of Health, the City of Philadelphia General Revenue, Medicaid, and other public and private funding sources. T. Dominique said the estimated funding allocation totaled $11,790,060.
T. Dominique said the expected outcome for the goal was to diagnose 95% of people with HIV and to link 95% of newly diagnosed individuals to HIV medical care within 96 hours of diagnosis. Data would be monitored from the Philadelphia EMR, Pennsylvania, and New Jersey Departments of Health and EvaluationWeb. The expected outcome of the HIV Care Continuum (HCC) and the Philadelphia EHE Initiative would be to increase the number of people who knew their HIV status to 95% and link these individuals to medical care within ours.

A. Williams said he had found that it was interesting that the PDPH DDC and the DHH were listed as partners but the PDPH Ambulatory Health Services (AHS) were not directly referenced. T. Dominique asked him why they should be included. A. Williams replied that the PDPH AHS was one of the PDPH organizations involved with HIV community engagement and direct services. He said PDPH AHS had multiple sites throughout the city and contributed significantly to implementing EHE activities. T. Dominique confirmed with A. Williams that he was requesting to include PDPH AHS as a partner in the future. C. Steib asked if PDPH AHS would be included as RW-funded clinical partners. A. Williams answered that not all PDPH AHS sites were funded in the same way. He said some were funded through DHH and others were funded through the state of PA. T. Dominique asked if they should be included in the category under facilities and community-based organizations or if they should make an exception for this organization. A. Williams said that they should be included because the DPPH AHS provided service to individuals who were often uninsured or were unable to receive services elsewhere. He believed that if they did not include PDPH AHS, they would be missing the organization that served a significant number of vulnerable populations.

T. Dominique said that PDPH DDC was included in the list because of their work with viral hepatitis and sexually transmitted diseases. She said she could not say definitely since she was not part of the meeting when the Integrated Plan was created. M. Ross-Russell said they had created this list to be comprehensive while attempting to be concise. A. Williams asked why they did not list all the PDPH organizations under PDPH to be concise and inclusive. A. Williams felt that the health centers were being left out. M. Ross-Russell said they did not intend to leave the health centers off the list. Rather, it was human error that lead to organizations missing from the list.

T. Dominique said they had finished reviewing the diagnosis section of the Integrated Plan. She asked if there were any recommendations or improvements they could forward to HIPC. A. William said they should strengthen avenues to PrEP through primary care physicians in addition to through DHH and PDPH DDC. He referenced a study from John Hopkins where researchers had interviewed cis black women about their barriers to PrEP. The researchers interviewed the women and learned that women felt they were stigmatized when they were prescribed PrEP by someone other than their primary care physician. A. Williams sent the research journal to the committee. The title of the research article was “Experiences of Black Women in the United States Along the PrEP Care Continuum: A Scoping Review.”

T. Dominique reviewed the Prevention goals. The first goal was to use biomedical interventions to reduce new HIV diagnoses by 75%. The first objective was to prescribe PrEP to 50% of people with a PrEP indication. The first key activity was to expand the current network of low-threshold sexual wellness clinics to provide HIV, STI, and hepatitis C virus (HCV) testing, PrEP, post-exposure prophylaxis (PEP), and linkage to HIV, STI, and HCV treatment in Philadelphia. The second objective 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 objective was to pursue new PrEP partnerships with the Pennsylvania and New Jersey Departments of Health. The fourth objective was to expand financial support for PrEP-related routine laboratory work, through provider and home-collected specimens, and

adherence services. The fifth objective was to continue to provide ongoing technical assistance for the implementation of PrEP. The sixth objective was to expand PDPH DHH's capacity to evaluate PrEP uptake. The seventh objective was to increase knowledge of PrEP among the most impacted populations through communications and outreach. The eighth objective was to increase the number of providers trained to prescribe PrEP. The ninth objective was to develop collaborations with providers to expand PrEP screening to people who inject drugs. The tenth objective was to support research into expanding PrEP access and uptake among underserved populations. The eleventh objective was to collaborate with the Pennsylvania Department of Health Data-to-PrEP initiative. The twelfth objective was to increase the uptake of antiretroviral therapy (ART) as a method of prevention.

T. Dominique reviewed the second objective of the Prevention goals. The objective was to ensure access to nPEP. The first key activity was to establish a centralized mechanism to distribute PEP through a PEP center of excellence. The second key activity was to establish PEP partnerships with the Pennsylvania and New Jersey Departments of Health. The third key activity was to develop an initiative to address gaps in the provision of PEP including capacity, education, and resources.

C. Steib asked if the document could be amended or updated. He said they should amend the Integrated Plan to include educating and expanding PEP knowledge to emergency services around the city. He said many sexual assault cases were handled by emergency services. He said these cases had represented a missed opportunity. T. Dominique asked if this suggestion could be included in the third key strategy and activities of objective 2 under prevention goals.

K. Carter said that many sexual assault survivors may not be able to speak due to trauma. He said it would be difficult to evaluate potential patients. G. Grannan asked for a definition of capacity. G. Grannan asked the committee what was the meaning behind including capacity in the third key activity of the second objective. He asked if the definition had included how time-dependent PrEP was. He said PrEP was effective if it was administered within 72 hours. J. Haskins said including capacity was more related to educating the community about PrEP. T. Dominique believed capacity was related to staffing. She said when the PEP Center of Excellence was created, they did not have enough people to staff it even though they were a 24/7 hotline. She believed capacity was similar to that situation.

T. Dominique proceeded to the next portion of the presentation. She reviewed the third objective of prevention goals. The third objective under prevention goal 1 was to support perinatal HIV prevention services for pregnant individuals. The first key activity was to provide specialized case management for pregnant persons living with HIV. The second key activity was to develop PrEP navigation support for pregnant HIV-negative women at risk of HIV acquisition. The third key activity of this objective was to conduct case surveillance for women with diagnosed HIV infection and their infants. The fourth key activity was to conduct perinatal HIV exposure reporting.

T. Dominique then reviewed the second goal of Prevention. The second goal was to increase the number of access points for evidence-based harm reduction services. The first objective was to expand access to harm reduction supplies through novel approaches. The first key activity was to

implement harm reduction vending machines intervention at pilot sites. The second key activity was to ensure the availability of syringes at pharmacies by maintaining the Pennsylvania Department of Health's standing order. The third key objective was to provide organizational development and capacity building to expand local partnerships and establish new organizations providing syringe service provider (SSP) services and new locations of service based on need and HIV public health data. The fourth key activity was to expand the capacity for syringe service programs to distribute and collect syringes from Ryan White HIV/AIDS (RWHAP)-funded sites. The fifth objective was to pursue the expansion of distributing syringes and other harm-reduction supplies in Emergency Departments and urgent care sites. The sixth objective was to engage with community members and stakeholders in program development and planning of harm reduction services through novel approaches to ensure that it meets the needs of people who use drugs and avoids duplications of services.

The second objective of goal 2 of prevention was to expand access to syringe service programs. The key activities to support this objective were to enhance linkage to substance use disorder treatment in SSPs, implement quality improvement plans as needed, provide more equitable SSP service geographically in Philadelphia, and advocate for the implementation of SSPs in the counties in the jurisdictions outside of Philadelphia and New Jersey counties in the EMA.

T. Dominique reviewed Prevention goal 3. The third goal was to reduce disparities in HIV-related prevention services in priority populations. The first key objective was to monitor local disparities along the status-neutral HIV. The first key activity to achieve the objective was to continue reporting data by demographics and risk groups in PDPH DHH HIV Surveillance Report. The second key activity was to maintain a bi-annual update of the EHE dashboard, which included HIV care metrics by demographics and risk groups. The third key activity of this objective was to measure MSM/ Transgender people who have sex with men (TSM) perspectives on HIV testing and PrEP access to monitor disparities in access to testing/PrEP among these groups.

The second objective of Prevention goal 3 was to reduce HIV-related disparities in new diagnoses among priority populations. The first key activity was to expand new PrEP clinical-community partnerships to engage focus populations. The second key activity was to continue the City-wide distribution of free condoms, including in high schools, locations accessed by youth, and syringe service programs. The fourth key activity was to expand the promotion and distribution of community-specific sexual wellness and harm reduction information and supplies through innovative approaches.

The third objective of Prevention goal 3 was to increase and support health promotion activities for HIV prevention in the communities where HIV was most heavily concentrated. The first key activity was to continue the distribution of condoms in the jurisdiction. The second key activity was to support media campaigns that advance HIV prevention and health promotion behaviors. The third activity of this objective was to encourage the provision of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, people who inject drugs (PWID), and people experiencing homelessness.
T. Dominique listed the partners involved in the Prevention goals. The organizations listed were PDPH DDC, PDPH Division of Substance Use Prevention and Harm Reduction (SUPHR),

Pennsylvania and New Jersey Departments of Health, RW-funded clinical providers, community-based organizations (CBO), and established SSP programs. T. Dominique identified potential funding sources for the prevention goals. The funding sources were the CDC HIV Prevention and Surveillance Prevention Cooperative Agreement, the Pennsylvania Department of Health, the City of Philadelphia General Revenue, Medicaid, and other public and private funding sources. T. Dominique estimated the funding allocation would be $12,800,184.
The expected outcomes would be an increase in the number of people on PrEP, especially in priority populations who have an indication for PrEP. These priority populations were cis-gender women who inject drugs, transgender individuals, MSM, MSM (13-24 years old), and PWID. The plan aimed to increase the percentage of cis-gender women who injected drugs to 75% of the population to be on PrEP. For MSM and MSM (13-24 years old), the plan aimed to increase the percentage of people in the demographic to 50% on PrEP. Likewise, the plan looked to increase the percentage of MSM (13-17 years old) on PrEP to 25% of the demographic. T. Dominique said the monitoring data source would be the Philadelphia Department of Public Health data and EvaluationWeb. T. Dominique said the expected impact on the HIV Care Continuum (HCC) and the Philadelphia EHE Initiative was an increase to 50% of people with a PrEP indication who were prescribed PrEP and a decrease by 50% in the number of PWID who report sharing syringes.

T. Dominique strongly recommended visiting the HIVPhilly.org website and reading the Integrated Plan. She said pages on actions taken were on pages 34 and 35. The information on goals and objectives was on pages 47 to 54. She asked the committee to think about how the information fits into the EHE and the pillars.

-Texas Judge Mandate Regarding PrEP Access-

A. Williams introduced himself as the Prevention Coordinator for the Philadelphia Department of Public Health's AHS division in their clinical services program. A. William had volunteered to present an overview of the Braidwood V. Becerra. He prefaced that though he was presenting the information, he was not an attorney. He said he would answer questions to the best of his ability.

There were six individuals at the center of the case. He said the Braidwood had referred to a self-identified for-profit Christian-owned business by Dr. Steven F. Hotze. The name Becerra referred to Xaviar Bercerra, who was the U.S. Secretary of Health and Human Resources. The plaintiffs protested that the mandatory Affordable Care Act (ACA) coverage for their employees had thrust economic harm to their employees. Braidwood Management had argued that their employees were forced to pay for health services they did not want nor need and this had included services they religiously objected to.

A. Williams said the case was an attack on the ACA. He said the plaintiffs did not have particularly strong reservations against PrEP but they did have a strong opposition against the ACA. He said funding sources backing the case sought to have a judge who had previously ruled against the ACA. He said this case had qualified as a shadow docket. He described shadow dockets as lawsuits specifically chosen to lay the foundation for future political agendas in higher

courts. A. Williams said the general strategy was stoking hatred against sexual minorities to invalidate health services that had benefitted many.

A. Williams said the plaintiffs had not only aimed to remove PrEP access but also to nullify preventative care mandates by the United States Preventive Services Task Force (USPSTF) for the ACA. A. Williams quoted from a peer-reviewed analysis of the court case by Dorman, D. McCluluskey. The quote said "In siding with the plaintiffs, Judge O' Conner has jeopardized access to critical health care services potentially affecting over 150 million insured Americans." A. Williams said this had affected about 45% of the US population. The business owners' third position said the owners' religious freedoms were infringed. They had opposed services that had supported LQBTQ+ on the grounds of religious rights. They argued that PrEP encouraged homosexuality and promiscuity.

The plaintiffs aimed to nullify other services than PrEP. A. Williams showed the committee a list of services the plaintiffs had aimed to change. These included cancer, chronic conditions, health promotion, pregnancy, and sexual and reproductive health. A. Williams said the plaintiffs had successfully painted the case as an MSM-specific issue when impeding PrEP amounts to the structural racism that perpetuates inequalities in healthcare along racial and ethnic demographics beyond its immediate impact on MSM communities.

PrEP was a central point of the EHE Plan. A. Williams said they knew that PrEP was successful in reducing the number of new HIV infections per year. He showed the graph depicting new HIV transmission rates falling by 8% from 2015 to 2019.

A. Williams reviewed the epidemiology of HIV in the United States. He showed the committee a chart depicting the percentage of people with HIV in each demographic. He said the populations most affected would be minority populations such as the Black/African American and Hispanic/Latino populations. In 2019, 40.3% of people with HIV were Black/African American and 24.7% of people with HIV were Hispanic Latino. Even though each accounted for less than 20% of the United States population.

A. Williams reviewed the different plans created in response to the court decision. Plan A was to file an injunction. A. Williams said this was in motion. They were also awaiting to see if the USPSTF ruling would stand. At the time, the court decision would only affect the individuals in the case.
Plan B would be to appeal the ruling and bring it to the Supreme Court. A. Williams said this was risky since it risked doing further harm to the ACA. The Supreme Court had a conservative majority and would likely rule against the ACA.

Plan C was to bring public awareness to the impact of Braidwood v. Becerra. A. Williams said that current contracts have been locked in for the current insurance year and they would need to wait until next year to see the effects of the court decision. A. Williams said they would need to initiate a bi-partisan campaign to support legislation that would alter the effects of the court decision.

K. Carter said they should demonstrate the impact that the court decision would have with numbers that people grasp. For example, he said they could show people the number of cis-gender people who would lose access to PrEP. He said they could also show the amount of money PrEP could save the state if fewer people were seeking HIV treatment because they used PrEP.

M. Ross-Russell said she had contacted Dr. K. Brady in anticipation of the presentation to ask her what government organizations were doing in response to the court case decision. She said the city of Philadelphia had assurances from the state Medicaid that they would honor the no-cost sharing clause for HIV prevention including PrEP. M. Ross-Russell said they were currently reaching out to insurers across the state for assurances. She promised to share information regarding the case to the committee.

T. Dominique reminded the committee that the meetings were informational and they encouraged the committee members to act on what they felt was right. She said as HIPC members, they were limited in some ways and she thanked M. Ross-Russell for providing the information on the state of PA and NJ's stance on the court decision. T. Dominique encouraged the committee members to vote in the Philadelphia elections on May 16th.

K. Carter asked if they could reach out to other organizations and to other EMA's to create a united response to the court decision. He reasoned that they should stand together because the result of Braidwood v. Becerra had affected the whole country. T. Dominique replied that they could not do that as HIPC members, However, if K. Carter had chosen to participate in another organization that advocates for that specific cause, the HIPC would not stand in his way. A. Williams agreed with T. Dominique and said it was important to vote in the election. He said the HIPC could not influence how the public votes but they could advocate for more people to vote. T. Dominique said it was important that people would vote for people who shared their values because the elected officials could be in office for a decade.

-Prevention Committee Survey-

T. Dominique said they had reviewed the Prevention Committee Survey together as a committee in the last meeting, but she did not allocate enough time for discussion. She asked the committee members to read the responses from the survey again and then request topics that they would like to discuss or have a presentation on in the next meeting. C. Steib asked if they could have more housing information. T. Dominique said there was a housing presentation at the January HIPC meeting. She asked what kind of housing discussion he had wanted. C. Steib said he was not present at that meeting. He said he would revisit the minutes of that meeting and hoped that would answer his questions.

M. Ross-Russell said C. Steib and T. Dominique were both at the EHE meeting last week. She said housing was a prevention issue as well in the meeting. T. Dominique said she asked those questions because she wanted to know how C. Steib wanted the housing discussion to be framed. C. Steib said he did not know yet what the discussion around housing would look like. He said he would review the previous presentation and revisit this topic.

Any Other Business:

None.

Announcements:

C. Steib said there was State HPG town hall in the King of Prussia area at the DoubleTree Hotel concentrating on the collar counties. They were inviting people from Philadelphia on May 17th at 3 p.m. C. Steib said he had information he could send to the committee about the event through email.

M. Ross-Russell asked if the event was virtual for those who could not attend in person. He sent a link to the event to the committee to register for the event.
G. Grannan asked if C. Steib would send transit directions with the informational email. C. Steib said he would send the directions after reaching out to the staff.

Adjournment:

C. Steib called for a motion to adjourn. **Motion:** G. Grannan motioned, and E. Rand seconded to adjourn the Prevention Committee meeting. **Motion passed:** Meeting adjourned at 4:15 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- April 2023 Meeting Agenda
- March 2023 Minutes