HIV Integrated Planning Council of the Philadelphia EMA
Thursday, April 12, 2018
2:00 – 4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Juan Baez, Katelyn Baron, Henry Bennett, Kevin Burns, Michael Cappuccilli, Mark Coleman, Lupe Diaz, Tiffany Dominique, Alan Edelstein, David Gana, Gus Grannan, Sharee Heaven, Peter Houle, George Matthews, Lorett Matus, Nicole Miller, Joseph Roderick, Samuel Romero, Terry Smith-Flores, Clint Steib, Coleman Terrell, Lorrita Wellington, Melvin White, Jacquelyn Whitfield

Excused: Pamela Gorman, La'Seana Jones, Gerry Keys, Christine Quimby, Ann Ricksecker, Adam Thompson

Absent: Johnnie Bradley, Keith Carter, Jen Chapman, Dorothy McBride-Wesley, Jeanette Murdock, James Tarver, Gail Thomas, Leroy Way

Guests: Sylvia Forman, Jeff Funston, Amy Hueber, Ronald Lassiter, Brittany Lee, Joseph Malloy, Ameenah McCann-Woods, Sonney Pelham, Erica Rand, Nicole Risner, Jason Simons, Leah Staub

Staff: Debbie Law, Briana Morgan, Nicole Johns, Stephen Budhu

Call to Order: S. Heaven called the meeting to order at 2:06pm. Those present then introduced themselves.

Approval of Agenda: K. Baron presented the agenda for approval. B. Morgan stated the agenda needed to be amended to add Public Comment section. K. Baron presented the updated agenda for approval. **Motion:** M. Cappuccilli moved, D. Gana seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes: K. Baron presented the March 8, 2018 minutes for approval. **Motion:** J. Whitfield moved, D. Gana seconded to approve the minutes. **Motion Passed:** All in favor.

Public Comment:

J. Malloy greeted the council and stated he wanted to bring up the issues with providers within the EMA. Recently some of Philadelphia's providers have been accused of racial discrimination. These issues have been publicized in the news; however, the HIPC has yet to discuss them. Due to the setting of the HIPC being both providers and consumers, J. Malloy suggested this issue should be put on the HIPC agenda in future. He urged the HIPC to contact some of the executive directors from the providers in question and invite them to attend an upcoming HIPC meeting.

Report of Chair: C. Terrell informed the council the Recipient (AACO) has had follow up meetings with the OHCD about HOPWA funding. In meeting(s) the discussion was centered around looking into the roles of Ryan White medical case managers, specifically how they may overlap with HOPWA housing case managers.

C. Terrell notified the council the Recipient has also contacted the University of California San Francisco about capacity building for data to care initiatives. The capacity building will help the Recipient to better understand trends of HIV care linkage. The relationship presents an opportunity to instill new techniques in the Philadelphia Ryan White service system that will help to better serve its clients.

M. White asked how the rate of HIV infection in Philadelphia compares to other large cities in America. C. Terrell replied Philadelphia still has a high rate of new HIV infection compared to New York and San

Francisco, but those cities have different resources available than that of Philadelphia. Philadelphia has made great strides in combating its HIV epidemic.

Report of Staff: None

Special Presentation: Foodbank Service Category— *Ameenah McCann-Woods, AACO*

A. McCann-Woods mentioned this presentation was in response to the request made by the HIPC in their January 2018 meeting to have a presentation that explained the food bank service category.

Within the presentation A. McCann-Woods stated she would review policy clarification notice 16-02, review the eligibility for Ryan White services, describe what the food bank/home-delivered meals category is, the implementation in the EMA, and how the service category is monitored.

A. McCann-Woods briefly reviewed the 9 counties within the EMA: Bucks, Chester, Delaware, Montgomery, Philadelphia, Burlington, Camden, Gloucester, and Salem. After brief review of the EMA counties A. McCann-Woods discussed policy clarification notice 16-02 (PCN 16-02). PCN 16-02 was issued by HRSA and it replaced PCN 10-02 on 3/1/2017. It provides clarification on:

- Eligible Individuals
- Service Category Descriptions and Program Guidance
- Allowable/Unallowable Uses of Funds

A. McCann-Woods reminded the council Ryan White is the payer of last resort and it will only cover services that are not covered by insurance or other funding avenues. To receive Ryan White funding clients must be screened to determine their eligibility.

These Ryan White certifications are required to determine their eligibility:

- Clients must be screened to determine eligibility for Ryan White services within a predetermined timeframe (30 days)
- Clients must be reassessed every 6 months to determine continued eligibility
- Once a client is certified, it is valid for every Ryan White funded service they receive during the time period of the certification
- If a person is not certified or is not certifiable they can NOT continue to receive Ryan White funded services.

Eligibility requirements for Ryan White services are as follows:

- HIV diagnosis (diagnosis is not collected again other criteria need to be provided every 6 months)
- Identity
- Residency within the EMA
- Insurance
- Income

G. Grannan asked how residency is assessed for those who are homeless. A. McCann-Woods replied persons who are homeless can state that on their application for services.

G. Grannan asked how much overhead does HRSA allow for administrative costs for the service category. A. McCann-Woods replied 10%. T. Dominique asked if clients may access Ryan White services, specifically the food bank, after they have received a positive HIV test, but before they have

been screened for other eligibility. A. McCann-Woods replied, yes, after a positive HIV test they can access the food bank, clients just have 30 days to get their certifications.

A. McCann-Woods reviewed the service definition for the food bank/home-delivered meal service category. The service category funds food items, hot meals, and/or voucher program to purchase food. Some essential non-food items are funded as well including: personal hygiene products, household cleaning supplies, and water filtration or purification systems. The service category does not fund: household appliances, pet foods, and other non-essential products. The food bank is a supportive service category intended to lessen food insecurity for PLWH who are Ryan White clients. The service category is not designed to alleviate all food issues within the Philadelphia EMA.

A. McCann-Woods reviewed the budget within each region for the food bank service category. Philadelphia: $204,980, PA Counties: $64,588, NJ Counties: $54,394, EMA total of $323,962. K. Baron asked why Philadelphia has a disproportionately higher budget than the other regions. A. McCann-Woods replied Philadelphia makes up around 70% of the HIV epidemic so funding is proportionate to the epidemic.

A. McCann-Woods explained the Recipient reviews units of food distributed by its sub-recipients. For home-delivered meals 1 unit equals 1 meal, the same goes for congregate meals, food vouchers and the food bank. L. Diaz asked how many units one entity can receive. A. McCann-Woods replied it is proportional to the funding and the number of clients that providers serve. Generally all providers require a referral from a medical case manager to access food services at that agency. Providers often cap clients with how many units a client may receive either on a monthly or yearly basis. The cap is designed to ensure the maximum number of clients are able to have access to food services. For individuals in emergency situations PHMC runs an Emergency Food Voucher Program. It is not meant to supplement client income. This is a last resort service. M. Cappuccilli asked if PHMC received federal money for the food bank service category. C. Terrell replied no, the food bank funds are still received by the Recipient. In the case of PHMC they purchase food vouchers and distribute them. PHMC has oversight of the food voucher program in the 9-county EMA. The Recipient has 8 subrecipients for the food bank service category. J. Malloy asked if PHMC takes into consideration that Philadelphia is the poorest major city when making food voucher decisions. A. McCann-Woods replied the food bank voucher system was not designed to service all clients and subrecipients do have eligibility criteria and limits for the amount one client can receive. These limits are in place to make sure most of the people who need food vouchers are able to receive them.

T. Smith-Flores asked about the under spending in the food service category in South Jersey. She asked are case managers aware of the food voucher program and it is properly advertised. She stated in some cases providers discriminate who is eligible for vouchers. A. McCann-Woods replied the distribution of vouchers is at the discretion of subrecipients, as mentioned many subrecipients have eligibility requirements for food bank vouchers. In the case of the South Jersey EMA counties the question is, are procedures being properly followed so eligible clients receive food services.

PHMC's emergency food bank voucher program is meant to assist individuals in emergency situations. The program is not meant to supplement the client's income nor is it an entitlement. Clients can use these resources as a last resort after accessing other community food programs. The program requires that any eligible person who applies for emergency food assistance do so through an AACO funded agency. To be eligible for the emergency food voucher program:

- Must have a household income of $58,350 or less per year

- Household may consist of client and if applicable their children younger than 18 years old and other disabled family members older than 18 years old

For those eligible for the program, clients will be able to use the program up 3 times per year, $300/year cap for individuals and income scale is used for families.

A. McCann-Woods reviewed the monitoring procedure by the Recipient. The Recipient tracks provider performance and reviews their processes. In the case of underspending the Recipient follows up with the agency to see what the issue is; e.g., staffing issues. Providers often buy food in bulk at the beginning of the fiscal year therefore spending may not be steady throughout the year, but it will level out towards fiscal year end. The Recipient tracks spending and presents underspending quarterly to the Finance Committee. If there is consistent underspending in a particular service category or region the Recipient may present a reallocation request to the Finance Committee.

Action Items:

- **Bylaws Language and Processes**

B. Morgan stated this action item comes from the Executive Committee, the purpose of this was for the HIPC to formally review and approve updated language and changes to its processes.

B. Morgan asked the council to review the golden rod form: Grievance Procedures handout. She explained the changes were language based, specifically description of the people living with HIV. Changes that were made are in strikethrough font. She added the pink form was the Grievance form itself and it coincided with the grievances procedures. Besides the Grievances Procedures other handouts had minor changes, and in some cases only one change to language. Language changes included: Ryan White Planning Council to HIV Integrated Planning Council, and PLWHA to PLWH.

J. Malloy asked if the HIPC have the authority to discuss large scale HIV issues, like large scale ASO activities. B. Morgan replied she does not speak on the behalf of the HIPC, but she will say within the bylaws the HIPC can discuss issues as they relate to PLWH, but not specific ASOs.

T. Dominique asked if the reallocation process no longer had the submission of the 10% increase budget. B. Morgan replied the process no longer includes the 10% increase submission, that procedure could be updated by committee vote if HRSA accepted a 10% increase budget in the future.

Motion: The Executive Committee moved, **Vote:** 18 in favor, 0 opposed, 3 abstentions. **Motion Passed**.

Discussion Items:

- **Epi Profile**

B. Morgan explained she would be doing a brief review of the epi profile, the full document is about 400 pages. The epi profile is a compilation of various data sources that include: U.S. Census Bureau, CDC, SAMHSA, foundations, state & local agencies, and health departments.

B. Morgan stated the first section of the epi profile is demographics and she shared some of the demographics within the profile with the council. Within the EMA there are 5.4 million people currently and 1.8 million live in Philadelphia according to the US Census Bureau. Salem county has the smallest population within the EMA at 64,000. 63% of people within the EMA are white, non-Hispanic, 20% identify as black, non-Hispanic, 6% identify as Asian, and 2% identify as multiracial. After review of the demographics of the entire EMA, B. Morgan reviewed demographics within the three EMA regions:

Philadelphia, South Jersey, and the PA counties. In Philadelphia, 42% of the population identify as black, 35% identify as white, 14% identify as Hispanic, 7% identify as Asian, and 2% identify as multiracial. In the South Jersey Counties, 67% identify as white, 15% black, 10% identify as Hispanic, 5% as Asian and 2% as multiracial. In the PA Counties, 78% identified as white, 9% identified as black, 5% identify as Hispanic, 6% Asian, 2% multiracial.

Following the review of race/ethnicity within the regions B. Morgan reviewed the poverty rate in each region. In Philadelphia 26% of individuals are living below the poverty line, in the NJ counties 11%, and PA counties 13%. Montgomery County had the lowest percentage of people living below the poverty line at 7%.

B. Morgan reviewed the poverty rate by the education rate within the EMA. Of those who had less than a high school degree, 19% of males and 24% of females were living in poverty. Of those who had a high school degree or equivalent, 9% of males and 13% of females were living in poverty. Of those who had some college education, 6% of males and 9% of females were living in poverty. Last, of those who had a bachelor's degree or higher, 3% of males and 4% of females were living in poverty.

B. Morgan displayed the median income by EMA region. Philadelphia had the lowest median income out of the all the regions with $34,000 annually, while NJ had the highest with $47,000 annually. In the EMA, Chester County had the highest median salary of $51,000 annually.

B. Morgan concluded the demographic overview with review of the percent uninsured by state. In Pennsylvania, as of 2016, 5% are uninsured, and in New Jersey 8% are uninsured.

After the demographic overview B. Morgan reviewed the second section of the epi profile, risk.

She began with displaying the "Pain Reliever Misuse & Heroin Use in the General Population, 2015 – 2016" chart. In 2016, 4.54% of Americans 18 or older reported misuse of prescription pain killers, within New Jersey 3.87% reported pain killer misuse, and 4.52% reported misuse in Pennsylvania.

For reported heroin use in 2016, 0.36% of Americans 18 or older reported heroin use, in New Jersey 0.55% reported heroin use, and in Pennsylvania 0.47% reported heroin use.

B. Morgan moved group discussion to HIV and STDs within the EMA. From CDC surveillance reports, 1905 people reported ever having an HIV test in the EMA. Of the ages groups that were considered, 35-44 years of age had the highest percentage of males and females reporting ever having an HIV test. In that age category 78% of females reported having an HIV test at some point and 70% of males reported having an HIV test.

B. Morgan presented data from the 2015 Youth Risk Behavior Surveillance (YRBS). Participants were asked if they binge drank in the last 30 days, marijuana use in the past 30 days, cocaine use ever, sniffed glue/inhaled paint, ecstasy use ever, heroin use ever, methamphetamines use ever, RX drugs without RX ever, injection drugs ever, and offered drugs on school property ever. Out of all the categories responses were highest for marijuana use in the past 30 days (21.60%) and offered drugs on school property (26.10%).

B. Morgan reviewed the number of STD cases in Philadelphia. In 2016 there were 15,580 STD cases, with the majority (7,524) being Chlamydia. Number of reported cases has risen each year from 2010 to 2016.

After an overview of the STD cases within the EMA, B. Morgan reviewed HIV statistics. The total number of PLWH in the EMA is 26,752. In Philadelphia there are 19,113 PLWH, in NJ counties there

3,350, and in the PA counties there are 4,289 PLWH. Of all PLWH within the EMA, 71% were male, 28% female, and 1% transgender. She made note that the PDPH is actively collecting HIV surveillance data about transgender individuals so the number may increase. 58% of all PLWH identify as black, 23% identify as white, 15% identify as Hispanic and 4% identify as other. Those aged 50 or older make up the majority of the epidemic at 52%, and most common transmission mode is MSM at 37%.

B. Morgan concluded her presentation and added the full epi profile will include the following:

- Race/Ethnicity
- Age
- Gender
- Education
- Poverty
- Income
- Languages spoken at home
- General assistance
- Disability
- Cause of death
- Tuberculosis
- Drug & alcohol use
- HIV testing behaviors
- Sex & drug use among high schoolers
- Sexual identity data
- Arrests
- Sexually transmitted infections (STIs)
- Maps with hot spots
- HIV/AIDS
- Newly-diagnosed HIV/AIDS cases
- By gender, race/ethnicity, age, and exposure category
- HIV/AIDS prevalence
- By gender, race/ethnicity, age, and exposure category
- Cumulative HIV/AIDS cases
- By gender, race/ethnicity, age, and exposure category
- HIV/AIDS deaths
- HIV testing
- Including testing location type, gender, race/ethnicity, age, risk category, and test results
- Service utilization
- ADAP client data
- Concurrent HIV/AIDS diagnoses
- Unmet need frameworks

- **Consumer Survey Report**

N. Johns stated copies of the consumer survey report are available online at hivphilly.org, and hard copies are available in the office. She explained she would briefly review the report and its recommendations. In total 2915 surveys were mailed and 392 valid responses were received by the OHP.

N. Johns reviewed the demographics of the survey. Average age of respondents was 54, and 72.2% of respondents were ≥ 50 years old. Only 2.4% were between 18 and 24 years old. Of the respondents roughly two-thirds were male (65.9%), 34.1% female, and 1.3% identified as transgender. 60.1% of respondents reported to have their own smart phone or computer with internet access. Of the respondents the majority were African American (62.1%), while 25.3% were White, 6.3% were Hispanic/Latino, and 6.3% were another race [includes biracial/multiracial]. The majority of respondents reported income between $1-$1000 monthly, and 10% reported no income at all. Almost 62% reported stable housing without voucher assistance (either renting or owning house/apartment), and 0.79% reported not having any type of housing.

After brief demographic review, N. Johns reviewed the co-occurring conditions that were reported in the survey. 19.1% reported having an incarceration history and those who had a previous history of incarceration were more likely to report income less than $1000/month and less likely to have attained higher than a high school education.

N. Johns reviewed other comorbidities reported in the survey. Of the responses, hypertension was the most common at 48.4%, followed by high cholesterol at 30.8%. Other conditions reported: diabetes, nerve issues, liver problems, kidney problems, cardiac problems, and cancer. Mental health disorders were also reported, and the most commonly reported was depression at 51%. Other mental health disorders reported: anxiety, bipolar disorder, schizophrenia/schizoaffective disorder, PTSD, eating disorder, OCD, substance use disorder, and dementia.

N. Johns reviewed Hepatitis C prevalence in the survey. In total, 30% of respondents reported a Hepatitis C diagnosis, of that 30%, 24% reported receiving treatment. Those who reported a Hep-C diagnosis were more likely to report an income lower than $1000/month. Those who reported to have received treatment for their Hep-C diagnosis were more likely to be disabled, retired or unemployed, compared to those who did not have a Hep-C diagnosis, or reported a HEP-C diagnosis that was untreated.

N. Johns reviewed the HIV-related outcomes within the survey. Mean number of years with HIV diagnosis was 16 years, while 10% of the participants having had HIV diagnosis for 1 year or less. 81% reported entering HIV care within 30 days of diagnosis, and 48.9% have had an AIDS diagnosis. Of those who were diagnosed with AIDS, 67.5% received an AIDS diagnosis at the time of their HIV diagnosis. 92.8% of respondents are taking HIV medications while 4.8% reported they were not. 83.3% reported an undetectable viral load.

N. Johns reviewed PLWH outlook on the Ryan White service system. 96.8% have a regular place for HIV care. Only 2 PLWH reported not seeing an HIV medical provider in the last 12 months. 56.6% reported 3 to 5 visits, 24.2% reported 6 or more visits, 11% reported 2 visits and 4.1% reported 1 visit. Overall it appears people are very satisfied with their MCM services. 86.9% said that their HIV medical provider had always taken time to explain their lab results, diagnoses, treatment plans and to answer their questions. 71.2% said that they always feel comfortable talking to their HIV medical provider about personal and sensitive issues.

N. Johns discussed the access to HIV services in the survey. The majority (91.3%) did not experience any access problems, while 8.8% reported not getting the services they needed. Those who reported problems accessing services were more likely to be: younger than mean age (54), race other than White, Hispanic, unemployed, uninsured, or have reported incarceration history. Common barriers to HIV care included: poverty, transportation is unavailable or unreliable (Medicaid transportation was mentioned often), Housing costs, and other health conditions, including mental health (depression, anxiety) make going to appointments and getting out of the house difficult

N. Johns reviewed the sexual behaviors and drug use that were reported in the survey. From responses, 4.3% report having a partner on PrEP and 12.8% reported having a partner HIV+ and on HIV medications. 1.8% reported having an HIV+ partner not on HIV medications. 12% of respondents reported vaginal sex without a condom in the last 12 months and 15.6% of respondents reported anal sex without a condom in the last 12 months. 7.4% of respondents reported using a street drug other than marijuana in the last 12 months. N. Johns noted the survey did not ask what specific drugs were used other than marijuana.

N. Johns concluded her presentation by discussing the recommendations from the consumer survey report. Recommendations were centered around poverty, transportation, homelessness prevention, direct material services, risk assessments, health literacy, incarceration, and prevention in HIV care. The recommendations are as follows:

1. HIPC should ease the burdens of poverty for vulnerable PLWH in the EMA by ensuring access to food, housing, emergency financial assistance, and help with health insurance co-pays and deductibles
2. HIPC and AACO should explore ways for Ryan White Medical transportation to provide transportation for PLWH who experience barriers due to Medicaid or Medicare transportation.
3. HIPC should explore how Ryan White funds can best be leveraged to prevent homelessness and provide housing for PLWH. The HIPC should consider options which include Housing First models, emergency financial assistance, and other interventions to prevent homelessness. Such efforts maybe require reallocating resources and adjusting service priorities.
4. The EMA can help PLWH manage and navigate these common barriers to retention and adherence through direct material services like transitional and short-term housing, food banks and home-delivered meals, alternatives to unreliable transportation like on-demand and ride-sharing services, and financial assistance for health insurance costs like premiums, cost-sharing, and deductibles.
5. RW Providers should use targeted risk assessments to predict which patients are at risk for poor retention. PLWH should receive appropriate supports and interventions before they are lost to care rather than interventions after they have missed appointments or are no longer adherent to ART.
6. Educational campaigns for PLWH to assist with health literacy, access, and adherence to treatment are recommended to help PLWH manage complex treatment.
7. The HIPC should assess access to and the quality of linkage programs and release planning for PLWH who are incarcerated in the EMA's county jails and New Jersey and Pennsylvania state correctional institutions. Recently incarcerated PLWH are vulnerable to falling out of care and having worsened health outcomes. Pre-enrollment in health insurance and other benefits should be a part of release planning for all incarcerated PLWH regardless of correctional institution. The EMA should work with the correctional systems to get needed services and support to PLWH, including telehealth when necessary.
8. At a minimum, our results speak to a need for training and technical assistance about discussing sexuality, STIs and PrEP for Ryan White clinical providers. Further evaluation about how sexuality and sexual risk is addressed by Ryan White clinical providers is required to fully understand training needs and provider-patient interactions.

Report of the Committees:

Comprehensive Planning Committee─ Tiffany Dominque and Adam Thompson, *Co-Chairs*

K. Baron stated when the committee met in March they discussed the HOPWA updates. Also in March the committee continued review of recommendations from their brainstorming activity. Ideas were grouped into red, yellow, and green categories to signify feasibility; e.g., red signifies not feasible at this time. So far, the committee has successfully reviewed the recommendations under the red and yellow categories and are in the process of reviewing ideas under the green category.

Executive Committee- K. Baron stated the committee has not met in April 2018 and has not met since February 2018.

Finance Committee─ Alan Edelstein and David Gana, *Co-Chairs*

A. Edelstein stated the committee did not meet in April 2018 and has no further report.

Needs Assessment Committee─ Gerry Keys, *Chair*

K. Baron stated the Needs Assessment Committee still meets with the Comprehensive Planning Committee.

Nominations Committee─ Kevin Burns and Michael Cappuccilli, *Co-Chairs*

M. Cappuccilli stated in March the committee reviewed 6 HIPC applications, and they decided to recommend 4 applicants for membership appointment by the mayor's office. In the committee's April meeting they discussed inviting current members to participate in discussions about member retention. The last half hour of the Nominations Committee meetings will be for group discussion, all are welcome to attend. Open forums will begin in June 2018 after new member orientation in May 2018.

Positive Committee─ Keith Carter and Jeanette Murdock, *Co- Chairs*

N. Johns stated the committee reviewed the community planning and recruitment strategies in their April meeting. The committee will recruit at the Prevention Summit, and volunteers from the committee will wear stickers that say "Ask me about the Positive Committee".

Prevention Committee─ Lorett Matus and Clint Steib, *Co- Chairs*

L. Matus stated the committee has not yet met in April, but in March 2018 the committee reviewed the integrated plan, and discussed two possible activities to add under strategy 1.2.3 of the plan. The committee also discussed the new Stop Enabling Sex Traffickers Act (SESTA) that has recently been passed into office.

L. Matus stated the committee has also discussed recruiting members from the PrEP work group. The committee suggested having members of the Nominations Committee attend future work group meetings.

Old Business: G. Grannan stated SESTA was signed yesterday, and because of this, websites such as backpage.com, the personal section of Craig's, and sub-Reddits have all been shut down. He reminded the council the language in the bill was vague therefore it was unknown what its future implications could be. K. Baron asked what people can do to advocate against SESTA and if there are any organizations who are staging protests. G. Grannan stated there are organizations who are starting to protest, and he will provide more information as it is made available.

New Business: none

Announcements: D. Gana announced this Saturday, April, 14, 2018 the Elder Initiative is doing a "Care for the Care Givers: Resisting Isolation and Improving Self-Care" work shop.

J. Simmons announced this Saturday, April 14, 2018, Action Wellness is hosting "Dining out for Life 2018: Food Truck Pop Up" from 11:00am- 3:00pm at the 1300 block of Locust Street.

Adjournment: **Motion:** J. Whitfield moved, D. Gana seconded to adjourn the meeting at 3:57 pm. **Motion Passed**: All in favor.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar
- HIPC Bylaws and Procedures