Hybrid: Philadelphia HIV Integrated Planning Council
Meeting Minutes of
Thursday, June 11th, 2026
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia, PA 19107

Present: J. Baez, T. Burroughs (Co-Chair), K. Carter, D. D'Alassandro, N. D'Souza, H. Docmanov, J. Ealy, M. Gordon, E. Harbaugh, S. Heaven (Co-Chair), N. Houston, S. Jacinto, C. Johnson, N. Johnson, A. Leger, J. Lugo, M. Mabou, A. Manley, P. Mukinay, J. Myahwegi, C. Nedev, P. Neumann, A. Onorato, A. Scruggs, S. Smith, E. Thornburg (Co-Chair), S. Wongus, S. Wynne

Excused: S. DiBianca, A. Edelstein, J. Haskins

Guests: Kathleen Brady (DHH), Lupe Diaz, N. Deal (Recommended), K. Fisher (Recommended), Cheryl Henne (PA DOH), Melanie Mercado-Miller (NJ HPG), Alex Wilson (DHH)

Staff: Tiffany Dominique, Elizabeth Fischer, Sofia Moletteri, Kevin Trinh, Kristin Wilson

Call to Order: E. Thornburg called the meeting to order at 2:05 p.m.

Introductions: E. Thornburg asked for introductions. People introduced themselves vocally in the room and through the Zoom chat.

Approval of Agenda:
E. Thornburg referred to the June 2026 HIV Integrated Planning Council (HIPC) agenda and asked for a motion to approve. **Motion:** E. Thornburg motioned; C. Nedev seconded to approve the June 2026 HIPC agenda. Members were asked to vote through a show of hands or through the Zoom poll. **Motion passed:** 18 in favor, 1 abstained. The June 2026 HIPC agenda was approved.

Approval of Minutes (*May 14th, 2026*):
E. Thornburg referred to the May 2026 HIPC meeting minutes and asked for a motion to approve. C. Nedev amended to be excused at the May HIPC meeting. S. Wynne amended to be excused from the May HIPC meeting. E. Harbaugh amended to be excused at the May HIPC meeting. **Motion:** K. Carter motioned; J. Ealy seconded to approve the amended May 2026 HIPC Meeting minutes. Members were asked to vote through a show of hands or through the Zoom poll. **Motion passed:** 15 in favor, 5 abstained. The amended May 2026 HIPC Meeting minutes were approved.

Report of Co-Chairs:
None.

Report of Staff:

S. Moletteri said the Office of HIV Planning (OHP) would be tabling at the HIV Education Summit hosted by Philadelphia FIGHT from 8:30 a.m. to 3:00 p.m. The theme of the event was mental health and wellness. S. Moletteri said members could still register. T. Dominique said OHP staff tabled at the Black Men's Wellness event at Temple on June 6th. She said K. Trinh, L. Fischer, and K. Wilson connected with other public health professionals to collaborate. T. Dominique said on the federal register, there was a call for people interested in being nominated for the Presidential Advisory Council on HIV/ AIDS. She said interested members should check the Federal Register for more information.

S. Moletteri said there would be a HIPC meeting held on June 18th to vote on other action items, including Final Awards Allocations and Priority Settings. A. Leger asked if the Comprehensive Planning Committee (CPC) would still be taking place. S. Moletteri confirmed the CPC meeting would not be taking place on June 18th, but would have a combined meeting with Prevention on June 24th from 2:30 to 4:30 p.m.

T. Dominique said Allocations are coming up in July and told members to expect more information in the following days. S. Moletteri said most of the subcommittee meetings would be cancelled in July due to the allocation process.

Action Items:

~Philadelphia DHH Integrated Plan~

K. Brady introduced herself as the Director of the Division of HIV Health (DHH). K. Brady gave background information on the Integrated HIV Prevention and Care Plan 2027-2031, which was due to CDC and HRSA on June 30th. The Integrated Plan provided a coordinated approach to all HIV prevention and care funding, described goals, objectives, and activities, and addressed focus areas for scaling up efforts to end the epidemic. She said she presented the Goals and Objectives to HIPC in February and made adjustments to the plan based on the HIPC members' feedback. For the Diagnose Pillar, Objective 1, Activity 1.2, K. Brady received feedback asking "How effective is self-HIV testing through telehealth?". She responded that this activity should not be "telehealth", but it should be an existing HIV self-testing program and the plan was updated to reflect this. C. Nedev asked about the linkage to care for individuals who did self-testing, including follow-up processes to ensure people completed the test and received their results. D. D'Alassandro asked if people can receive self-test kits by mail through Philly Keep on Loving (PKOL). K. Brady responded that linkage to care for people who self-test was supported in two main ways. First, partner organizations may follow up with users to help connect them to care and Pre-Exposure Prophylaxis (PrEP) services. Second, the test kits include instructions and resources that guide users to HIV care and prevention services through PKOL and the client services unit. She noted that mail distribution of self-test kits had been available before the pandemic and had greater usage since then. She added that to improve access to HIV testing, they have OraSure rapid tests and INSTI fingerstick tests, though INSTI was not yet available through mail order. She said there was a plan to pilot at-home use of the fingerstick test before starting. T. Dominique asked if the piloting was an example of the novel HIV strategies and if the pilot test would determine whether or not it would become full-fledged. K. Brady said it would expand the reach of HIV testing in the community. She said they have also tried pharmacy-based testing. Ultimately, K. Brady said DHH was trying to increase access points so they can reach people who may not have access to medical care or the HIV prevention system.

K. Brady continued that Objective 3 would be changed to "Implement 1 to 2 novel HIV testing Initiatives by 2031." For Activity 3.1, K. Brady said she received feedback that asked: "What pharmacies are offering HIV testing in which zip code areas?" K. Brady said DHH funds two subrecipient agencies to provide HIV testing in three locations. She said they were awarded through a competitive request for proposal (RFP). One clinic, Sunray Pharmacy, was located in zip codes 19134 and 19139. She said there are no additional funds for any other pharmacies at this time. She said other pharmacies would do HIV testing, such as CVS Pharmacies with Minute Clinics. She said the CVS Pharmacies bill insurance, but Sunray was free.

K. Brady said she received feedback that suggested adding bullets to the Progress Towards National HIV Goals. K. Brady said it was hard to add bullets because there was currently no National HIV Strategy, meaning this statement was a placeholder until there was a new National HIV Strategy.

K. Brady continued that she received a lot of feedback for the Treat Pillar. She said the feedback for Goal 1 was addressed through grammatical revisions. In Activity 1.2, K. Brady gave an example of a low-threshold HIV treatment site, such as Sonic Clinic, which was funded by HRSA HIV dollars. Since it's an End the Epidemic (EHE)-funded clinic, the only eligibility criteria was to be living with HIV. She said low-threshold means the client can just walk in and be seen, making it easier for clients to access care.

C. Nedev asked if K. Brady had information about the funding stream around the physical infrastructure inside facilities. He said many low-barrier treatment sites did good work, but experienced lower-quality care due to the infrastructure (such as having no sink in the lab). K. Brady said there had been renovations around the time of the pandemic for private areas to meet with case managers and counselors. She said there were no issues with the space and they provide high-quality care. She said the Medical Director of the Sana Clinic was Jessica Meisner, who was a Penn physician. C. Nedev said that he had experience at a different clinic and asked about other clinics that were struggling with infrastructure. K. Brady acknowledged that while some sites face challenges, Prevention Point staff were committed to serving the population and were effective in delivering care. She noted that the organization continuously worked to improve services and participates in the RAISE learning collaborative through the University of Washington. She also said they are partnering with Mazzoni to strengthen the low-threshold integrated care model and emphasized that staff are motivated and engaged in ongoing quality improvement efforts. C. Nedev asked about non-Part A clinics that were doing testing and treatment. Since these clinics don't have the capacity for clients, they were sending them to other treatment sites, and those clients are getting lost in that transition. K. Brady said that the strategy to reduce clients being lost during transitions was to connect clients with medical case management immediately at diagnosis. She said there was a city-wide policy that clients were linked to care by 96 hours after diagnosis. D. D'Alassandro requested that people in the room identify themselves when they have questions or comments. K. Brady said there was a website for providers to tell DHH about a patient lost in care and DHH would do outreach and relink them to care. In the Treat Pillar, K. Brady said Activity 1.3 was written vaguely because it was subject to the availability of funding.

In Objective 2, Dr. Brady reported feedback that asked if the objective could be reworded. She said that DHH changed the objective to "Continue to assess the needs of people aging with HIV through 2027; Implement 1 to 2 population-specific strategies by 2028, with a goal to increase and maintain existing viral suppression rates of people aging with HIV by 2031". For Activity 2.1, K. Brady explained that the activity corresponds to the following part of the objective "Continue to assess the needs of people aging with HIV through 2027". She explained this was a new priority area for research, and that the literature would help identify the needs of people aging with HIV that need to be addressed, and potential interventions to address these needs.

For Goal 2, Objective 1, K. Brady explained that the objective means that 95% of people with HIV (PWH) who have been out of care between 2027 and 2031 would be re-engaged in care by 2031. A. Leger asked if there was a way to reword the objective to make the intended meaning clearer. K. Brady said she could change the wording to show the intended meaning such as "Re-engage 95% of people out of care between 2027 and 2031 back into medical care by 2031". J. Lugo asked if re-engage meant people who were previously in care and were no longer in care. K. Brady said they call it engage and reengage and includes people who have never been in care and people who were in care and are no longer in care. To clarify Activity 1.3, K. Brady explained that current funding allocated per medical case management site was insufficient and that funding was a main limiting factor, particularly as overall resources are decreasing. She noted that there had been some underspending and recent changes in specific service category requirements, which had contributed to rebalancing of allocations. As a result, she said they were recommending lower allocations in certain service categories in order to redirect those funds toward medical case management and better support full funding of that system. A. Leger asked if the reallocated funds were being moved from other service categories that have been underspent. K. Brady said non-clinical funded sites received more funding than clinical funded sites for medical case management. She said that being able to move those funds around from other sources to appropriately fund the right number of salaries at those sites.

For Goal 2, Objective 2, K. Brady changed the wording to "Continue to provide housing services to address social and structural influences of health, and to improve engagement in HIV care to 98% by 2031." Objective 3 received feedback noting that it was not a SMART goal and to ensure behavioral health care services include access to therapy, psychiatry services, and co-occurring mental health and substance use care. K. Brady changed Objective 3 to "Continue to provide behavioral health care services to address social and structural influences of health, and to improve engagement in HIV care to 98% by 2031". She noted that "behavioral health" encompasses all mental health services, such as therapy, psychiatric services, and substance use disorders. She said the Department of Behavioral Health and Intellectual Disability Services funds all of those services, as well as Community Behavioral Health, which was the Medicaid component. For Activity 3.1, K. Brady said they wanted to expand telehealth for behavioral health services for PWH. She said there were behavioral health consultants in Ryan White clinics that have more than 350 patients, which was the minimum amount to support a full-time Behavioral Health Consultant. She said if there was additional funding, it could support the activities rather than having it come out of the grant funds.

For Objective 4, K. Brady changed the objective to "Continue to provide supportive services to address social and structural influences of health, and to improve engagement in HIV care to

98% by 2031". For Activity 4.1, "Continue to provide supportive services that reduce individual barriers to engagement in HIV care and treatment", K. Brady clarified that these are Ryan White supportive services for PWH. She said these services help improve access to HIV treatment.

For the Prevention Pillar, Goal 1, Objective 1, K. Brady clarified that this was a progressive goal between 2027 and 2031. She said the goal was to increase the number and percent of people with PrEP indication who were on PrEP to 75% by 2031. She said that was the percent of people that DHH thinks would need to be on PrEP to end the HIV epidemic. S. Moletteri asked what the current percentage of individuals on PrEP is. K. Brady said they get the number of people who were on PrEP through AIDS View. Using those same markers, she said Philadelphia was well over 50% at this point in time. She does not see getting to 75% being an issue because the approval of Lenacapivir had resulted in many more individuals being prescribed PrEP. C. Nedev asked what was being done to market PrEP clinical indicators to clinicians, and noted concerns that many providers do not understand who needs PrEP. K. Brady said their message was that PrEP was for everyone. She said they have Prevention Clinical Associates that go to various clinics such as emergency departments, urgent care sites, primary care sites, obstetrics and gynecology sites, and train providers to do routine opt-out HIV testing in their populations. She said they have a provider action toolkit which includes training modules for these practices depending on their needs such as sexually transmitted infection (STI) testing, HIV testing, Post-Exposure Prophylaxis (PEP), PrEP, linkage to HIV care, and more. She said DHH was focusing on developing campaigns that empower communities to talk to their doctor and advocate for themselves for services they need.

For Activity 1.5, "Increase financial support for PrEP-related routine laboratory services and PrEP adherence services", K. Brady said there were patient assistance programs that provided free medication, but laboratory services and provider visits were typically not covered. She said that there was a need for additional PrEP navigation service, especially in regard to increasing injectable PrEP use. She said DHH was notified of a CDC supplemental opportunity that would provide an additional 2 million dollars for this fiscal year. This would focus on increasing the use of injectable PrEP.

For Objective 2, K. Brady clarified that up to 250 persons was not a goal, but the capacity limit for the objective. She explained that increasing PEP use could lead to fewer exposures. So, if PrEP use and viral suppression were increased, it's expected that there would be fewer non-occupational exposures to HIV. She said the larger goal was that 100% of people who have a need for PEP would be able to get it. A. Leger said K. Brady's explanation was clarifying, but making it clear in the objective wording would be beneficial. K. Brady said she would wordsmith the objective to be clearer.

For Prevent Pillar Goal 2, Objective 1, Activity 1.1, K. Brady explained that DHH has many programs where medical sites, community-based sites, schools, carceral facilities, public health vending machines, and through PKOL's mail order program. This activity specifically targets youth access to condoms.

For the Respond pillar, K. Brady explained she changed the language of Objective 1 to "Maintain, through 2031, a robust core HIV public health data system to identify 100% of outbreaks of HIV".

For the Cross-Cutting pillar, K. Brady clarified that Objective 1 would be measured by statistical significance. For Goal 3, Objective 1, K. Brady changed the language to "Maintain and improve a regional quality management program for HIV prevention and care, and increase the proportion of providers meeting established benchmarks by 20% by 2031". She said the 20% would need to be confirmed by the Information Service Unit and could change, but the structure of the objective would remain the same. K. Brady changed the language of Goal 3, Objective 3 to "Continue to make key performance indicators public for the EMA's HIV prevention and care activities through 2031". K. Brady changed the language of Goal 4, Objective 1 to "Through 2031, conduct strategic community engagement and collaboration with external community partners that increase access to and retention in HIV care and prevention services by at least 20% among priority populations".

K. Brady said the performance measures were corrected. She noted that there were many provider trainings, and aggregated data would be provided to HIPC at a later time. She said determination was sometimes required for funded subrecipients, and many were offered to non-funded agencies and staff. She said part of the work was finding the agencies that need training. K. Brady said cross-cutting was determined by shortening the plan, goals, objectives, and activities from the last Integrated Plan into a cross-cutting pillar.

K. Brady explained that DHH had already had three meetings covering the plan overview and Q&A, a review of goals and objectives, and response to feedback and concurrence. K. Brady read the concurrence article and asked for the HIPC's concurrence with the Integrated HIV Prevention and Care Plan 2027-2031.

S. Moletteri explained that members could vote with concurrence, non-concurrence, or concurrence with reservations. E. Thornburg and T. Burroughs said they want to hear members' thoughts before motioning. There were no further comments.

Motion: K. Carter motioned for concurrence, D. D'Alassandro seconded to concur with the Integrated HIV Prevention and Care Plan 2027-2031 presented by the Philadelphia DHH for approval.

J. Baez: In Concurrence
T. Burroughs: In Concurrence
K. Carter: In Concurrence
D. D'Alassandro: In Concurrence
N. D'Souza: In Concurrence
H. Docmanov: In Concurrence
J. Ealy: In Concurrence
E. Harbaugh: In Concurrence
N. Houston: In Concurrence
S. Jacinto: In Concurrence

C. Johnson: In Concurrence
N. Johnson: In Concurrence
A. Leger: In Concurrence
J. Lugo: In Concurrence
M. Mabou: In Concurrence
A. Manley: In Concurrence
P. Mukinay: In Concurrence
J. Myahwegi: In Concurrence
C. Nedev: In Concurrence
P. Neumann: In Concurrence
A. Onorato: In Concurrence
S. Smith: In Concurrence
E. Thornburg: Abstained
S. Wynne: In Concurrence

Motion Passed: 23 in concurrence, 1 abstained. The Philadelphia HIV Integrated Planning Council concurs with the Integrated HIV Prevention and Care Plan 2027-2031.

~Pennsylvania Integrated Plan~

C. Henne presented the 2027-2031 Integrated HIV Prevention and Care Plan for the Commonwealth of Pennsylvania. She said Section 1 featured the Introduction followed by Section 2: Community Engagement & Planning Process, which includes who was involved, the HIV Planning Group's (HPG) role, subcommittees and work groups, the Special Pharmaceutical Benefits Program (SPBP) Advisory Council, engagement strategies for PWH, the priority settings process, and collaboration. C. Henne said Section 3: Contributing Datasets & Assessments featured the situational analysis and information that was gathered for the point in time. She said the goals and objectives were based on the data in Section 3. She said Section 5 noted the Goals and Objectives, which housed the biggest changes in the Pennsylvania Integrated Plan. In this section, there was a table with every recommendation, priority, and any feedback. She said this table featured the location of the information that was addressed within the plan. She said the actual plan was made into Appendix A, which was not included in the narrative component of the plan. She said this was done to make the document more user-friendly.

C. Henne said Section 6 included the implementation, monitoring, and jurisdictional follow-up. She said this section states how the plan would be implemented and updated in the future. She noted that the Pennsylvania HPG concurred with the Integrated Plan. C. Henne said Appendix A was the work plan that was structured following the pillars. This section listed the goals, strategies, and activities. The activities addressed what the need, gap, or barrier was, the implementation partners, data baseline, and target goals and evaluation metrics. C. Henne noted that not all goals listed were considered SMART Goals. She noted that the Prevention Pillar had 5 strategies and 16 activities, the Diagnose Pillar had 3 strategies and 11 activities, the Treat Pillar had 5 strategies and 13 activities, the Respond Pillar had 3 strategies and 14 activities, and the Support Pillar had 4 strategies and 23 activities. She said all pillars combined have a total of 77 activities in the plan.

C. Henne showed Appendix B, which included a full list of definitions and resource links to relevant background information. She said Appendix C included the collaborators, sorted by the county, funding source, and services provided. She asked for questions and recognized that all members had the opportunity to read through the plan. C. Henne requested concurrence from HIPC for the 2027-2031 Integrated HIV Prevention and Care Plan for the Commonwealth of Pennsylvania.

S. Moletteri thanked C. Henne for consistently joining HIPC meetings to seek feedback and comments from the HIPC members. C. Henne said she hoped the collaboration would continue and expand in the future. She intended to leave insights and suggested continued collaboration to representatives in her division. T. Dominique agreed with S. Moletteri that it was helpful to connect with the PA Department of Health monthly.

Motion: E. Thornburg asked for a motion. K. Carter motioned for concurrence, S. Smith seconded to concur with the 2027-2031 Integrated HIV Prevention and Care Plan for the Commonwealth of Pennsylvania.

J. Baez: In Concurrence
T. Burroughs: In Concurrence
K. Carter: In Concurrence
N. D'Souza: In Concurrence
H. Docmanov: In Concurrence
J. Ealy: In Concurrence
M. Gordon: In Concurrence
E. Harbaugh: In Concurrence
N. Houston: In Concurrence
S. Jacinto: In Concurrence
C. Johnson: In Concurrence
N. Johnson: In Concurrence
A. Leger: In Concurrence
J. Lugo: In Concurrence
M. Mabou: In Concurrence
A. Manley: In Concurrence
P. Mukinay: In Concurrence
J. Myahwegi: In Concurrence
C. Nedev: In Concurrence
P. Neumann: In Concurrence
A. Onorato: In Concurrence
A. Scruggs: In Concurrence
S. Smith: In Concurrence
E. Thornburg: Abstained
S. Wynne: In Concurrence

Motion Passed: 24 in concurrence, 1 abstained. The Philadelphia HIV Integrated Planning Council concurs with the 2027-2031 Integrated HIV Prevention and Care Plan for the Commonwealth of Pennsylvania.

~New Jersey Integrated Plan~

M. Mercado-Miller introduced herself and the New Jersey 2027-2031 Integrated HIV Prevention and Care Plan. She presented the New Jersey HIV Planning Group (NJHPG)'s community-generated, data-driven HIV epidemic response recommendations to the NJ Department of Health Division of Syndemic and Substance Use Services. She noted that they operated under Plan B. She said the NJHPG's main goal was to inform and assist the State's Integrated HIV Prevention and Care Plan with partners from all fields. She said the NJHPG fulfilled that role of planning through the completion of SMARTIE recommendations. M. Mercado-Miller said the NJHPG's values include: Community-centered, decision-making, integrity, accountability and ownership, transparency, and altruism.

M. Mercado-Miller explained the NJHPG structure which included the Executive, Governance, Community Engagement, Strategic Planning, Data and Research, and Priority Setting Committees. She said internal partnerships include the complementary branch of HIV Community Support and Development Initiative (HCSDI) and the Northeast/Caribbean AIDS Education and Training Center (NECA AETC).

M. Mercado-Miller overviewed impacts from 2022-2026 including MY Voice, Our Stories, which was a community-centered storytelling cohort to actively integrate lived experiences directly into system planning. Another was the Universal Database which utilized *Find Help* as the centralized, universal database resource. She also said the Continuing Education Unit (CEU) Tracking and Logistics, which was streamlining CEU tracking for the Ryan White Network, while collaborating with FOCUS and PHD to resolve logistical challenges in implementing requirements for external partners. She also discussed hospital-clinic partnerships which formalized connections between Emergency Rooms and local clinics. She said the NJHPG was currently analyzing results from a recent survey sent to Local Boards of Health (LBOH); findings would be used by NJHPG and NJ Department of Health to determine a coordinated, statewide response. M. Mercado-Miller said the Housing Opportunities for Persons with AIDS (HOPWA) Program Expansion streamlined resource distribution and realigned housing services. Key initiatives included updating maximum rent standards, integrating local Section 8 and HOPWA services, and releasing new funding opportunities to strengthen statewide HIV housing infrastructure. She also said they expanded the number of harm reduction sites from 7 in 2021 to 55 as of September 2025. M. Mercado-Miller noted that the Harm Reduction Center authorization process was regulated in 2023 by establishing standardized applications and corresponding rules. She said there were increased routine HIV testing programs, notably through the Public Health Detailing Project, which engaged 15 primary care and residency practices to advance routine testing and PrEP screening.

M. Mercado-Miller said the NJHPG had completed five focus groups throughout New Jersey and was currently completing analysis from those focus groups. She noted that they are trying to reach Goals focused on community engagement, social determinants of health disparities, integration, workforce development, testing and awareness, linkage and suppression, infection reduction, and cluster detection. M. Mercado-Miller said they planned to include metrics for new diagnosis, knowledge of status, linkage to medical care, viral suppression, PrEP, housing status, and stigma. M. Mercado-Miller gave status updates, including the conducted provider survey,

conducted focus groups, were currently updating the plan and the epidemiological snapshot, and were currently securing letters of concurrence.

M. Mercado-Miller said her team was thankful for the collaboration with the Philadelphia group with town halls and data sharing. She was seeking concurrence for the New Jersey 2027-2031 Integrated HIV Prevention and Care Plan for approval.

E. Thornburg asked for a motion for the New Jersey Integrated Plan.

Motion: E. Thornburg asked for a motion. J. Lugo motioned to concur, A. Leger seconded to concur with the New Jersey 2027-2031 Integrated HIV Prevention and Care Plan for approval.

J. Baez: In Concurrence
T. Burroughs: In Concurrence
K. Carter: In Concurrence
N. D'Souza: In Concurrence
H. Docmanov: In Concurrence
J. Ealy: In Concurrence
E. Harbaugh: In Concurrence
N. Houston: In Concurrence
S. Jacinto: In Concurrence
C. Johnson: In Concurrence
N. Johnson: In Concurrence
A. Leger: In Concurrence
J. Lugo: In Concurrence
M. Mabou: In Concurrence
P. Mukinay: In Concurrence
J. Myahwegi: In Concurrence
C. Nedev: In Concurrence
P. Neumann: In Concurrence
A. Onorato: In Concurrence
S. Smith: In Concurrence
E. Thornburg: Abstained
S. Wynne: In Concurrence

Motion Passed: 21 in concurrence, 1 abstained. The Philadelphia HIV Integrated Planning Council concurs with the New Jersey 2027-2031 Integrated HIV Prevention and Care Plan.

Committee Reports:
~Executive Committee~
None.

~Finance Committee~
K. Carter reported that the Finance Committee voted for the Final Allocation Budget. T. Dominique said HIPC would vote on the budget at the HIPC meeting on June 18th.

~Nominations Committee~
J. Baez reported that the Nomination Committee did not meet this week in place of the New Member Orientation. T. Dominique said 16 new members attended the Orientation. S. Moletteri thanked those members in attendance for joining.

~Positive Committee~
K.C. reported the Poz Committee would meet on Tuesday, June 16th. The Positive Women's Network would be presenting at this meeting.

~Comprehensive Planning Committee~
S. Wynne reported that they would meet together with the Prevention Committee on June 24th. S. Wynne announced that they would be voting on the Priority Setting at the June 18th HIPC meeting.

~Prevention Committee~
J. Ealy reported that on June 1st, D. Surplus had resigned from HIPC, and the committee was looking for a co-chair. The combined CPC/Prevention Committee meeting would receive a presentation from Merck on their latest HIV treatment drug, IDVYNSO.

Other Business:
K. Trinh requested members fill out the HIPC Survey, which would be sent in the chat or through email to members in-person. He said the feedback would help improve the HIPC meetings. E. Thornburg reiterated that people should follow the link to fill out feedback before the meeting ends.

Announcements:
None.

Adjournment:
E. Thornburg called for a motion to adjourn. **Motion:** T. Burroughs motioned, K. Carter seconded to adjourn the June 2026 HIPC meeting. **Motion passed:** Meeting adjourned at 4:07 p.m.

Respectfully submitted,

Elizabeth Fischer, staff

Handouts distributed at the meeting:
- June 2026 HIPC Agenda
- May 2026 HIPC Committee Meeting Minutes