VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, February 11, 2021
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Michael Cappuccilli, Keith Carter, Mark Coleman, Lupe Diaz (Co-Chair), Alan Edelstein, Dave Gana, Gus Grannan, Pamela Gorman, Sharee Heaven (Co-Chair), Gerry Keys, Kailah King-Collins, Marilyn Martinez, Lorett Matus, Sam Romero, Evan Thornburg (Co-Chair)

Guests: Ebony Boswell, Jazzmin Boyd, Janielle Bryan, Debra D'Alessandro, Tira Faison, Mike Frederick, Meghan Gannon, Krista Hein, Loriel Johnson, Ameenah McCann-Woods (AACO), Luis Otano, Desiree Surplus, Evelyn Torres (AACO), Michael Valentin, Adam Williams, Javontae Williams (AACO)

Staff: Beth Celeste, Debbie Law, Nicole Johns, Mari Ross-Russell, Sofia Moletteri, Julia Henrikson

Call to Order: S. Heaven called the meeting to order at 2:04 p.m.

Introductions: S. Heaven asked everyone to introduce themselves via the Zoom chatbox.

Approval of Agenda: S. Heaven referred to the February 2021 HIPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, G. Grannan seconded to approve the February 2021 Planning Council agenda. **Motion passed:** 66% in favor, 33% abstaining.

Approval of Minutes (*January 14, 2020*)
S. Heaven referred to the January 2021 HIPC minutes S. Moletteri distributed via email. S. Heaven asked for a motion to approve the January 2021 minutes. **Motion:** K. Carter motioned, P. Gorman seconded to approve the January 2021 meeting minutes via a Zoom poll. **Motion passed:** 72% in favor, 25% abstaining.

Report of Co-Chairs:
No report.

Report of Staff:
No report.

—Roles and Responsibilities—

M. Ross-Russell reported that they would discuss HIPC roles and responsibilities. This would be especially helpful for new members, future allocations, and understanding HIPC processes.

M. Ross-Russell directed attention to page 14 of the Planning Council Primer which was updated in 2018. This page outlined the roles and responsibilities for the three following entities: CEO (mayor), recipient (AACO) as designated by the CEO to carry out grant functions, and the Planning Body. She noted that the roles and responsibilities in the primer could be found on the HRSA website.

M. Ross-Russell reviewed the checklist of responsibilities which can be seen below:

ROLES / DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Body
Establish Planning Council/Body	✓		
Appointment of Planning Council/Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocation			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	*Optional*
Development of Services Standards		✓	✓
Clinical Quality Management		✓	*Contributes but not responsible*
Assessment of Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

M. Ross-Russell clarified that the "Needs Assessment" category includes focus groups, surveys, literature reviews, etc. that HIPC and OHP worked on. HIPC's needs assessments were especially useful for priority setting and allocation preparations since such processes must be based on documented need. AACO has also created needs assessments and surveys.

For the "Comprehensive Planning" category, HRSA issues a guidance around the community plan. In this instance, she noted, the Integrated Plan would be ending in fall of 2021. She added that there was also the addition of the EHE plan. Both plan guidances came from HRSA, HAB, and the CDC with the documents to be completed by both HIPC and AACO.

The Priority Setting process involved HIPC reviewing all service categories and prioritizing them based on criteria developed by the Planning Body with OHP staff. The bylaws, she noted, mandated that Priority Setting be conducted every three years or less. She added that this was an objective and subjective process developed by the council.

Resource Allocation, she noted, was a legislatively mandated process, and allocations were carried out annually every summer for submission with the application.

As part of Allocations, there were also directives which were instructions from HIPC to the recipient. These directives for the recipient could contain instructions for specific populations (e.g. PWID, MSM, etc.), specific service categories, or geographic areas.

Procurement of Services, she explained, was a reference to the contracting process. HIPC was not involved with the contracting process. HIPC dealt with allocations but not subcontractors. Procurement of Services and Contract Monitoring were both AACO responsibilities. Evaluation of Services was also a recipient responsibility. However, if HIPC were involved with this portion, it would be through a needs assessment activity.

Development of Service Standards, she noted, was part of the procurement process with which HIPC was not involved. However, HIPC could choose to be involved with this in the future. For Clinical Quality Management, HIPC received presentations from AACO and provided feedback, but otherwise, this was a recipient responsibility.

Assessment of Efficiency of the Administrative Mechanism was a HIPC responsibility. This meant that they would assess how rapidly the recipient distributes funds once AACO receives the grant award and ensure the funding gets to providers for the continuation of service delivery.

Planning Council operations and support was a joint responsibility between the recipient and HIPC. She explained that the Office of HIV Planning acted as Planning Council support.

M. Ross-Russell concluded the overview on roles and responsibilities.

There were no questions from the council.

Public Comment:
None.

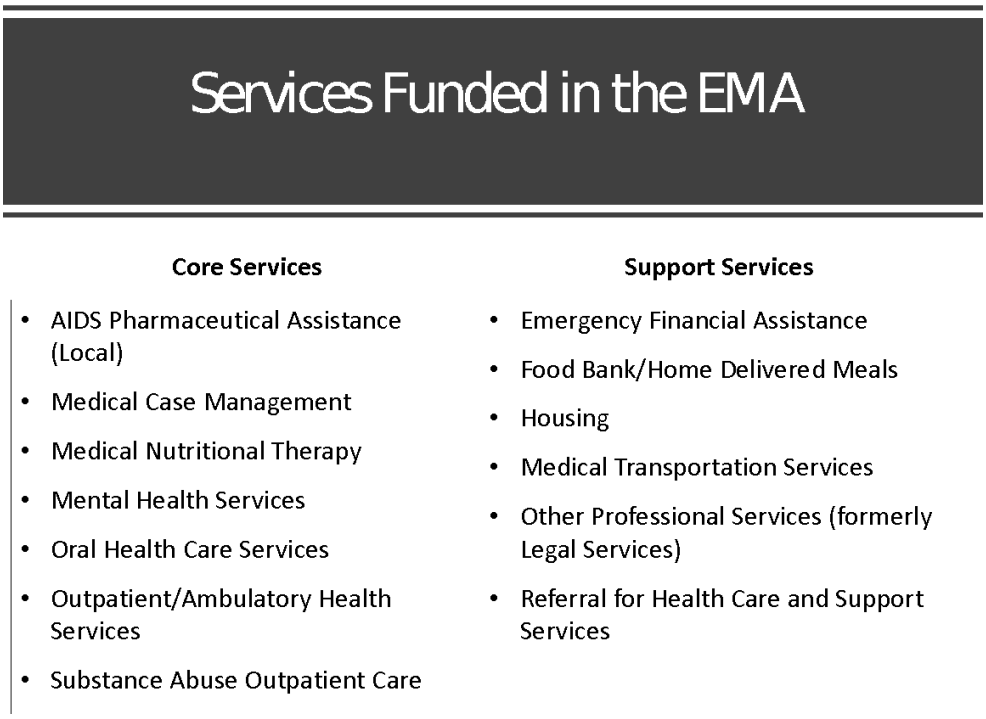
Presentations:

—Review of Service Categories—

A. McCann-Woods wished everyone a good afternoon and introduced herself as the Health Program Analysis Supervisor for AACO. She explained that she would be presenting on the services categories under RWHAP Part A. The purpose of this presentation was to offer useful information for future allocations decisions. This would also offer a deeper understanding of RWHAP Part A service definitions and data.

A. McCann-Woods explained that per HRSA Standards and Guidelines, all clients who engaged in Ryan White care services (core and supportive) must be: an individual living with HIV and Ryan White eligible and certified every six months. Ryan White, she added, was the payer of last resort.

She listed all of the service categories funded throughout the EMA, Philadelphia County, its surrounding PA, and Southern NJ Counties. She listed the following services:



A. McCann-Woods noted that each slide would contain the service category, an example of the service, limitations, and considerations. She started with the core services.

She read the AIDS-Pharmaceutical slide. This service includes the local pharmaceutical assistance program and supplemental means of providing medication assistance. She gave an "on the ground" example: "An HIV-positive individual goes to a Philadelphia City Health Center and does not have health insurance. These funds will allow this patient to receive their prescriptions

(30-day fill) until their insurance status is changed." As for limitations/considerations, she noted that this category could not be used for Emergency Financial Assistance. She added that ADAP funds could not be used for LPAP support (only RWHAP Part A grant award or Part B base award funds).

She read the Medical Case Management slide. This service was client-centered and focused on improving health outcomes in support of the HIV care continuum. Medical Case Managers met with their clients face to face, via the telephone, and other acceptable means regularly to provide referrals to ancillary services such as: food, housing assistance, obtaining birth certificates, etc. She gave an "on the ground" example: "A new client meets with their new MCM. After completing their assessment and plan, it has been identified the client needs a referral for food. The MCM provides the food voucher." As for limitations/considerations, she noted that the client must complete an intake with the Health Information Hotline at 215-985-2437 to connect to a medical case management agency of their choice.

She read the Medical Nutritional Therapy slide. This service included: nutrition assessment, screening, and evaluation; food and nutritional supplements; nutrition education and counseling; and occurred in individual or group settings. She offered an "on the ground" example: "A doctor reviews their patient's bloodwork and finds that they have high cholesterol. The doctor refers their patient to the medical nutritionist on site. The patient agrees to meet with the nutritionist to work on a plan to lower their cholesterol over the next six months." As for limitations/considerations, she noted that the medical provider must refer clients and that the nutritional plan was developed by a registered dietitian or other licensed nutrition professional

She read the Mental Health slide. This service provided outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services. It could occur within an outpatient group or individual session. It may also include Behavioral Health Consultants located in RW Part A funded medical facilities (advises physicians and provides short-term counseling). She offered an "on the ground" example: "A client may be referred to Mental Health services by any Ryan White provider. Said client may have expressed they are dealing with symptoms of depression or anxiety." As for limitations/considerations, she noted that this service must be provided by a licensed mental health professional.

She read the Oral Health Care slide. This service covered outpatient diagnostic, preventive, and therapeutic services provided by dental health care professionals. She offered an "on the ground" example: "An individual has a tooth ache and goes to a RW Part A dental clinic for help."

She read the Outpatient/Ambulatory Health slide. This service included Outpatient diagnostic /therapeutic services, was provided by licensed healthcare providers, and was consistent with the Public Health Service's guidelines. She offered an "on the ground" example: "An individual may report they have not seen a doctor in over one year. Their medical case manager will refer and link them to a medical provider of their choice to re-engage in medical care. The individual can also seek medical care on their own."

She read the Substance Abuse* Outpatient Care. This service involved outpatient services to treat drug or alcohol use disorders, including screening, assessment, diagnosis and/or treatment,

and may include syringe access services if allowed by current law and applicable HHS guidance. She offered an "on the ground" example: "A client reports to their MCM that they relapsed over the weekend and is interested in counseling services. The MCM refers their client to an outpatient program for an intake." As for limitations/considerations, she noted that this service included a credentialing process to onboard counselors and therapist which is a cumbersome process that may lead to delayed intakes. She added that this service was dictated by HRSA and that they were limited in service distribution.

A. McCann-Woods moved onto the support service slides.

She read the support service slide, Emergency Financial Assistance (EFA). She said that this service was limited to one-time or short-term payments for essential utilities and medications (Emergency Medications Program). She offered an "on the ground" example: "A client reports to their MCM that they received a shut-off notice from PECO. The MCM completes and submits a DEFA application for financial assistance." As for limitations/considerations, the service was a direct payment to the agency/vendor (no cash to clients) and was a payer of last resort, and for limited amounts, uses, and periods of time.

She read the Food Bank/Home Delivered Meals slide. This service included food banks, home-delivered meals, and/or food vouchers. It also included essential non-food items such as: personal hygiene products, household cleaning supplies, and water filtration or purification systems. She offered an "on the ground" example: "A client reports to their MCM that their income isn't enough to carry them through the end of the month and allow them to buy food. The MCM will refer the client to a local food bank and the client may be eligible for food vouchers." As for limitations/considerations, the service did not include household appliances, pet foods, and other non-essential products. Additionally, nutritional services and nutritional supplements must be provided by a registered dietitian and are considered Medical Nutrition Therapy, not food bank.

She read the Housing slide. She said that this service was limited short-term assistance (emergency rental assistance through EFA, transitional group residential settings, housing assistance) and must be provided by medical/supportive services OR enable a client to access services. She offered an "on the ground" example: "A client currently sleeps in an emergency shelter and was recently approved for a bed at a local transitional housing facility for 180 days. The client will receive housing support to ensure they are adherent to medical care and work on permanent housing." As for limitations/considerations, new clients must have access to housing services, the service distribution cannot be in the form of direct cash payments, and it cannot be used for mortgage payments. She added that while they could not help with mortgages under Part A, the Division of Housing Community Development (DHCD) could assist with mortgages, oil, and security deposits.

She read the Medical Transportation slide. She explained that this service contained non-emergency transportation services to core medical and support services (SEPTA passes, taxi vouchers, shared rides). She offered an "on the ground" example: "A patient completes their medical visit at the clinic and does not have the fare to go back home on SEPTA. The doctor/nurse will give the patient a SEPTA pass to get home." As for limitations/considerations,

all trips are classified as one-way, and since RWHAP Part A was a payer of last resort, clients must first use LogistiCare.

She read the Other Professional Services slide. She explained that "Legal Services" was now under this category and included assistance with benefits, discrimination because of their HIV status, power of attorney, and living will. She offered an "on the ground" example: "An individual is denied SSI benefits for the 2nd time. He contacts local legal services for a consultation." As for limitations/considerations, she said that legal assistance was not available for criminal cases.

She read the Referral for Health Care and Support Services slide. She said that this was the central point of access for MCM services. AACO staff also provided I/R about other AACO-funded care and prevention programs and handled consumer complaints. She offered an "on the ground" example: "An individual calls AACO's health information hotline for a referral to MCM services. The worker will complete an assessment and refer the client to the appropriate providers. If no openings are available at a particular agency, staff will provide services for the interim period." As for limitations/considerations, referrals provided by OAHS providers were reported under OAHS, and referrals provided by MCMs were reported under MCM. A. McCann-Woods offered the AACO number for MCM access/RWHAP service grievances: (1-800-985-2437).

There were no questions.

—CSU & ISU Presentation—

E. Torres introduced herself as the Program Administrator at AACO. First, she would present what needs were reported by consumers. Then, she would present on nine months of consumer data around services accessed by clients during nine months of the last Ryan White year. Thus far, they only had nine months of data, and the Ryan White year had not yet ended. She explained that this was specifically for Ryan White Part A, but she noted that they also deliver the same type of services to Ryan White Part B rebate dollars. Some services were the same, but others were different or augmented. For example, through RWHAP Part B, linguistics or translation services were funded. This service was not funded under Part A. Parts B and A can to support each other.

E. Torres acknowledged the Division of Community and Housing Development (DCDH) and their coordination and funding for the EFA process. They paid for security deposits, oil, mortgages. This could all be accessed through the same EFA application.

She pointed to the first set of data that identified clients' needs on the slide titled "Gaps in Services as Reported by Consumers 2019, by Percent." She explained that this was all 2019 data. However, the data from the MMP was weighted by the City of Philadelphia from the 2015-2018 MMP cycles. She noted that the CSU data was directly from the AACO Helpline. CSU, she added, also had other responsibilities, such as handling the grievance line. So this information is taken from intake staff does with clients. In 2019, CSU had 2,202 intakes. As for the averaged MMP data, E. Torres explained that this was both a local and national initiative funded by the

CDC. The MMP data works on gathering information from preselected PLWH, including those who are in care. A scripted interview process involves questions around overall health and wellness, satisfaction with medical care, and needs assessment. She explained that participants could choose to opt-out of the process and that the process was monetarily compensated.

She noted that the data presented was in percentages. For example, CSU reported that 30.5% of clients needed Medical Care at intake. Since there were a total of 2,202 intakes, that meant that 671 requested Medical Care. For the MMP around Medical Care, 7.6% or 1,328 people were in need of this service. She did not review the other numbers. These numbers could be reviewed in the distributed PowerPoint.

E. Torres next reviewed support services on the second slide titled "Gaps in Services as Reported by Consumers 2019, by Percent." She explained that when clients reported to CSU, they were mostly in search of MCM. In terms of client grievances, clients had the most issue with transportation, closely followed by housing. 1,028 intakes of the 2,202 total in CSU data reported housing as an issue. Within the MMP data, 13.2% or 2,307 individuals said that housing was an issue. She reiterated that 17,478 clients in total were surveyed for MMP. E. Torres reminded the council that both MCM and Other Professional Services provided Benefits Assistance.

E. Torres next reviewed the slide titled "Service Usage 3/1/20-11/30/20." She explained that this included data on service usage, number of clients, and units, all gathered through ISU to report to HAB/HRSA on an annual basis. When reviewing the data, you could clearly see how many clients were serviced. She explained that "unit" was not the same for every service and would change depending on how a service needed to be measured. For example, for MCM units were by the hour, AIDS-Pharmaceutical Assistance/LPAP was by 30-day prescription, and Oral Health was measured in visits. She added that MAI dollars were included in this data, which funded both MCM and Ambulatory Health Services. She listed all of the data, including "clients served" and "# of units." Please refer to this slide for more information.

E. Torres next reviewed the supportive services data, starting with EFA-Food. She said that EFA-Pharma was recently underspent due to a change from 30-day to 14-day prescriptions. If people needed it, they could still offer an additional 14-day prescription. Overall, people could still use the service with no issue, and the change improved efficiency.

As for Housing Services, there were three categories. The first, Housing Services: Legal, helped with evictions, misunderstands of law, etc. Next, with Transitional Housing, clients could be supported with short-term housing until they could access permanent housing. This initiative was to help keep people housed during this transitional period. Lastly, Rental Assistance was used to help people who were first moving in or behind on rent.

Next, E. Torres looked at Medical Transportation. She explained that this service was captured in "one-way trips," but this did not affect how the service was provided. For example, just because trips are captured "one-way" did not mean that clients could not receive a return ride. Lastly, she looked at Referral for Health Care Supportive Service data. She explained that this internal data had not yet been run.

E. Torres noted that COVID-19 had greatly impacted people's day-to-day lives. For Medical Transportation services, as an example, they served 957 clients and 7,556 one-day trips. However, for pre-COVID data from 3/1/19 – 2/29/20, they served many more clients: 2,545 clients and 36,972 one-day trips.

L. Diaz asked if, as they saw a change in service utilization, were they moving money from underspent categories to services that needed more support? E. Torres answered that if underspending was under 10%, AACO would decide where to move the underspending. M. Ross-Russell agreed, adding that HIPC had not yet received a formal reallocation request. She estimated that they would soon receive this request due to the large amount of underspending in the 3Q Spending Report. She noted that there had been some shifts in money, however. For example, earlier in the year, HIPC approved movement of underspending into Mental Health Services. However, this would be an ongoing process, and within the next Finance Committee meeting, it was possible that they would have a reallocation request.

E. Torres announced AACO was experiencing a transitional period. C. Terrell was now the Acting Director for the Division of Disease Control and was also serving as the Finance Budget Lead for the COVID Vaccine Team at PDPH. K. Brady would be the Acting Director for AACO as a temporary assignment lasting about 3-6 months.

A. McCann-Woods clarified that with the slide Emergency Medication versus LPAP, she said Emergency Medication was a 14-day fill while LPAP was a 30-day fill. E. Torres added that LPAP could not pay for emergency prescriptions and that this had to go through EFA. A. McCann-Woods said that, as an exception, there was one medication under Emergency Assistance that required a 30-day prescription because that was how the medication had to be scripted.

A. Williams asked how they imaged C. Terrell's assignment would impact how they moved forward in terms of their collaborative potentials for fighting HIV and COVID. E. Torres responded that they would have no issue with continuity moving forward because of their great staff and K. Brady's exceptional amount of experience. J. Williams noted that K. Brady had been at the Health Department for 23 years.

Everyone thanked E. Torres and A. McCann-Woods for their presentations.

Presentations:

—Recruitment Ad-Hoc Workgroup—

M. Ross-Russell said that the Ad-Hoc Workgroup had been under discussion for a while now. When discussing Planning Body structure, they looked into their committee meetings, how to deal with moving forward, and how to address issues with recruitment and retention, etc. The conversation around recruitment and retention originally began within Nominations Committee and was occasionally brought up within other committee meetings.

The concern, she explained, was that they did not want to put too much pressure and responsibility on one committee, so Nominations decided to work more heavily on retention and allow HIPC to discuss recruitment further. N. Johns reminded the group that at the last HIPC meeting, C. Steib suggested adding the Recruitment Ad-Hoc Workgroup to February's HIPC agenda. M. Ross-Russell explained that this would be a small workgroup to address recruitment. They could decide to come up with an action plan, pick certain groups to work with, have HIPC members and Poz members assist with training and meet incoming members' needs, etc. There were many possibilities for the workgroup.

As it stands, M. Ross-Russell said HIPC was not in compliance regarding the 1/3 community membership/service consumer representation. They had 1/3 consumer membership, but they did not have the mandated percentage of unaligned consumer members. This meant that these members could not be staff, government, or part of the board of a RWHAP provider.

N. Johns said that the group would be meeting intermittently for a small amount of time. They could discuss the parameters of how the Council would like the workgroup to operate. K. Carter mentioned that the Retention and Recruitment team for the national Planning CHATT LC (Learning Collaborative) would be meeting for the next 5 to 6 months. The LC team could help to come up with a solid plan for the whole Planning Body as well. N. Johns asked K. Carter to give a short description of the LC.

K. Carter said that in November of 2020, Planning CHATT asked for volunteer groups from each national RWHAP Part A Council to work with each other. Together, they would come up with suggestions and solid plans with deadlines and goals. He said that the LC team should also meet with the ad-hoc workgroup to offer helpful feedback and keep communication open. The HIPC team—himself, S. Moletteri, and M. Cappuccilli—already met for a quick discussion before their first LC meeting.

M. Cappuccilli added that the HIPC team discussed the ad-hoc workgroup and decided that, no matter the structure the ad-hoc group decided on, the team's goals are: to assist and answer, or be a part of the workgroup, by bringing information from the national Learning Collaborative. K. Carter said that they were supposed to look at other initiatives, such as Houston's work with LEAP. He suggested that they look at LEAP to see how they could incorporate it into their plan.

M. Ross-Russell said that she went through her older files and found the original LEAP training. The training needed to be reviewed and updated. She agreed that it would be beneficial to get additional input from Poz Committee and HIPC on the LEAP training—they could work on updating and making LEAP useful.

K. Carter made a motion to come up with an ad-hoc committee for recruitment and retention to work in conjunction with the Planning CHATT LC team to develop one plan for recruitment and retention.

M. Cappuccilli noted that recruitment and retention were separate issues. He asked if they wanted to make a recruitment and retention workgroup or just a recruitment workgroup. K. Carter said that these two went hand in hand, so it may be beneficial to include both. D. Law

noted that retention was long-term and recruitment may be a more short-term initiative. M. Ross-Russell asked if they were creating a friendly amendment to the motion. M. Cappuccilli suggested that it was and that they should focus on recruitment. L. Diaz asked if they needed to put a timeframe on the motion or if the timeframe would be decided after the ad-hoc committee was made. N. Johns said that within the motion to form the workgroup, it needed to have a charge. Therefore, it would be wise for formality-sake to include the timeframe and who to report back to within the motion.

K. Carter suggested that July or August of 2021 would be a fair time frame since the LC stopped meeting in June of 2021. N. Johns reminded the group that Allocations was also occurring during August, so September may be more reasonable.

A. Williams asked who could vote on the motion. M. Ross-Russell said that only appointed members could vote. They would vote by roll call .

K. Carter restated the motion.

Motion: K. Cater made a motion to establish an ad-hoc workgroup to strategize recruitment efforts and reach demographic goals and come back with a finalized plan to HIPC by September 2021, J. Baez seconded.

Vote:

L. Matus: in favor
L. Diaz: abstaining
S. Heaven: abstaining
G. Grannan: in favor
E. Thornburg: abstaining
M. Coleman: abstaining
K. Carter: in favor
D. Gana: in favor
M. Cappuccilli: in favor
S. Arrighy: in favor
K. King-Collins: in favor
P. Gorman: in favor
A. Edelstein: in favor
S. Romero: in favor
G. Keys: in favor
M. Martinez: in favor
J. Baez: in favor

Motion passed: 13 in favor, 4 abstaining, 0 opposed

Committee Reports:

—Executive Committee—
No report.

—Finance Committee—
No report.

—Nominations Committee—
S. Romero reported that the Nominations Committee met before this HIPC meeting and focused on council retention and outreach by Nominations members. This discussion included feedback on barriers to attendance, texts for meeting reminders, and personalized outreach. They also discussed the onboarding of members, how to convey the role of the Planning Council, and tools to utilize. They also held an informal pre-orientation for new members. They would meet again next month.

—Positive Committee—
N. Johns reported that she reached out to some Poz Committee members about the meeting they were supposed to have onTuesday. They did not end up meeting then, so they would instead be meeting this coming Tuesday at 7 p.m. She asked those interested to reach out to herself or S. Moletteri with any further questions around this. Poz Committee would also start working with the ad-hoc workgroup.

—Comprehensive Planning Committee—
G. Grannan reported that the committee met last month to discuss the basic charge of CPC and what their next six months or so would look like. They would meet again next Thursday.

—Prevention Committee—
L. Matus reported that the Prevention Committee met last month and continued to look at the EHE. M. Ross-Russell added that they also reviewed DExIS, and N. Johns said that within EHE, they reviewed Pillar 0 and the Situational Analysis.

—Retention and Recruitment LC—
K. Carter reported that this was covered under the earlier action item.

Any Other Business:
L. Diaz asked N. Johns to pull up rules for committee members' etiquette. She reminded everyone that, prior to virtual meetings, people were to call the office if they were running late—now, they should email S. Moletteri if they were running late. L. Diaz said that people should speak with respect to each other and mind the tone that they use. She noted that many of individuals in the Council may have grown up with trauma and that tone can sometimes be triggering. She also asked that members do not share other people's personal information. There should be no personal attacks, and they should focus on issues, not individuals. Attendees should avoid side conversations and cross-talk, so muting was very important within the virtual setting. She asked that people also feel free to ask questions when they need information.

A. Williams noted that to remain inclusive, it was also important to realize that people with disabilities and on the autism spectrum may have difficulty with "tone management."

S. Heaven said that Planning Council meetings were business meetings, but they were also a part of a very diverse family. They needed to be mindful of each other. S. Heaven said that people often need reminders, including herself, of how to most efficiently get work done, especially in this virtual environment.

S. Heaven added that if anyone needed a buddy on the Council, they should find ways to reach out to each other, especially people they knew, for any needed support. M. Ross-Russell said that throughout the process, some people may have questions that they would like to pose to staff. The simplest way to email any staff member, she explained, was the first name of the staff member and @hivphilly.org.

Announcements:

S. Heaven announced that the next virtual meeting for HIPC was scheduled for March 11, 2020.

M. Ross-Russell announced that for new members, their letters were in the mayor's office awaiting signature.

Adjournment:
S. Heaven called for a motion to adjourn. **Motion:** K. Carter motioned, L. Matus seconded to adjourn the February 2021 HIPC meeting. **Motion passed:** Meeting adjourned at 3:42 p.m.

Respectfully submitted,

Sofia Moletteri, staff

Handouts distributed at the meeting:

- February 2021 HIPC Meeting Agenda
- January 2021 HIPC Meeting Minutes