VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, March 11, 2021
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Juan Baez, Elise Borgese, Ebony Boswell, Jazzmin Boyd, Allison Byrd, Mike Cappuccilli, Keith Carter, Lupe Diaz (Co-Chair), Alan Edelstein, David Gana, Meghan Gannon, Gus Grannan, Sharee Heaven (Co-Chair), Gerry Keys, Kate King, Kailah King-Collins, Marilyn Martinez, Lorett Matus, Erica Rand, Sam Romero, Clint Steib, Desiree Surplus, Nicole Swinson, Evan Thornburg (Co-Chair), Adam Williams

Guests: Chris Chu (AACO), Tira Faison, Mike Frederick, Krista Hein, Blake Rowley, Ameenah McCann-Woods (AACO), Luis Otano, Anna Thomas-Ferraioli (AACO), Mike Valentin, Javontae Williams (AACO)

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

Call to Order: E. Thornburg called the meeting to order at 2:04 p.m. She asked everyone to introduce themselves.

Introductions: E. Thornburg also asked everyone who had not already introduced themselves to do so via the chat box.

Approval of Agenda:
E. Thornburg referred to the March 2021 HIPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, L. Matus seconded to approve the March 2021 Planning Council agenda. **Motion passed:** 80% in favor, 20% abstaining.

Approval of Minutes (*February 11, 2020*):
E. Thornburg referred to the February 2021 HIPC minutes S. Moletteri distributed via email. E. Thornburg asked for a motion to approve the February 2021 minutes. **Motion:** K. Carter motioned, D. Gana seconded to approve the February meeting minutes via a Zoom poll. **Motion passed:** 68% in favor, 32% abstaining.

Report of Co-Chairs:

L. Diaz reported that the she was part of the LGBT subcommittee under the state's COVID-19 Equity Commission. They were attempting to become a site for COVID-19 vaccination distribution for LGBTQ individuals and HIV positive patients. The subcommittee noted that there were many individuals hesitant to receive the vaccine due to stigma and fear of outing themselves.

E. Thornburg reported that AACO was awarded an extended $800,000 for the EHE plan and that funding was continuing. She would get more information from Dr. Brady.

Report of Staff:

J. Henrikson reported that new members should have received their appointment letters. D. Surplus said she had received her appointment letter, and M. Gannon confirmed that she had received hers as well. D. Law asked that those who received their appointment letters say so in the Zoom chat box.

J. Henrikson reported that HRSA sent out an update for the Integrated Plan Guidance. The guidance is expected to be released in June 2021, and the expected plan deadline for submission is December 2022.

S. Moletteri reminded everyone that the HIPC Confidentiality forms were sent out via email, and it was intended for HIPC members to keep each other's information confidential. Within the email, she noted that there was also a contact survey. The contact surveys were for OHP staff and asked about preferred contact method for meeting reminders and preferred committee participation. If anyone needed her to resend the email, she asked that they email her at sofia@hivphilly.org.

Public Comment:
None.

Presentations:

—nPEP—

A. Thomas-Ferraioli introduced herself as the EHE Advisor at AACO, noting that she joined the team on December 21, 2020. Previously, she was working at the New York City Department of Health. However, she was originally from Philadelphia and was excited to be back in the city.

A. Thomas-Ferraioli reported that the PEP Centers for Excellence project were directly supporting EHE Pillar 3: Prevent. This pillar dictated that by 2025, 50% of people with a PrEP indication will be prescribed PrEP, and 100% of people seeking nPEP will be prescribed treatment. She read activity 3.1.6. of EHE: Increase awareness and establish a centralized mechanism to distribute PEP through pharmacy partnerships, PEP centers of excellence, and PEP hotline.

A. Thomas-Ferraioli read the "Overview" slide. Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. She noted that program goals included building capacity to prescribe PEP. She noted that goals would be reached regardless of people's insurance status.

She read the "Barriers" slide. Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. She asked if there were barriers unique to Philadelphia. Regarding the "time sensitivity" part when prescribing PEP, she noted that this

could be a barrier. Within ERs, even when people enter ERs with emergent needs, they still have long wait times.

She next read the "PEP Call Center: Primary Goals" slide. Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. A. Thomas-Ferraioli added that if patients were to call after hours in search of PEP, it was their goal that a provider could call a starter pack into a pharmacy so people could immediately start PEP.

A. Thomas-Ferraoli read the "PEP Call Center Flow" slide. Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. The flow chart on top, she explained, represented daytime protocol, and the bottom portion represented nighttime protocol.

She read the slide, "PEP Centers for Excellence Goals" slide. Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. She explained that this list of goals was meant for brick and mortar sites. When building their clinical model, she explained that they had a goal to receive patients on a walk-in basis. The fourth goal—convert all appropriate and eligible participants to PrEP—was an episodic prevention method. During a patient/doctor conversation around PEP, it may become apparent that the patient was a good candidate for PrEP.

A. Thomas-Ferraioli next read the slide titled "Lessons Learned from the NYC PEP Centers for Excellence." Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. She said that C. Alcala managed the centers and was not working in Florida. C. Alcala reported that the centers were very successful in reaching disproportionality impacted communities, meaning that those using the call centers were reflective of epidemic demographics. Most participants in the program, she reported, were MSM who were either Black or Hispanic. Most participants found PEP through social media or the internet, showing that social media was impactful. Regarding the last bullet on the slide, she explained that this highlighted the need for walk-in ability as a way to lower barriers for PEP uptake.

She read the second slide titled "Lessons Learned from the NYC PEP Centers for Excellence." Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information. She explained that the first bullet was an estimate of PEP uptake in Philadelphia based on comparative data between NYC and Philadelphia. Regarding the last bullet on this slide, she explained that follow-up with patients was necessary for HIV testing.

A. Thomas-Ferraioli read the "Discussion Questions" slide. Please refer to *Ending the HIV Epidemic: PEP Centers of Excellence* presentation for more information.

D. Gana asked about the size of the emergency starter pack/how many days the packs were for. A. Thomas-Ferraioli was unsure, though it would give patients enough time to see their care provider in person. She added that they were packaged in a blister pack. K. Carter asked that A. Thomas-Ferraioli report back with an exact answer.

C. Steib said that his organization's ER had successfully partnered with a child protection program to ensure that all individuals reporting sexual assault were offered PEP. Afterwards, they come back to his department to monitor them for two to three days after their ED visit. Furthermore, the patient would be asked to see them again after 28 days. He said that partnerships may be helpful and bring great success. A. Thomas-Ferraioli agreed that partnerships were helpful, and they wanted to have partnerships that reached beyond EDs and to wherever people may request or need PEP.

B. Rowley asked about training for providing PEP. He knew of people who had requested PEP for condom breakage, but were refused PEP within ERs because it was not seen as an emergency. These patients were turned away and told to visit their primary care physicians. He asked if there would be mandatory trainings as well as a list of all "emergencies" that would warrant PEP.

A. Williams noted the following barriers to PEP: languages access on all levels including Rx information, informed consent, etc., and adequate provider training in gender-affirming care.

J. Williams offered to provide more of the insight about questions raised. AACO knew that there were existing gaps, especially with individuals being denied PEP. This called for an intervention with providers which included resources on what to prescribe, who needs it, and when they need it. Unfortunately, this was not yet fully fleshed out. They were only at the start of the PEP conversation and brainstorming how they wanted to outline and plan. AACO already contracted with a few hospital systems who were practicing PEP, so they could look to them while also continuing to close knowledge gaps. AACO knew they needed to institute a robust training program. Currently, AACO did not have this, but knew it was necessary for launching this PEP program. B. Rowley asked them to keep in mind that condom breakage was no different than sexual assault regarding risk present. J. Williams agreed, saying that if people are seeking PEP, they should receive it. C. Steib agreed, noting that refusal of PEP from EDs was not uncommon.

M. Cappuccilli asked if for the large proportion of patients who never returned for PEP follow-up, if NYC model had built in an outreach system. A. Thomas-Ferraioli said that there was no outreach system. They could keep this in mind when building up Philadelphia's program, especially regarding the reengagement component.

K. Carter asked the difference between protocol for PEP versus nPEP. A. Thomas-Ferraioli said that nPEP was nonoccupational PEP, the "n" standing for nonoccupational. She explained that PEP was for providers who experienced needle sticks, etc., and had in-house occupational health teams. The program they were currently focusing on emphasized nonoccupational exposure to HIV. However, even those who had occupational exposure would not be turned away under this program.

G. Grannan asked whether this program accounted for nonoccupational needle sticks as well. A. Thomas-Ferraioli said yes. The program was not limited to sexual exposure and that any exposure applied. G. Grannan said if they were having issues with people not getting access because of condom breakage, it was even more likely that PWID would be turned away. He suggested this be emphasized in any provider trainings.

D. Surplus asked if there were any suggestions on how pharmacists could be more involved with the program. At her pharmacy, she explained, they had certain locations where PrEP was always in stock if someone needed their prescription. A. Thomas-Ferraioli said that in NY, there was a pharmacy partnership with Walgreen Pharmacies. This was important since Walgreens were so ubiquitous within the city. In addition to having NY pharmacy partnerships within the city, they also had others outside of the five boroughs, e.g. Fire Island. Ultimately, pharmacies had an essential role within the program.

T. Faison said that yes, they had seen barriers related to pharmacy stock. Patients would have to wait a day or so for medications to be ordered. A. Thomas-Ferraioli said it was vital to have pharmacies agree to maintain stock in certain locations.

K. Carter asked if there was HRSA or CDC had guidance around PEP medications. K. Hein said that there were PEP guidelines which suggested two PEP regimens. There was one for the patients that had other pre-existing conditions and one for individuals who were otherwise healthy. These guidelines for preferred regiments could possibly be found on the CDC website.

G. Grannan said that some organizations/workplaces had ER agreements and could get individuals fast-tracked. People had to present their identity and organization to get fast-tracked. He said that this program seemed to be working towards a fast-track system as well.

J. Williams said that the preferred PEP regimen for otherwise healthy adults and adolescents was Tenofovir Disoproxil Fumarate (TDF, 300 mg) + Emtricitabine (FTC, 200 mg) once daily plus Raltegravir (RAL, 400 mg) twice daily or Dolutegravir (DTG, 50 mg) once daily.

T. Faison said that the data for Philadelphia showed that individuals were not accessing PEP. She asked more specifics on the data for people receiving PEP, e.g. was it for needle sticks, sexual assault, etc. A. Thomas-Ferraioli said that they needed to look further into PEP uptake data. As of now, their information/data was mostly limited and experiential. In citywide population surveys administered by AACO, they asked how many people had received PEP in the prior year. However, this information was not conclusive since the denominator was unknown, or, in other words, they did not know how many people needed/wanted PEP. She said she could pull more nation-wide data that might be helpful.

K. Hein noted that ACME Pharmacy had select locations in the area that kept nPEP (Tivicay + Truvada OR Isentress + Truvada) and PrEP in stock to help increase access. Their pharmacists were trained to help with billing of medications (copay assistance). She asked individuals to send her an email if they needed more information.

Action Item:

—Reallocation Request—

A. Edelstein said that within the meeting packet from S. Moletteri, there was reallocation request language on page 15. A. Edelstein explained the reallocation request process for individuals new

to the process. Generally, he explained, towards the end of the funding year (FY) there is underspending identified by the recipient. The recipient must ask the Planning Council to approve the reallocation of underspending to continue spending down all allocated dollars. A. Edelstein read the reallocation request language from AACO:

> *The previous contract year 2020-2021 ended on February 28, 2021. The administrative mechanism employed by the HIV Integrated Planning Council has proven very effective in mitigating underspending at the conclusion of the contract year. This request comes before the Finance Committee post the contract period because of administrative delays due to the COVID-19 pandemic. If approved, this administrative mechanism will assist the Recipient in its endeavor to finalize and close contracts.*
>
> *The Recipient is requesting permission to reallocate any remaining underspending to the following direct service categories, including but not limited to:*
> - *Emergency Financial Assistance*
> - *Food Bank/Home Delivered Meals*
> - *Medications*
> - *Oral Health Care*
> - *Medical Transportation Services*

L. Matus noted that the language said "including, but not limited to." She asked about other service possibilities. A. McCann-Woods said that the bulleted service categories were most commonly overspent. However, there could be others, such as MCM and Outpatient Ambulatory Care that could also benefit from underspending funds. However, the five categories listed would directly affect consumers and were not dependent upon staff or benefits-related in any way. The services were directly related to food, medications, labs, consumable office supplies, etc. However, the reallocation request allowed AACO license to distribute underspending to other service categories if needed.

C. Chu said that the five service categories would easily eat up underspending and had identifiable cost that could be applied directly to allocated dollars. A. McCann-Woods added that this included underspending above the 10% threshold. C. Chu noted that underspending went to the aforementioned service categories nearly 100% of the time.

A. Edelstein asked if AACO currently had a projection for underspending. C. Chu responded that last FY, they had about $400,000 underspending and only $7,000 the FY before that. Therefore, underspending could be somewhat unpredictable, especially because of COVID-19's effect on services. A. McCann-Woods added that, typically, the request would come earlier in the FY, but COVID-19 put a hold on some processes.

G. Grannan asked for a rough estimate of the source of underspending. He acknowledge that the data may not yet exist. A. Edelstein also mentioned that HIPC should keep the quarterly spending reports in mind. A. McCann-Woods said they would likely have more accurate information in April.

A. Edelstein said that a lot of underspending was due to vacancies and personnel. C. Chu said that this was especially true during the pandemic. A. McCann-Woods said this was also true at recipient level.

M. Ross-Russell noted that a lot of patients were now using telemedicine. This meant there was a lot less uptake for other service categories, such as transportation. Services provided in person were not operating as they used to which was causing a trickle-down effect. Staffing/hiring via Zoom was also a very different process that could impact the hiring process.

A. Williams asked if it was usual for there not to be an amount applied to each category for reallocation. A. McCann-Woods said this was typical since AACO did not know the full amount at this time in their process.

A. Edelstein asked for a description of the process for once AACO decided which services to put dollars into once they had a full picture of underspending. A. McCann-Woods said that AACO offered quarterly spending reports to offer a picture of how services were being spent above or below the 10% threshold. Secondly, at the recipient level, they understood that there would always be some amount of underspending in their system. Lastly, the five service categories listed, AACO knows, always had a high need and could be spent down. C. Chu added that providers also would report shortages, and would request that they receive any underspending at the end of the year. M. Ross-Russell added that during the course of the year, when Finance Committee meets, the recipient would come to the Finance Committee and present on reallocation requests during the course of the year. Those requests include dollar amounts from the underspending and how much would be moved into the categories which would receive the underspending.

M. Cappuccilli said that as a grant recipient, his past organization had to send in quarterly reports on their progress. Their program analysist would ask them to include what they accomplished as well as any needs that they had. Including needs was especially important so the recipient could reach out to them, knowing they would be able to spend down any extra dollars they could receive.

Motion: A. Edelstein called for a rollcall vote to approve the Ryan White Part A FY 2020-2021 EMA: Reallocation Request as recommended by the Finance Committee.

L. Diaz – abstaining
N. Swinson – abstaining
M. Martinez – in favor
E. Borgese – in favor
E. Thornburg – abstaining
K. King-Collins – in favor
D. Gana – in favor
A. Byrd – in favor
A. Williams – in favor
G. Grannan – in favor

S. Romero – in favor
M. Cappuccilli – in favor
C. Steib – in favor
E. Boswell – in favor
G. Keys – in favor
K. Carter – in favor
A. Edelstein – in favor
K. King – in favor
S. Heaven – abstaining
J. Baez – in favor
L. Matus – in favor
D. D'Alessandro – in favor

Motion passed: 18 in favor, 0 opposed, 4 abstaining.

Discussion:

—Bylaws—

E. Thornburg read the Article IV: Officers of the bylaws. She read the contradicting portion of the bylaws: "At least one Co-Chair (either community or governmental) shall be HIV-positive. It is the goal of the Planning Council that at least one of the elected Co-Chairs is HIV-positive."

D. Gana explained that this was discussed within the Executive Committee and that they had highlighted the two contradicting parts within this bylaw. He explained that HIPC was currently out of compliance with statement 1, as they did not have a HIPC co-chair that was HIV positive. As the Executive Committee was discussing it, they felt it was more of a goal that they have an HIV-positive co-chair. The reason they felt that it should be a goal rather than mandatory, was because the position mandated that the HIV-positive individual be open about their status.

M. Ross-Russell noted that language in goal, pointing out "elected" vs "appointed." The two goals went together since "elected" indicated a community co-chair whereas "appointed" indicated the governmental co-chair. M. Ross-Russell also explained that the bylaws dictate that if bylaw language were to change, there needs to be a 30-day period between initial proposal of the change and the final vote. She said that the next HIPC meeting was 27 days from now, so they could not vote until the May 2021 meeting.

K. Carter clarified that this was not a federal mandate, it was just within the HIPC bylaws and something they practiced as an EMA. M. Ross-Russell said, yes, these bylaws were developed and updated by HIPC over the last 20 years—there have been changes and amendments over the years. She said that the bylaws were the guidelines on HIPC wished to carry out their business.

K. Carter suggested that the "best" individuals should sit up front, especially those who could facilitate large groups. He felt that they should consider who the best person possible for co-chair was whether they were HIV positive or not.

C. Steib added that within Executive Committee, they discussed how co-chairs had to remain impartial. When HIV-positive individuals were co-chairs, that would mean losing the vote of an HIV-positive individual and limit their ability for commentary. D. Gana asked if there were any other opinions on the matter.

D. Gana said that the proposal, for clarity, was to change the bylaws keep the second portion—it is the goal of the Planning Council that at least one of the elected Co-Chairs is HIV-positive—and to remove the first portion. This meant that it was a goal to have an HIV-positive co-chair, but not a hard requirement. K. Carter added that co-chair was a difficult position and obligation, and might be too much stress for someone, especially HIV-positive individuals with other obligations. He said it was still vital that HIV-positive members still speak up and feel represented within the council, however.

A. Williams suggested that they propose the exact language they would change the bylaws to. M. Ross-Russell said the Executive Committee decided to remove the first sentence and keep the second in the highlighted portion of the bylaws within the meeting packet. C. Steib asked that they keep the process in movement by making an official recommendation to change the bylaw language.

G. Grannan proposed that within Article IV: Officers of the bylaws, the sentence "[a]t least one Co-Chair (either community or governmental) shall be HIV-positive" and "the goal of the Planning Council that at least one of the elected Co-Chairs is HIV-positive" be kept, D. Gana seconded.

E. Thornburg said that, as Health Equity Advisor, there was less use of the phrase "people who are HIV-positive" with preference of "PLWH." She asked if they wanted to change "people who are HIV-positive" to "PLWH."

A. Edelstein made a friendly amendment, to change "people who are HIV-positive" to "PLWH" within the HIPC bylaws, D. Gana seconded. G. Grannan accepted the friendly amendment.

—Ad-hoc Recruitment Workgroup—

E. Thornburg brought up the Ad-Hoc Recruitment Workgroup language. Please see the meeting packet for more details.

S. Moletteri explained that this was voted on last month. Though there was a timeline on the workgroup to have something for HIPC by September 2021. None of the other details had yet been fleshed out. They needed to figure out which direction they wanted to go in (population specific, what a recruitment plan would look like, etc.). They could also dive further into this within the Ad-Hoc Recruitment Workgroup meeting, itself. They also needed volunteers to participate within the ad-hoc workgroup.

She noted that she, M. Cappuccilli, and K. Carter were all currently participating in a nationwide Recruitment and Retention Learning Collaborative (LC) with Planning CHATT. Therefore, the three of them planned on participating in the workgroup, though they would not necessarily lead it. They also planned to bring in Poz Committee feedback to assist with the workgroup's input.

S. Moletteri noted that the Retention and Recruitment LC assigned "homework" after each of the monthly meetings. She said that these questions were brought to Poz Committee for specific feedback and ideas around recruitment. The last Retention and Recruitment LC questions involved "marketing" techniques and how to market HIPC. The plan was to bring the questions to the ad-hoc workgroup as well to help with direction but not lead its direction.

M. Cappuccilli explained these three entities would be in open communication. It was yet to be decided when or how the Ad-Hoc Recruitment Workgroup wanted to meet and who it would consist of. K. Carter said that the ad-hoc recruitment would be part of the full HIPC. He explained that they would likely discuss barriers such as the Digital Divide and they were need of everyone's help and input.

K. Carter said that the Ad-Hoc Recruitment Workgroup was to especially help HIPC meet the mandated 1/3 of unaligned consumer members within HIPC.

S. Moletteri asked that people either email her or let her know in the chat if they are interest. L. Diaz, S. Arrighy, A. Williams, and D. Surplus all expressed interest through the Zoom chat box.

M. Ross-Russell said that the first step was to find out who was interested and then set up the timeframe. They would likely meet monthly. M. Cappuccilli asked if the ad-hoc workgroup had to meet with Robert's Rules or if it could practice a more lenient style. M. Ross-Russell said that they do, but realistically, not all committees followed Robert's Rules fully. The ad-hoc workgroup could alter their process slightly. She said that within the bylaws, they mandated a loose interpretation of Robert's Rules and did not follow parliamentarian rules. M. Cappuccilli said that the expectation was that the ad-hoc workgroup could do a brief report as subcommittees do. He said that taking minutes and providing a rough agenda would also be helpful.

Committee Reports:

—Executive Committee—
No report.

—Finance Committee—
No report.

—Nominations Committee—
M. Cappuccilli reported that Nominations Committee discussed orientation for their new, 11 members. He said that D. Law would reach out to new members and encourage them to look at the OHP website resources. M. Cappuccilli said that they also discussed demographics.

D. Law said that there were a couple of questions about the HIPC appointment letters in the chat. The appointment letters were sent out from the Mayor's Office and that OHP had received copies. She asked that those who received letters comment in the chat or email her or S. Moletteri. D. D'Alessandro asked if it would be sent out via USPS. D. Law said yes.

K. Carter asked about demographics. D. Law said they needed more African American/Black members from Philadelphia and 1 or 2 members from PA and NJ counties. They are short in county minority representation. Overall, they needed more unaligned consumer members, as they were currently below their threshold. M. Cappuccilli said they had about 25% unaligned consumer members and needed a third.

—Positive Committee—
S. Moletteri said Poz Committee met on Monday in the evening. They discussed the Recruitment and Retention LC questions all relating to marketing HIPC. They also discussed the digital divide, meeting times, COVID-safe outdoor meetings, a digital resource fair (for tech and other stuff), and refurbishing computers. K. Carter said they also discussed how they wanted to know more about the CARES money and how it was used to help with the digital divide within the city. They were also talking about safe spaces for people to access internet, since people's homes may not always be that space.

—Comprehensive Planning Committee—
G. Grannan reported that they were starting to look at the allocations process and review the data that they had collected. He said that CPC would be busy moving forward, so interested individuals should join. They also discussed the fact that one of the two CPC co-chairs was no longer on the council, so they needed to find a second co-chair. CPC also asked members to start reading through documents provided such as EHE, the Integrated Plan with updates, EPI Data, NHAS, etc.

—Prevention Committee—
C. Steib reported that they met last month and reviewed Goal 3 of the 2021-2025 NHAS plan for recommendations and feedback. They would continue that during their next meeting scheduled for March 24, 2021 at 2:30 p.m.

—Retention and Recruitment LC—
No further report.

Other Business:
M. Ross-Russell reported that there would be a HRSA Site Visit coming up during the last week in April. Some of HIPC would be involved, especially HIPC and subcommittee co-chairs.

C. Steib asked when they, as a body, could meet in person again. M. Ross-Russell said she did not know. Likely, when the city okayed businesses and offices to work in-person, OHP could as well. However, things were everchanging with vaccine rollout and infection rate. OHP would likely work towards hybrid model. She said she would keep everyone updated.

S. Heaven said that as a City employee, she agreed that this was contingent on how well rollout was happening. E. Thornburg said that as someone working on the COVID-19 response, they needed to first reach herd immunity before meeting in person. Within a month, they should be opening new places for vaccine distribution, and with the release of J&J single vaccinations, this could be even quicker. Community acceptance needed to hit a tipping point as well since there was much suspicion/distrust around the vaccine. She encouraged everyone to advocate for hybrid meeting spaces. This would help keep everything accessible.

Announcements:

K. Carter announced that Gilead was having a virtual training institute around stigma and bias, telehealth and barriers to healthcare, ending the epidemic, etc. They would start on March 16, 2021.

D. D'Alessandro said she would send a link to Sofia to share that the Office of Census was hosting Zoom-based training to become a vaccine-champion in your community. They would be offered in Spanish, English, and Mandarin.

E. Thornburg said that there were two Pfizer and Moderna test groups for PLWH. Within the Moderna group, they had 179 PLWH individuals with only one person as part of the placebo group with no differing affects for people who were not cero-converted. She said that the vaccine was perfectly safe for PLWH.

C. Steib announced that the Prevention and Education Summit would be virtual again this year and that they had opened up submissions for webinar workshops that would close on the March 24, 2021. If people wanted to submit proposals for workshops, they should go to the Philadelphia FIGHT website.

Adjournment:
E. Thornburg called for a motion to adjourn. **Motion:** C. Steib motioned, K. Carter seconded to adjourn the March 2021 HIPC meeting. **Motion passed:** Meeting adjourned at 4:11 p.m.

Respectfully submitted,

Sofia Moletteri, staff

Handouts distributed at the meeting:

- March 2021 HIPC Meeting Agenda
- February 2020 HIPC Meeting Minutes
- Ryan White Part A FY 2020-2021 EMA: Reallocation Request
- HIPC Bylaws Article IV: Officers
- Recruitment Ad-Hoc Workgroup Language