Meeting Agenda

VIRTUAL:
Wednesday, September 27th, 2023
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes
  - Comprehensive Planning Committee (August 17th, 2023)
  - Prevention Committee (June 28th, 2023)
- Report of Co-Chairs
- Report of Staff
- Presentation
  - National HIV and Aging Survey
- Discussion Items
  - Prevention Committee Work Plan
  - allocations parking lot
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Comprehensive Planning Committee meeting is
VIRTUAL: Thursday, October 19th, 2023 from 2:00 p.m. – 4:00 p.m.

The next Prevention Committee meeting is
VIRTUAL: Wednesday, October 25th, 2023 from 2:30 p.m. – 4:30 p.m.

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Comprehensive Planning/Prevention Committee

Comprehensive Planning Committee
Meeting Minutes of
Thursday, August 17th, 2023
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: K. Carter, Lupe Diaz, Gus Grannan (Co-chair), Debra Dalessandro (Co-chair)

Guests: Laura Silverman (DHH)

Excused: Gerry Keys

Staff: Beth Celeste, Sofia Moletteri, Tiffany Dominique, Mari Ross-Russell, Kevin Trinh

Call to Order: G. Grannan called the meeting to order at 2:08 pm.

Introductions: G. Grannan asked everyone to introduce themselves.

Approval of Agenda:
G. Grannan referred to the August 2023 CPC agenda and asked for a motion to approve. **Motion:** L. Diaz motioned; D. Dalessandro motioned to approve the August 2023 Comprehensive Planning Committee agenda via a Zoom poll **Motion passed:** 3 in favor. The August 2023 CPC Committee agenda was approved.

Approval of Minutes (*June 15th, 2023*):
G. Grannan referred to the June 2023 Comprehensive Planning Committee minutes. **Motion:** D. D. Dalessandro motioned; G. Grannan seconded to approve the June 2023 Comprehensive Planning Committee meeting minutes via a Zoom poll. **Motion passed:** 2 in favor, 1 abstaining. The June 2023 Comprehensive Planning Committee Minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
M. Ross-Russell recalled that P. Gorman had a question about the National Institutes of Health (NIH) having different criteria or definitions for unmet needs. After the meeting, she researched the topic and found numerous articles. She noted that most of the articles she discovered were either quite dated or originated from foreign countries. M. Ross-Russell then turned to the Kaiser Family Foundation for additional information. She admitted that she couldn't read through all the details due to the abundance of information available. She mentioned that the majority of the definitions she found referred back to the existing definitions from the Department of Health and

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Human Services. She assured the committee that they were still in the process of sorting through this extensive information.

Discussion Items:

–Consumer Survey Write-up and Findings Review–

T. Dominique began her presentation by reporting the findings of the Consumer Survey 2022 results. Using her slide presentation, she turned to a chart depicting information on the Geographic Method and Responses. She explained that the Office of HIV (OHP) had distributed 2500 surveys by mail, with a deliberate effort to include 730 surveys in Spanish, as discussed in previous meetings. Out of the surveys distributed, they received a total of 272 responses. Of these, 114 were mailed responses in English, 7 were mailed responses in Spanish, and 150 responses were completed online in English. T. Dominique mentioned that they had removed two responses during the data-cleaning process.

The graph summarized the survey results by the participants' place of residence. She noted that residents from the Pennsylvania suburbs accounted for only 11% of the responses, despite comprising 20% of the eligible metropolitan area (EMA). New Jersey residents, on the other hand, accounted for 32.7% of the responses, even though they made up 13% of the EMA. Philadelphia residents represented 52.5% of the responses, aligning with their 67% share of the EMA. Additionally, there were 10 responses that did not fit into any specific region, accounting for 3.6% of the total survey responses.

During the discussion, D. Dalesandro had two questions. Her first question pertained to whether living outside the EMA had disqualified their response, to which T. Dominique confirmed that it did. Her second question related to why the chart did not display the number of Spanish online responses. T. Dominique explained that they only revealed the number of responses if it exceeded 6 responses for privacy reasons.

G. Grannan commented on the issue of not disclosing the number of Spanish responses in the New Jersey suburbs, stating that it was not difficult to infer the number using simple math. Both G. Grannan and D. Dalesandro questioned the reasoning behind applying this methodology. D. Dalesandro expressed her desire to meet with a staff member to ask questions and gain a better understanding of the topic.

T. Dominique reiterated that protecting the anonymity of the responders was required by law. M. Ross-Russell added that they took extra precautions because confidentiality laws could be violated if the respondents believed that their privacy or information was breached, regardless of whether their data was actually identifiable.

D. Dalesandro thanked M. Ross-Russell for her explanation and commended the New Jersey counties for their high response rate. She noted that 58% of the responders were sex assigned as male at birth, 41.4% were assigned as female at birth, and 0.6% were not assigned either sex. T. Dominique further pointed out that 70% of women who answered the survey were black, and 41% of men who answered the survey identified as black. In summary, most of the respondents were black, accounting for 54% of the survey responses, while 33% were white, and 16%

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identified themselves as Latinx or Hispanic. Additionally, 11% of respondents identified themselves as belonging to other racial categories.

On the next slide, there was a bar graph comparing Hispanic/Latinx and non-Hispanic respondents by sex at birth. Out of the 36 respondents who identified themselves as Hispanic/Latinx, 63.90% were identified as male at birth, and 36.10% were identified as female at birth. For non-Hispanic/Latinx respondents, 58.90% were identified as male at birth, and 40.50% were identified as female at birth.

T. Dominique then moved to the following slide, which featured a pie chart illustrating the educational attainment of the respondents. According to the chart, 31% of respondents held a high school diploma, 19% had obtained a 2 or 4-year degree, 16% received some high school education but did not graduate, 9% had a Master's degree or doctorate, 6% had received vocational training, and 5% had an 8th-grade level education or less.

D. Dalesandro requested that OHP include the percentages next to the pie chart key for easier readability since she had color blindness and struggled to distinguish between yellow and orange. T. Dominique thanks her for her suggestion.

T. Dominique then reviewed the monthly income data of the respondents. She reported that 11% of respondents had no income for the month, 23.2% had a monthly income of $1,000 or less, 24.6% had a monthly income of $1,001 to $2,000, 18% had a monthly income of $2,001 to $3,000, and 23.2% had an income of $3,001 or greater. T. Dominique reminded the committee that the income portion of the survey relied on self-reported data, which tended to skew towards higher incomes. She mentioned that in the previous survey, 50% of respondents had reported a monthly income of $1,000 or less. She attributed the current findings to the fact that this survey was conducted after the pandemic, suggesting that respondents were now earning more income.

In response to D. Dalesandro's question about the frequency of these surveys, T. Dominique stated that surveys were conducted every 5 years. She then revisited K. Carter's inquiry about how COVID-19 had impacted the respondents. T. Dominique explained that they had included questions related to COVID-19 in the survey. According to the responses, 73% of respondents did not report a change in housing due to COVID-19, 55% did not experience a change in wages, and 83% did not face disruptions in care despite the pandemic. She clarified that one of the survey questions asked whether the respondent had lost more than a week of pay due to COVID-19, and based on this question, 45% of respondents had reported a loss or change in a week of pay.

K. Carter expressed surprise that more people were not gaining income due to the assistance of COVID-19 safety net programs. T. Dominique explained that those programs provided lump-sum payments, whereas the survey question was centered around monthly income. Respondents may have considered their average earnings when responding to the question.

M. Ross-Russell added that the results of the survey were likely influenced by the demographics of the respondents. She noted that previous surveys had more respondents from a wider range of

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age groups. She estimated that over 50% of respondents in this survey were over the age of 50, which had likely impacted the income data.

The next slide featured a pie chart summarizing housing data within the EMA. According to the chart, 65% of respondents either rented or owned their homes. Additionally, 11% of respondents reported staying with family or friends, and 8% mentioned that they lived in public housing or were part of a housing choice voucher program. T. Dominique indicated that they would delve deeper into this topic to identify regional differences, such as a higher likelihood of Philadelphia residents renting or owning their homes compared to other regions.

T. Dominique then provided an overview of the upcoming slides, which would examine demographics by region. These slides would cover information related to employment status, income, housing status, ethnicity, race, and sex at birth. The next slide would contain a chart depicting the survey participants' employment status. T. Dominique noted that the Philadelphia region had more respondents answering this question and that they were more likely to be employed. Conversely, they were also more likely to report a disability compared to other regions. In the Pennsylvania counties, there was a greater number of people with disabilities compared to those who were employed. She acknowledged that the Pennsylvania counties had a smaller number of respondents, which could have influenced the data.

T. Dominique then reviewed participant income data by region and noted significant variance between the regions. She expressed surprise at the higher number of participants in the Pennsylvania counties who reported a monthly income in the $1,000 to $2,000 range, considering the employment data. She concluded that the data appropriately represented income ranges across all regions. Respondents from Philadelphia tended to report monthly incomes in the $1,000 to $2,000 range. Respondents from New Jersey and Pennsylvania counties tended to have monthly incomes in the $1,000 to $2,000 or $3,000 and greater range.

Returning to the topic of housing, T. Dominique reiterated that Philadelphians were more likely to own or rent their homes compared to residents of other regions. Additionally, Philadelphians were more likely to be in various housing categories compared to other regions, including housing for People Living With HIV (PWLH), staying with family or friends, transitional housing, shelter, and other types of housing.

She moved on to review survey data on participants' ethnicity by region. T. Dominique pointed out that there were more non-Hispanic respondents in the survey. She reminded the committee that only 36 individuals who identified as Hispanic/Latinx had responded to the survey. After reviewing the chart, she cautioned that the low number of participants in this group made it challenging to draw generalizations.

T. Dominique proceeded to review survey data on race/ethnicity by region. The chart displayed data on black, white, and other racial categories in the three regions. She clarified that the "other races" category encompassed races such as Native American, Asian, Alaska native, biracial, etc. She noted that there were more white respondents in New Jersey than in the other two regions, while Philadelphia had the highest number of black respondents.

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The committee then proceeded to review data on sex assigned at birth by region. T. Dominique noted that, on average, Philadelphia had the highest number of respondents who had answered this question on the survey. Approximately 30% of respondents in Philadelphia identified as assigned male at birth, while 23% identified as assigned female at birth. In New Jersey, 20.60% of respondents reported being assigned male at birth, and 12.30% reported being assigned female at birth. In the Pennsylvania counties, 8.60% of respondents indicated being assigned male at birth, and 4.80% indicated being assigned female at birth.

The upcoming slides would cover survey information on incarceration, health insurance, COVID-19, telehealth, co-occurring conditions, mental health, and Hepatitis C. T. Dominique mentioned that only 190 respondents had answered the question related to incarceration. Among them, about 40 respondents reported that they had been incarcerated since their HIV diagnosis. These respondents accounted for 20% of those who answered the incarceration-related question. She noted that 22% of the respondents who had been incarcerated were male, compared to 17.9% who were female. Those who had been incarcerated were more likely to report a monthly income of $1,000 or less compared to those without an incarceration history. T. Dominique also pointed out that education levels varied widely regardless of incarceration status.

D. Dalesandro suggested that they should first ask people about their HIV status before inquiring about their incarceration status. She believed it would be valuable to assess the effects of the criminal justice system on this specific population. T. Dominique thanked D. Dalesandro for her suggestion and mentioned that they would consider it in the next survey, with the caveat that they should avoid overburdening respondents with too many questions.

G. Grannan asked for clarification on the number of questions in the survey, to which M. Ross-Russell responded that there were 78 questions in total. She explained that the survey was created through a collaborative process involving input from various committees, beginning in 2021. Once the questions were finalized, the survey was submitted to the Philadelphia Institutional Review Board (IRB) for approval. She also noted that the survey was costly to produce due to expenses related to paper printing, mailing, and creating an online version for 2,500 surveys. S. Moletteri mentioned that some questions related to COVID-19 might become less relevant over time, to which T. Dominique responded that even if they replaced those questions, the survey would still contain numerous multipart questions, making it feel longer than 78 questions.

T. Dominique then reviewed the health insurance data from the Consumer Survey. She reported that 86.9% of respondents had some form of health insurance or medical services coverage. Among them, 35.2% had Medicaid or Medical Assistance, Health Choices, or an ACCESS card, while 22.9% had Medicare. Additionally, 17.8% reported being insured through work or a union, 6.4% through the Affordable Care Act, 9.3% under the Health Partners plans, 4.2% had bought their insurance directly, and 0.4% were insured through Veterans Affairs or military health care. T. Dominique clarified that respondents were allowed to write in the type of insurance they used, and the Consumer Survey reported what the respondent had written.

Regarding the impact of COVID-19, T. Dominique mentioned that 73.5% of respondents did not report any housing changes, while 25.5% reported some housing changes. However, the survey

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did not allow respondents to specify how their housing had changed. In terms of wages, 31.7% of respondents reported losing at least one week of wages or more due to the pandemic, while 55.5% did not indicate any impact on their wages. Similarly, the question about the effect of COVID-19 on wages did not specify the nature of the changes, such as reduced hours or direct wage reductions.

T. Dominique proceeded to review the survey data on COVID-19's impact on care. She noted that 10.5% of respondents admitted to missing doses of HIV medications, while 8.9% missed other essential non-HIV medicines. In contrast, 83.9% did not experience any disruption in their HIV medication doses, and 72% did not miss any medical appointments due to COVID-19.

The next slide featured a chart displaying respondents' access to the internet and their preferred type of medical service. T. Dominique mentioned that she would skip this section of the presentation, as it had already been discussed in detail during previous meetings. She asked if the committee had any questions before moving on, to which K. Carter indicated that he did not have any questions, and the committee did not raise any further queries.

The next question on the survey asked respondents the types of health conditions they had. 39% of respondents had high blood pressure. 30.08% of respondents had high cholesterol. 16.53% of respondents reported having lung or breathing problems. 13.56% of respondents had diabetes. 13.56% of respondents reported having nerve issues. 12.29% of respondents had cardiac problems or heart disease. 9.75% of respondents had cancer. 8.05% of respondents had kidney problems. 7.63% of respondents had liver problems. Less than 6 respondents reported that they did not know the health conditions that they had. 24.58% reported having none of the above health conditions. 8.90% of respondents did not answer the question. T. Dominique said respondents were allowed to choose more than one answer. For example, 93 respondents reported having high blood pressure. These 93 people could have chosen more than one health condition to answer the question.

T. Dominique reviewed the survey results on the question about mental health. 43.64% of respondents reported having depression. 43. 64% of respondents reported having anxiety. 13.14% of respondents reported having Post-Traumatic Stress Disorder. 12.71% of respondents reported having Bipolar Disorder. 10.59% of respondents reported having a mood disorder. 9.75% of respondents reported having a substance use disorder. 5.93% of respondents reported having Obsessive Compulsive Disorder. 4.66% of respondents reported having Schizophrenia/Schizoaffective Disorder. 3.39% of respondents reported having Dementia. Less than 6 respondents reported having an eating disorder. 2.97% of respondents did not know what mental health condition they had. 29.24% of respondents reported that they did not have any of the mental health conditions mentioned above. 8.9% of respondents did not answer the question on the survey. T. Dominique reminded the committee that the respondents were able to choose more than one option. She said they were not able to learn how COVID-19 had affected the respondents in the closed-ended questions. She noted that they were able to recognize the impact of COVID-19 on mental health in the open-ended questions on the survey. Many of the respondents wrote that COVID-19 exacerbated depression and other underlying mental health conditions.

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Following the report on mental health, the committee continued to the Hepatitis section of the presentation. T. Dominique reported that 57.6% of respondents had never been diagnosed with Hepatitis C (HCV). 11.8% of respondents said that they either had HCV or had been treated or cured. 2.1% of respondents had HCV and had not been treated/cured.
T. Dominique gave an overview of the HIV-related Health Outcomes and Service Access section. The survey question would be related to limited access to HIV services in the past 12 months, HIV case management, gynecological service access, self-reported service utilization and unmet service needs, barriers to medical care and other services, and qualitative responses about barriers to care.

The first question in this section asked if the respondent needed HIV medical care in the last 12 months and could not get it. The answer was broken down by sex, race/ethnicity, personal monthly income, and education. T. Dominique said they needed to combine non-binary sex into one category since the sample size was too small. She said they had done the same for race and ethnicity where they collapsed populations that were deemed too small into one category. T. Dominique said only 24 respondents had said they were not able to access HIV medical care and 166 people had said it was not an issue for them. Among the 24 respondents who did have trouble finding services, 45.8% were black, 41.7% were white, 4.2% were biracial, and 8.4% were another race or ethnicity not previously mentioned.

The survey results recorded the self-reported monthly income of the respondents. Among the 24 respondents who had difficulty receiving services, 8.3% had no monthly income, 29.2% had a monthly income of $1,00-$2,000, 20.8% had a monthly income of $2,001 - $3,000, 20.8% had a monthly income of $3,001 - $4,000, 4.2% had a monthly income of $4,001 - $5,000, 0% reported having a monthly income of $5,001 - $6,000, and 12.5% reported having a monthly income of $6,001 or more.

T. Dominique read the data regarding education levels for the 24 respondents who had difficulty receiving HIV medical care. Of the 24 respondents, 4.2% received an eighth-grade education or less. 25% of the 24 respondents received some high school education. 29.2% of the 24 respondents graduated with a high school diploma or GED. 12.5% of the 24 respondents received some college education but did not graduate. 8.3% of the 24 respondents received vocational training certification. 16.7% of the 24 respondents received a 2-year or more college degree. 4.2% of the 24 respondents received a Master's degree or doctorate.

Survey respondents were also asked about their employment status. Among the 24 respondents who had difficulty finding HIV medical care services, 24% were employed full-time. 20% of the 24 respondents were working part-time. 4% of those respondents were self-employed. 8% of those respondents were not employed and were looking for work. Another 8% of the 24 respondents were not employed and not looking for work. 8% of the 24 respondents were retired. 28% of the 24 respondents were disabled. Of the 24 respondents who had difficulty finding HIV medical care, they did not find any respondents who reported being homeless/marginally housed or having no medical insurance.

The next question asked if the respondents had an HIV case manager. Out of 182 responses to this question, 152 respondents answered that they did have an HIV case manager. Of the 152

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respondents who did have a case manager, 55.9% identified themselves as male, 39.5% identified themselves as female, and 0.7% preferred to not answer the question regarding gender. 59.6% of these respondents were black/African American. 28.5% of these 152 respondents were white. 1.3% of the respondents with an HIV case manager were biracial while 10.3% identified themselves as race or ethnicity not mentioned above.

The survey results recorded the self-reported monthly income of the respondents. Among the 152 respondents who had an HIV case manager, 12% had no monthly income, 24.7% had a monthly income of below $1,000, 28.7 had a monthly income of $1,00-$2,000, 14.7% had a monthly income of $2,001-$3,000, 5.3% had a monthly income of $3,001-$4,000, 4% had a monthly income of $4,000-$5,000, 3.3 reported having a monthly income of $5,001-$6,000, and 7.3% reported having a monthly income of $6,001 or more.

T. Dominique read the data regarding education levels for the 152 respondents who reported they had an HIV case manager. Of the 152 respondents, 6.6 received an eighth-grade education or less. 11.8% of the 152 respondents received some high school education. 32.2% of the 152 respondents graduated with a high school diploma or GED. 15.1% of the 152 respondents received some college education but did not graduate. 4.6% of the 152 respondents received vocational training certification. 17.8% of the 152 respondents received a 2-year or more college degree. 8.6% of the 152 respondents received a Masters degree or doctorate. 3.3% of these respondents chose an answer that was not listed.

T. Dominque reviewed the employment information of the 149 respondents who reported that they had an HIV case manager. 30% of respondents reported they were employed full-time. 15% of respondents reported they were working part-time. 1% of respondents reported they were self-employed. 9% reported they were not employed and were seeking work. 7% of respondents said they were not employed and they were not looking for work. Another 7% said they were retired. 30% of the respondents said they were disabled. 1% of respondents did not answer the question.

The committee moved to the question regarding Gynecology. The next question in the survey asked respondents if their primary medical provider had asked them about family planning or birth control. Of those who answered the question, 41 respondents or 36.6% answered “yes” and 71 respondents or 63.3% said “no”. 92 participants were asked if they received gynecological or women’s healthcare at the same place as their other medical care or if they were referred somewhere else. Most respondents said they did get gynecological services at the same place. About 59.7% choose this answer. 30.4% of respondents who answered the question were referred to a different location. Three respondents said their medical provider did not refer them anywhere for gynecological services or take care of their reproductive health. The proceeding question asked respondents when they last received gynecological care. 51.52% answered “in the last 12 months. 25.2% of respondents answered “within 1-2 years” and 8% of respondents said they received services more than 2 years ago.

T. Dominique said they did not ask the question about planning by gender since they recognized that family planning was important and could happen to all genders. D. Dalesandro said there was a key question that was often asked when it came to family. They asked people once per

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year if they planned on becoming a parent in the next year. D, Dalesandro said that Dr. K. Brady had worked hard to persuade Ryan White providers to use gender-neutral terms when asked the question since anyone could become a parent. D. Dalesandro suggested they should include this question in the next survey. M. Ross-Russell said she believed they had a question similar the one D. Dalesandro had referenced. She said the question was about whether the respondent's physician had asked them about family planning. She believed that the question was still in the survey. T. Dominique confirmed that the question was still in the survey. K. Carter said this was a great question place in the survey since it would check if providers were disseminating important public health knowledge to the public. M. Ross-Russell said they had many questions like that in the survey and they were all geared toward prevention. S. Moletteri said they had many discussions about including both gynecological care and women's healthcare. She said they wanted to be more inclusive but they did not want people to be confused about the phrasing of the language. S. Moletteri said they were open to changing the language in the future.

Respondents were asked about their service utilization. Respondents were able to say they used a service within the last 12 months. They could say they needed a service but could not get the service. Another option was replying that they had never heard of the service. The last option was saying that they never needed the service. T. Dominique said they had spent much time reviewing this information during the allocations meetings where the information was broken down by region. She said they were most concerned about people who needed a service but could not receive it as well as services people had never heard of. 8.9% of respondents said they needed legal services but could not get them.

T. Dominique highlighted that 11% of respondents had never heard of housing assistance. 8% of respondents needed a support group and could not find it. T. Dominique found that it was alarming that 10% of respondents had never heard of Direct Emergency Financial Assistance (DEFA). 6.8% of respondents had never heard of treatment adherence services. T. Dominique mentioned that most people receive treatment adherence during their regular care and do not think about it. She said they should not take the percentage number at face value. 5.1% of respondents had never heard of legal services and an additional 4.7% of respondents had never heard of food bank services. K. Carter said that people may also not understand that asking their case manager for rent assistance was using DEFA services. T. Dominique said that they stressed during the allocations meetings the difference between needing and ser but not receiving it and never hearing about a service. She remembered that many constituents in New Jersey had not heard of DEFA.

In the next section, T. Dominique said one of the goals of the survey was to see if there was any correlation between transportation barriers and the type of insurance that respondents had. They found that 38% of respondents who had transportation barriers also reported that they used Medicaid as their insurance. She then said that 23.5% of those with transportation barriers used Medicare as their insurance. She noted that many of the numbers on the chart were suppressed; this had meant there were few people who answered this question.

The survey asked why people were not able to get the services that they needed. T. Dominique said that about 57% of the people replied that they were able to get the services that they needed. For the respondents who were not able to get the services they needed, they answered with a

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variety of reasons. The most frequent reasons for why they were barred from services were difficulty with COVID-19, depression, can't afford co-pay, transportation barriers, no insurance, and lack of knowledge of service locations. T. Dominique concluded that the vast majority of respondents were able to get the services they needed.

T. Dominique first reviewed the demographic information of the respondents. She noted that income distribution men who have sex with men (MSM) of color had equally distributed income among the demographic. T. Dominique said that when she looked at the demographics, she saw that MSM of color were either employed or disabled. She said most MSM of color who responded to the survey had received their high school diploma and some college. She compared this to white MSM. She noted the respondents for high school and below had suppressed numbers while 21 of the 31 white MSM who responded to the survey stated they were college graduates. She noted that the white MSM respondents had a monthly income that generally was either $1,000 - $2,000 or $3,000 or more. She stated that this difference was not found when compared to the income distribution between white women and women of color. She said they would be getting a copy of the presentation so they could pour over the details at their leisure.

The next slide had a chart about harm reduction. T. Dominique said they asked respondents if they were offered information about harm reduction in their medical visits by their primary care physician. 27.5% or 65 respondents reported they were offered condoms and safer sex kits. 18.6% or 44 respondents were offered STD testing including hepatitis C. 11.4% or 27 respondents were offered information on how to tell someone about their HIV status. 11.8% or 28 respondents were offered information on mammograms.

T. Dominique gave her six impressions based on the report. The first was that most respondents reported having regular HIV medical care; about 94.6% reported having regular HIV care and 92% reported being prescribed antiretroviral therapy (ART). 81.3% reported having an undetectable load. The survey found that persons were more likely to achieve viral suppression if they received care at a Ryan White Facility compared to non-Ryan White Facilities. Most respondents expressed challenges related to mental health during COVID-19 and beyond such as loneliness, anxiety, and depression. PLWH were willing to use telehealth beyond the pandemic but social determinants of health and demographics were still important predictors of utilization and sustainability. T. Dominique said they had seen this while examining the respondents' access to the internet.

The frequent barriers to care were often transportation, stable housing, and a history of incarceration. Finally, the survey highlighted how the EMA's Ryan White population was aging and they needed to re-examine how PLWH were cared for in the healthcare system.

S. Moletetteri reached out to the co-chairs of the committee and determined that they would like more information. The final slides of the presentation should be related to HIV testing, substance use, and child care.

The next slide would cover the data about where people reported getting tested for HIV. The data showed that the doctor's office was often the most frequent place to get tested. 60.2% of respondents said this was where they were tested. 12.3% of respondents said they were tested at

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a public or community health center. T. Dominique then analyzed the data by the last date the respondents had their last HIV test. She said most respondents knew they had HIV for a long time. She said when looking at who tested within 12 months, she found that 49% of the 217 respondents tested within the last year. 31% of respondents reported they had tested 5 years ago or longer. She said the survey showed that 64% of respondents were tested at a doctor's office no matter what year they were tested. 12% of respondents were tested at a community health center. On average 4% of respondents were tested at a jail.

T. Dominique highlighted that the number of people who were tested at a doctor's office had increased in recent years. 53% of respondents were tested in a doctor's office 1-2 years ago. This has increased to 71% for those who had tested in the last 12 months. T. Dominique called attention to the fact that 6.5% of respondents were tested in a jail in the last 12 months while the data showed that respondents did not get tested at a jail unless it was longer than 5 years ago. She wondered why there was such a change between each year. D. Dalesandro said she had worked with the prison system before and offered to give her insight. She said prisons had increased their efforts to get tested. In addition, most prisoners did not want to disclose their HIV status and simply allowed themselves to be tested. She said that when a new person had moved to a new area and they did not forward their medical information, they would be tested. S. Moletetteri said that there were more vans testing people on the street. D. Dalesandro said S. Moleterri made a good point and said that many of the testing vans were not available during the pandemic.

The survey would ask respondents about their use of alcohol and tobacco and whether they received treatment. 43% of the 32 respondents who answered the question said they used a substance other than marijuana and that they received use or alcohol treatment. 18% of those who used a substance other than marijuana said they did not receive treatment. Another 37.5% said they did not feel like they needed treatment. When they looked at alcohol usage, 31.4% of the 20 respondents who answered the question said they received alcohol use treatment. Eleven respondents reported that they shared injection equipment. About 20% of these respondents said they were able to receive treatment. 27 respondents reported using marijuana before or after sexual activity. About 28.6% of these respondents reported that they were able to receive treatment. 50% of the 27 respondents reported that they were not able to receive treatment while 6.7% of the 27 respondents said they did not need treatment.

G. Grannan said that treatment was not equally available for all substances. He asked how they had accounted for the fact that not all substances had a treatment. For example, methamphetamine did not have a treatment. M. Ross-Russell acknowledged that G. Grannan was correct and they had grouped the substances the way that they did because of the nature of the cross-tabulation. G. Grannan said it was a way of thinking that was baked into the healthcare field. He said many were fearful of speaking about substances without also talking about treatment. D. Dalesandro said she believed the data was still useful. She said treatment could take many forms and be perceived in many different ways by the average person. She referenced her family member who was getting help with his cocaine substance use. She said he was going to a 12-step program and that was a form of treatment. G. Grannan said he was not disagreeing with her and said he believed they should not be recording hormone usage in their survey. D. Dalesandro agreed with him. He believed they needed to speak about substance use and treatment as two separate things. He said with the way funding was set up in Philadelphia, this

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was not possible. T. Dominique reminded the committee that they could not make generalizations with the data due to the small sample size.
M. Ross-Russell said one of their hopes for the Consumer Survey was to learn what information they wanted to explore further for the Needs Assessment. M. Ross-Russell said they were likely going to have other focus groups. She said they were trying to reach people who met a certain demographic. She encouraged the committee to think about the next steps or ideas they could obtain from reading the survey.

T. Dominique continued with the presentation. The next section was a cross-tabulation between substance use and the mode of usage. T. Dominique said they had suppressed all the numbers for the chart. Oral substance usage was the main way for substance use. 45% of respondents who used drugs orally received treatment. 50% of those who used drugs orally reported that they did not receive treatment. For people who used substances through injection, 34.3% said they received treatment and 33% said they did not receive treatment. 8% of these respondents believed they did not need treatment. Similarly, 31.4% of those who inhaled substances said they were able to find treatment while 8.3% said they were not able to find treatment. 5.5% of those who inhaled substances believed they did not need treatment. 14.3% of respondents who used substances anally said they were able to find treatment. 16.7% of respondents who used substances but wanted treatment said they were not able to find treatment. 0.6% of those who substances anally said they did not believe they needed treatment.

Respondents were asked about childcare service usage. T. Dominique said they had collapsed genders that were not male or female into one category due to the small sample size. 64.7% of respondents who wanted the service and received it were women identified at birth. 35.3% of respondents who received childcare services were men identified at birth. Among the respondents who wanted childcare services, 6.1% of respondents were women identified at birth. 3.2% of respondents were men identified at birth who wanted the service but could not receive it. Respondents were asked if they had heard of childcare services. 50% of the respondents who had never heard of childcare services were women and the other 50% were men. There were respondents who said they never needed the service. 37.9% of respondents who chose this answer were women at birth, 56.1% were men at birth and 6.1% were gender non-conforming.

T. Dominique then looked at a pie chart about respondents who needed and received childcare. 53% of the respondents who met this criteria stated that they rented or owned their house or apartment. 24% of the respondents who needed and received childcare services stayed with their friends. 23% of respondents who needed childcare and received it reported that they used the Housing Opportunities for Persons With AIDS (HOPWA) program.

When looking at respondents who needed childcare but did not receive it, they found that 60% of the respondents owned or rented their homes, 20% were in public housing, 10% were staying with their friends, and 10% were in a different type of housing. T. Dominique said she did have data on childcare needs and employment. She said 41% of respondents who needed childcare and were able to receive childcare were employed full-time. 35% of respondents who needed childcare and were able to receive it were employed part-time. T. Dominique said that when asking respondents who needed childcare services and whether their provider spoke to them about their lab work, 60% of respondents said that their provider did. They did a cross section

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between people who needed childcare services and whether they were comfortable speaking with their provider about personal issues 47% of respondents said they were always comfortable speaking with their providers. 29% of respondents said they were comfortable most of the time to speak with their provider and 23% of the respondents replied that they felt that some of the time they were comfortable with their provider about speaking on their personal issues. T. Dominique said the sample size for those who answered the question about childcare was small.

M. Ross-Rusell said that over the years Ryan White funding had changed and currently it was defined that a service must directly benefit a person who was positive for HIV before it could benefit an affected family member. An example that M. Ross-Russell had given was that a person who was HIV positive benefited from a food bank or readily created meals because they did not have to cook for their family who may not be HIV positive as well. She said that if a child was HIV negative, the service could be received if the parent was HIV positive.

T. Dominique said the questions about childcare had originated from an earlier meeting during the allocations process where they saw they had an older population answering the survey and they did not know if childcare services and harm reduction were needed. She said these questions were not in the written report and were included in the presentation to answer any questions that the committee may have.

–Allocations Parking Lot–
The committee agreed to table the discussion for the next meeting.

Other Business:
None.

Announcements:
D. Dalesandro said the state HIV Planning Group was still seeking new members. She asked the committee to contact her if they were interested.

Adjournment:
G. Grannan called for a motion to adjourn. **Motion:** K. Carter motioned, and L. Diaz seconded to adjourn the Comprehensive Planning Committee meeting. **Motion passed:** Meeting adjourned at 3:57 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- August 2023 Comprehensive Planning Committee Meeting Agenda
- June 2023 Comprehensive Planning Committee Minutes
- Allocations Parking Lot Document

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Prevention Committee
Meeting Minutes of
Wednesday, June 28th, 2023
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, David Gana, Gus Grannan, DJ Jack, Clint Steib (Co-chair), Emily McNamara Erica Rand, AJ Shruggs, Desiree Surplus

Guest: Mary Bouchaud (Jefferson University)

Excused: Lorett Matus (Co-chair), Debra D'alessandro

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

Call to Order/Introductions: C. Steib asked everyone to introduce themselves and called the meeting to order at 2:34 p.m.

Approval of Agenda:
C. Steib referred to the June 2023 Prevention Committee agenda and asked for a motion to approve. **Motion:** D. Gana motioned; G. Grannan seconded to approve the June Prevention Committee agenda via Zoom poll. **Motion passed:** 4 in favor, 1 abstaining. The June 2023 agenda was approved.

Approval of Minutes (*May 24th, 2023*):
C. Steib referred to the May 2023 Prevention Committee minutes. **Motion:** G. Grannan motioned; D. Gana seconded to approve the May 2023 Prevention Committee meeting minutes and agenda via a Zoom poll. **Motion passed: 7** in favor. The May 2023 Minutes were approved.

Report of Co-chairs
None.

Report of Staff
S. Moletteri reminded the committee that allocations meetings were scheduled for next month and that the Office of HIV Planning website had been updated with materials for their preparation. The resources were accessible under the Planning Council tab in the allocations section. There, committee members and other site visitors could access an online PDF version of the 2023 Allocations Service Categories Booklet. This booklet contained all service categories and their definitions as well as additional information such as the Consumer Survey.

On the same page, S. Moletteri presented flyers for each regional meeting to the committee members. She encouraged them to distribute these flyers and encourage others to register for both segments of the regional meetings of their representation. She also provided an overview of the regional meeting format, explaining that each region would have one mandatory meeting on Tuesday and Thursday, with an optional session on Wednesday for members to ask questions.

Continuing down the page, S. Moletteri highlighted a section titled "Preparation for FY2024 Allocation Process." This section included a PowerPoint presentation and a video created in 2020 to guide committee members through the process. Beneath the PowerPoint and video was the allocations preparation worksheet.

Following the worksheet was the FY2024 Allocations Preparation Checklist. S. Moletteri emphasized the usefulness of this checklist and briefly reviewed its contents. She mentioned a quiz available for members to test themselves prior to the meeting. Additionally, she reminded the committee members that the first allocations meeting would be for New Jersey, starting on July 11th.

Presentation:

-Aging Symposium Update-

K. Carter introduced himself and his presentation topic, focusing on his report about the HIV Summit & Symposium held on May 23rd, 2023 at the Double Tree Hotel in King of Prussia. The event was organized by the Department of HIV Health (DHH) in collaboration with its partners. K. Carter explained that the rationale behind this event was Philadelphia's notable population of individuals aged 50 and above living with HIV. He emphasized that Philadelphia had around 15,000 residents with HIV, with 10,000 of them being over the age of 50. K. Carter attended the symposium to learn about the services available to older people with HIV.

DHH had formed partnerships with several community organizations, including LGBT Elder Initiative, Philadelphia FIGHT, Action Wellness, Positive Women's Network, National Reunion Project, and Visible 365.

With limited in-person attendance, K. Carter noted that approximately 89 individuals participated on-site, while 21 joined online. He mentioned that the meeting format had been shaped by active community members who were involved in the planning process. The event encompassed presentations about the End the Epidemic Plan (EHE) and a keynote speech by J. Haskins, a member of the HIV Integrated Planning Council (HIPC). K. Carter praised J. Haskins for delivering an engaging and informative speech that left a positive impact on the audience. The symposium also comprised seven workshops and concluded with a panel discussion.

K. Carter outlined three main goals of the conference. Firstly, it aimed to foster constructive dialogue among the community, service providers, and social services. This goal encompassed ensuring providers were well-equipped to treat individuals with HIV, engaging community members in the process. Secondly, the conference aimed to educate providers and community members on accessing services to enhance health outcomes. Lastly, it sought to provide DHH with insights to develop services that effectively catered to the diverse aging adult population living with HIV in the Philadelphia EMA.

Following the presentation, attendees were able to participate in seven workshops. K. Carter expressed satisfaction with the active and enthusiastic participation in each workshop. Larger workshops took place in the main conference room, while smaller, more intimate workshops were held in separate rooms. The topics covered in each workshop were as follows:

- Managing HIV in Older Adults
- Benefits and Employment issues for Over 50
- Death and Dying/End of Life Issues: Healing from Trauma as Long-Term Survivors
- Criminalization of HIV/AIDS Across the Lifespan
- Medical Management of HIV in Trans and Gender Non-Conforming Older Adults with HIV
- Elder Housing Resources: Access, Safety, Understanding Vouchers vs HOPWA
- Getting your affairs in Order: Insurance (Life, LTC, etc) Wills, Advanced Directives, and Power of Attorney.

K. Carter discussed the 'Managing HIV in Older Adults' workshop, led by Dr. Schwartz. He emphasized the need for improved HIV screenings, similar to screenings for diabetes and high blood pressure, to reduce HIV-related deaths. K. Carter also highlighted the importance of community members understanding how to maintain viral suppression, defined as having fewer than 200 copies of HIV per milliliter of blood.

Transitioning to the workshops that piqued his interest, K. Carter first mentioned the 'Death and Dying/End of Life Issues: Healing from Trauma as Long-Term Survivors' workshop. He stressed the significance of preparing for death as a natural part of life. He also linked COVID-19 to memories of the early days of the HIV-AIDS epidemic. K. Carter then spoke about the 'Medical Management of HIV in Trans and Gender Non-Conforming Older Adults with HIV' workshop, praising A. Scruggs and A. Harrison for addressing barriers to treatment. Lastly, he discussed the 'Benefits and Employment Issues for those over 50' workshop, underscoring the importance of understanding available opportunities to prevent the loss of benefits, such as Supplemental Security Income (SSI).

Afterward, K. Carter touched on the Closing Plenary, expressing gratitude to speakers such as H. Zinman and moderator A. Pacheco-Branch for engaging the audience with thought-provoking questions. He aligned with J. DeMarco's sentiments during the plenary, emphasizing the need to care for elderly people with HIV who are homeless. He highlighted the broader issues faced by homeless seniors and called for collaboration with authorities to provide necessary services.

K. Carter shared workshop links and conference resources with committee members and extended thanks to DHH’s A. Thomas-Ferraioli and A. Pacheco-Branch for their hospitality and efforts in providing gender-neutral restrooms. He also recognized the Health Federation’s D. D’Alessandro and her team for facilitating the meetings, ensuring chat room monitoring and seminar facilitation.

K. Carter opened the floor for questions. D. Gana inquired about access to the presentation PowerPoint and workshop links. T. Dominique explained that the presentation was available on

the HIVPhilly.org website under the Planning Council section. M. Ross-Russell asked for K. Carter's personal thoughts on the event. K. Carter noted that over 50% of the city's population with HIV was above the age of 50, with more comorbidities compared to those without HIV. He emphasized the need to address these challenges and viewed the summit as a starting point to educate the community and understand their needs. He suggested a potential follow-up, depending on funding availability. K. Carter added that the summit had not extensively covered HIV prevention messaging for individuals over 50, and he stressed the importance of targeted messaging to reduce HIV transmissions in that age group.

C. Steib asked M. Ross-Russell if a workgroup within the Prevention Committee could explore this topic further. M. Ross-Russell endorsed the idea, emphasizing that the challenges faced by individuals over 50 with HIV were distinct and required focused attention.

K. Carter noted the need for health providers to be aware of medication interactions for those with HIV, as patients might not always disclose all medications. D. Surplus shared her practice of encouraging patients to use the same pharmacy and considering all factors affecting patient health.

K. Carter raised the idea of fall detection services for seniors living alone, expressing concern for their safety. M. Ross-Russell and K. Carter discussed the feasibility of such services, considering local resources and Ryan White funding.

C. Steib thanked K. Carter and proposed seeking more information from national organizations like the Department of Aging and the National Council on Aging regarding HIV and aging. K. Carter also suggested creating a list of screenings, such as breast cancer screening, for their clients.

Action Item:
-Co-chair Election-
L. Matus and C. Steib, the co-chairs of the Prevention Committee, announced their intention to step down from their roles and began the search for new members to take over their responsibilities. C. Steib mentioned that D. Surplus had volunteered to run for L. Matus' co-chair position. C. Steib then invited D. Surplus to introduce herself and explain what she could bring to the committee.

D. Surplus introduced herself as a pharmacist with 16 years of experience at ACME Pharmacy, holding the credential of HIV Specialist (AAHIVS). She revealed her licensure in Delaware, Maryland, and Pennsylvania and mentioned her current role as a community outreach coordinator, involving collaboration with various organizations, providers, and patients. She noted her three-year involvement with the Philadelphia HIV Integrated Planning Council and expressed her desire to leverage her background as a pharmacist and community outreach coordinator to serve the community.

C. Steib noted that L. Matus was currently on vacation and outlined two potential plans for moving forward. The first option was for either L. Matus or C. Steib to step down as co-chair, while the other would continue until a volunteer emerged. The second option involved having

three co-chairs temporarily until a replacement was found. Considering D. Surplus' availability and motivation, C. Steib proposed proceeding with the election. Following this, they would address the logistical aspects of the co-chair positions. He also mentioned that they wouldn't convene the next month due to allocations meetings, providing them time to finalize the logistics.

C. Steib initiated a roll-call vote to elect D. Surplus as the new co-chair of the Prevention Committee. D. Surplus was then placed in a separate room while the committee deliberated the topic.

K. Carter: In Favor
A. Shruggs: In Favor
C. Steib: In Favor
D. Gana: In Favor
D.J. Jack:
E. Rand: In Favor

Motion Passed: Five in favor. The motion to elect D. Surplus as co-chair of the Prevention Committee was passed.

D. Surplus rejoined the committee, and S. Moletteri communicated the committee's decision to position her as co-chair. D. Surplus expressed her honor at the appointment and her enthusiasm for taking on the role alongside her fellow committee members.

T. Dominique inquired of C. Steib about what prospective co-chairs should know if they were considering volunteering. C. Steib explained that interested individuals should reach out to L. Matus, T. Dominique, or himself. He elaborated that co-chairs have an additional meeting, separate from the regular Prevention Committee meetings, to review the agenda and brainstorm new topics. C. Steib shared his experience of overseeing significant changes as a co-chair, noting the integration of prevention efforts with HIPC, adapting PrEP concepts for Philadelphia and the Pennsylvania counties, and navigating the challenges posed by the pandemic. He expressed optimism about the fresh ideas and energy that new co-chairs would contribute to the committee.

M. Ross-Russell reminded the committee that aspiring co-chairs needed to have one year of good standing with both the committee and HIPC. K. Carter inquired about the possibility of retaining three co-chairs. M. Ross-Russell clarified that the structure of the Prevention Committee and the co-chairs' desires would determine whether they could maintain three co-chairs.

Any Other Business:
None.

Announcements:
None.

Adjournment:
C. Steib called for a motion to adjourn. **Motion:** K. Carter motioned, and D. Gana seconded to adjourn the Prevention Committee meeting. **Motion passed:** Meeting adjourned at 3:30 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- June 2023 Meeting Agenda
- May 2023 Prevention Committee Meeting Minutes