

MEETING AGENDA

Tuesday, October 20th, 2026

12:00 p.m. – 2:00 p.m.

- ◆ Call to Order
- ◆ Welcome/Introductions
- ◆ Approval of Agenda
- ◆ Approval of Minutes (*September 15th, 2026*)
- ◆ Report of Co-Chairs
- ◆ Report of Staff
- ◆ Presentation Item
 - SPBP & ADDP
- ◆ Other Business
- ◆ Announcements
- ◆ Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next Poz Committee meeting will be held on

Tuesday, November 17th, 2026 from 12:00 – 2:00 p.m.

Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107

(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

**Hybrid: Poz Committee
Meeting Minutes of
Tuesday, September 15th, 2026
12:00 p.m. – 2:00 p.m.**

Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia, PA 19107

Present: B.C., K.C., D., M.D., M.G., L.J., R.N., M.P., G.R., P.S., J.S., J.T., S.W.

Staff: T. Dominique, E. Fischer, D. Law, S. Moletteri, K. Trinh, K. Wilson

Call to Order/Introductions: K.C. called the meeting to order at 12:18 p.m. and asked for introductions.

Approval of Agenda:

K.C. referred to the September 2026 Poz Committee agenda and asked for a motion to approve. S. Moletteri amended the agenda to have the social hour first, then the presentation. **Motion: J.S. motioned, G.R. seconded to approve the amended September 2026 agenda. Motion passed: All in favor.** The amended September 2026 Poz Committee agenda was approved.

Approval of Minutes:

K.C. referred to the August 2026 Poz Committee minutes and asked for a motion to approve. **Motion: J.S. motioned, K.C. seconded to approve the August 2026 minutes. Motion passed: 2 in favor.** The August 2026 Poz Committee minutes were approved.

Report of Chair:

K.C. said he went to the Ryan White conference in Washington, DC.

Report of Staff:

S. Moletteri said the HIV & Aging presentation would occur later in the meeting.

Discussion Item:

~Social Hour~

S. Moletteri asked meeting participants about their prior knowledge and engagement with HIPC and Ryan White Part A. L.J. said she had a Ryan White (RW) card but had concerns about what it actually did. S. Moletteri said Ryan White was a payor of last resort, so if nothing else covers the cost, the RW Program would. K.C. added that the card must be updated every six months and the information must stay up to date.

D. Law said the Positive (Poz) Committee was a subcommittee of the HIV Integrated Planning Council (HIPC). HIPC members allocated money to each RW service. Individuals with a Ryan White card qualified for the services it provided, but only after exhausting all other funding options. She noted that the HIPC decided only overall service categories, while case managers and providers decided how clients received those services. The Poz Committee gave consumers the opportunity to discuss topics related to HIV services and care. Today, the committee would discuss HIV & Aging.

S. Moletteri said that there were only a certain number of providers that provide Ryan White services. She added that the HIPC could influence how the Ryan White services were distributed. For example, the Poz Committee created a widely distributed plain-language document outlining all Ryan White services available to clients. HIPC members created directives to the Division of HIV Health (DHH) with the expressed purpose of meeting certain goals. For example, they crafted a directive ensuring food banks served the community with quality, culturally relevant foods. DHH was required to report on the results of the directives to HIPC.

L.D. noted that case managers typically conduct needs assessments every six months to complete mandatory paperwork. However, because of high staff turnover and case managers frequently changing within each six-month period, she recently chose to discontinue services with their previous wellness center. She added that the wellness center cut back services, specifically housing assistance.

D. Law said HIPC discussed overall services, and not specific case-by-case situations. She said case managers handled those case-by-case situations. S. Moletteri said the greater council did discuss the services, but if there was interest in a particular area, they could do a presentation on that. She noted that the Comprehensive Planning Committee completes the priority settings, which include all the services. K.C. said clients need to be more independently engaged in their care and should advocate for themselves.

S. Moletteri noted that there has been discussion of how to ease the burden of case managers from large caseloads and turnover.

K.C. added that OHP hosted town halls and made recommendations to improve the system. He noted that clients should call the client service number if they had any issues with their care.

S. Moletteri explained that the Client Services Unit was a hotline that was funded by Ryan White Part A that connects clients with a case manager or reporting services or providers. K.C. added that the Client Services Unit reported issues clients relayed to them for resolution.

J.T. shared that the Ryan White program had successfully helped him receive care throughout his life. He said it has helped him with dental services. K.C. shared a similar experience.

M.D. said he had previously been involved in the Planning Council and would like to reengage with it. S. Moletteri said OHP was actively recruiting members for the HIPC. She said members were required to attend a monthly HIPC meeting and a monthly subcommittee meeting. She said they could fill out a physical or virtual application after the meeting.

K.C. noted that joining the HIPC was an effective way to stay up to date on accurate information. L.D. commented that in the groups she had participated in, Ryan White services didn't come up in discussion very often. She said Ryan White was only discussed during site visits. She said many social workers did not bring up the Ryan White program unless the client inquired about it. She said she had never been given a list of services before. S. Moletteri asked what information the group wanted. She noted that one member wanted to learn more about the Special Pharmaceutical Benefits Program (SPBP) changes and program cuts.

L.D. said she wanted to hear the presentation first before asking questions. K.C. asked if there was anything that members wanted to see changed. L.D. said she wanted to know what services were still operating after the funding cuts. S. Moletteri responded that there were still fully funded services that were available. She noted that the Ryan White program supports 27 services that could be funded, but Philadelphia EMA funded only a selection of those services.

L.J. said her transportation coverage was cut because she traveled across county lines. She asked if the RW program could help her with transportation. K.C. said RW should cover all transportation to any medical appointments. L.J. clarified that she was using a different service for transportation. M.D. suggested using RW to pay for the transportation. S. Moletteri said the mode of transportation provided could change from provider to provider. L.J. expressed frustration that her doctor and case manager left at the same time.

Presentation Item:

~HIV & Aging~

E. Thornburg said they were from DHH and were the Health Ethics and Access Officer. They said Aging with HIV was a prioritized area within the DHH since over 50% of people with HIV were over 50 years old. They said biomedical interventions have allowed PWH to live well into their 80s.

E. Thornburg provided historical context on HIV and aging. They explained that early assumptions about the health of people aging with HIV were influenced by "survivor bias and luck." Many of the first individuals to survive beyond age 50 had financial resources, strong support systems, and access to quality healthcare and experimental treatments. As antiretroviral therapy (ART) became more widely available, more populations began aging with HIV. Originally, HIV was a terminal prognosis but changed to a chronic illness. They noted that PWH had life expectancies that were similar to those without HIV. Public health responses initially included neglect and quarantine, then shifted to increased funding for prevention, research, testing, and medical case management, leading to today's advanced treatments. They also noted that HIV-related stigma looked different than what it once looked like. Stigma could be found through disinformation online and in living assistance facilities, and in the conversation of what happens at death. Overall, biomedical breakthroughs like ART have changed HIV care.

E. Thornburg discussed the unique needs of aging with HIV, including the early onset of frailty and certain cancers. PWH may begin experiencing frailty between ages 50-55 compared to ages 60-65 in the general population. E. Thornburg also defined polypharmacy as taking five or more medications regularly. Prescription cascades occur when medication side effects can resemble symptoms of aging rather than medication interactions. They encouraged individuals to ask their pharmacist how their medications interact with each other.

E. Thornburg said sexual health, coercive consent, and sexual content were typically not talked about for people above 50 years old. They also discussed that these individuals may be on fixed incomes and that retirement could reduce an individual's income, even if they previously had a higher income. They also said many older adults live in homes not equipped for aging, affecting quality of life.

E. Thornburg explained that dental health, difficulty chewing, or physical limitations like carrying groceries or preparing food can affect an individual's ability to maintain nutrition. They emphasized that the aging population may start to eat foods that were easier to eat, which may not have adequate nutrition. They suggested frozen vegetables as an affordable alternative because they were precut, easier to prepare, and easier to chew. They also explained that older adults may have decreased hunger or thirst, which can affect food and water intake. These individuals may need reminders to eat and drink. E. Thornburg also noted that pipe condition, refrigerator temperatures, proper preparation, and storage all affect food and water safety.

E. Thornburg asked the group what food was most unsafe to prepare for those over 65. L.J. noted that eggs were unsafe for older adults. E. Thornburg agreed and noted that eggs were easy to undercook and many older adults get food poisoning from them. They recommended fully cooking the eggs. E. Thornburg added that the fridge should be at 36-38 degrees Fahrenheit.

E. Thornburg explained that there were changes in cognition and comprehension associated with aging; PWH may experience HIV-associated non AIDS conditions (HANA), which may affect cognition. They noted the importance of monitoring cognitive changes.

L.D. asked when to see a neurologist for cognition issues. E. Thornburg recommended speaking with a primary care provider for initial testing and referrals, if necessary.

E. Thornburg explained that older adults had safety concerns, such as feeling safe at home, with care providers, and while using public transportation.

E. Thornburg continued that demographics were shifting. While wealthy, older White men used to make up the majority of the aging with HIV population, there had been an influx of Black, Indigenous, and People of Color (BIPOC) men who have sex with men (MSM) and Black women who were aging with HIV.

E. Thornburg noted two challenges: assessing emerging issues related to aging and monitoring frailty. They encouraged folks to see a geriatrician specializing in care for aging adults. They added that another challenge was finding best practices for different populations, since each population has different needs. Other challenges include interventions to limit or disrupt the erosion of independence and prevent HANA. They emphasized that the goal was to keep older folks living independently.

E. Thornburg said the DHH was crafting a clinician's guide to train HIV providers to be more adept at the aging process and intervene earlier. They noted several indexes, surveys, and tests that were being included in the guide. The Clinician's Guide included sections on Frailty, Comprehension, Health Disparities, Medication, Nutrition, and Social. B.C. asked when the Clinician's Guide would be completed. E. Thornburg said the draft was finished, but had to go through other leaders to be approved. After approval, they would distribute it.

M.G. said Jefferson Hospital had a program in which a medical student stayed in close contact with clients to ask specific questions and organize a home visit. She explained that a

multidisciplinary group of students would complete a home visit, report any changes, and then follow up with clients to share any available services.

E. Thornburg continued that another project DHH completed was the Aging & Thriving Summit. This was an annual one day event of sessions led by experts with lived experience, was developed and executed by older adults with HIV, and included multiple evaluations for attendees.

E. Thornburg explained that Will Clinics worked in tandem with provider agencies. They included a file of life, which E. Thornburg explained was how a person wanted to be cared for if they went to the hospital. Will Clinics provide power of attorney, living wills, Do Not Resuscitate/Do Not Intubate (DNR/DNI), and decedent funerary requirements.

K.C. noted that legal issues could occur if someone had a partner who they were not legally married to. E. Thornburg said there's a presumed decision making process. K.C. advised caution of who had power of attorney.

E. Thornburg said they would notify the HIPC of the next Will Clinic. M.G. shared that her doctor told her that many people would specifically note on their will to continue giving them diabetes or HIV medication even if they had a DNR/DNI. E. Thornburg responded that providers should continue to administer those other medications even if the patient had a DNR/DNI.

E. Thornburg continued that they had facilitated focus groups with over 40 participants who were aging with HIV. There were 6 groups – 2 general and 4 population-specific. E. Thornburg noted that there was high veteran representation. These focus groups gave insights on HIV services, care, case management, and housing programs. Many participants discussed neuropathy, auditory and vision needs, accessible housing vs. social support, provider retirement, MCM turnover, transportation, satellite clinic locations, grief support, stigma in aging support programs, challenges to accessing care, and pain management. E. Thornburg noted that multiple participants emphasized the importance of their pets and said they would prioritize their pet's emergency over their own health needs.

E. Thornburg discussed a scientific working group at Penn's Center for AIDS Research (CFAR), where they serve as one of three co-leads alongside two clinicians who specialize in geriatrics and HIV-related liver disease. Together, they have expertise in aging, HIV, liver disease, sociological barriers, frailty, and smaller populations aging with HIV. They conducted six focus groups, held inaugural meetings, and conducted exploratory research. They also provided microgrants to explore other implications of HIV and used implementation science to evaluate effectiveness. The group collaborated with labs and social scientists to explore ways to address aging at cellular and biological levels.

E. Thornburg reported that they recently received funding for a Hearing Loss Support program to assess clients' hearing and provide hearing aids and one replacement pair. The process would begin by February 2027. B.C. asked if clients needed a case manager to qualify for this program. E. Thornburg responded that clients must be referred through their case manager. G.R. asked if

the program was only for Philadelphia residents, or the EMA counties as well. E. Thornburg said they would check to see the geographic criteria and report back.

E. Thornburg noted that they were also exploring grief, loss, and death ethos programs to encourage more positive and open conversations about death, Dandelion Initiatives, frailty index, education and training on aging for HIV providers, and addressing outstanding viatical settlement contracts. Viatical settlements involve debt an individual owed because they took out a personal loan and sold it to someone who bought their life insurance. K.C. asked about the details of these contracts. E. Thornburg said it was unknown since everybody has different citations and private exchanges.

R.N. asked if the focus groups would be held virtually or in-person. E. Thornburg clarified that the focus groups already took place but would contact the HIPC if they conducted more. L.J. asked to learn more about the hearing aid program.

Other Business:

None.

Announcements:

T. Dominique said there would be a workshop on September 18th from 9 AM - 2 PM on HIV and Aging. OHP would be tabling at the event.

Adjournment:

K.C. called for a motion to adjourn. **Motion: G.R. motioned and M.P. seconded to adjourn the September 2026 Poz Committee meeting. Motion passed: All in favor. Meeting adjourned at 1:50 p.m.**

Respectfully submitted,

Elizabeth Fischer, staff

Handouts distributed at the meeting:

- September 2026 Poz Committee Agenda
- August 2026 Poz Committee Meeting Minutes