# COMPREHENSIVE PLANNING COMMITTEE

## *MEETING AGENDA*

VIRTUAL:

**Thursday, October 15, 2020**

**2:00 – 4:00 p.m.**

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

- **Call to Order**
- **Welcome and Introductions**
- **Approval of Agenda**
- **Approval of Minutes *(September 17, 2020)***
- **Report of Staff**
- **Report of Chair**
- **Public Comment**
- **Discussion Items**
  - **Elders' Needs Assessment**
  - **Committee Structure**
  - **COVID-19 Survey**
  - **Integrated Plan Monitoring**
- **Old Business**
- **New Business**
- **Announcements**
- **Adjournment**

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

The next Comprehensive Planning Committee meeting will be held on
**Thursday, November 19, 2020 from 2:00 – 4:00 p.m. VIRTUALLY**

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**Philadelphia HIV Integrated Planning Council**
**Comprehensive Planning Committee**
**VIRTUAL: Meeting Minutes of**
**Thursday, September 17, 2020**
**2:00p.m.**
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

**Present:** Allison Byrd, Clint Steib, Gerry Keys, Gus Grannan, Keith Carter, Marilyn Martinez, Pamela Gorman, Susan Arrighy, Tyrell Mann-Barnes

**Guests:** Blake Rowley, Chris Chu (AACO), Jennie Vanderlaag, Jessica Browne (AACO)

**Staff:** Nicole Johns, Sofia Moletteri, Mari Ross-Russell, Beth Celeste

**Call to Order/Introductions**: C. Steib offered to table the meeting until G. Grannan arrived. He called the meeting to order at 2:03 p.m.

**Approval of Agenda**: C. Steib presented the September 2020 agenda for approval via Zoom poll. **Motion**: K. Carter motioned, A. Byrd seconded to approve the agenda. **Motion passed**: 88% in favor, 13% abstaining.

**Approval of Minutes:** (*August 20, 2020*) G. Grannan presented the previous meeting's minutes for approval via Zoom poll. **Motion**: G. Keys motioned, K. Carter seconded to approve the August 20, 2020 meeting minutes. **Motion passed**: 75% in favor, 25% abstaining.

**Report of Chair:**

G. Grannan had no report.

**Report of Staff:**

N. Johns reported OHP was working on the fall training series from now until beginning of December. The next training would be on needs assessment activities. There would be seven trainings in total on alternating Fridays from 12- 1 p.m. Registration was set up so someone could either register for all of them or pick the ones that interest them. The trainings would be recorded and put on Facebook and the OHP website. If there were any questions, contact OHP staff.

**Public Comment:**

None.

**Discussion Items:**

***—COVID-19 Survey Marketing and Distribution—***

N. Johns reported that the COVID-19 survey tool is completed and she just received the Spanish translation. A few HIPC members were going to check the Spanish version to ensure that it was accessible. She noted that S. Moletteri worked on the marketing for both Spanish and English flyers. The office was submitting the tool for exemption by the city's IRB, the survey should be exempt since it would be an evaluation of the care system and not research. They would submit it within the next few weeks. The survey would be online because of COVID-19, though paper surveys will be mailed out per request. They could be mailed to clinics, support groups, individuals, etc. with prepaid postage.

N. Johns said the plan was to launch the survey in mid-October and keep it open until mid-December. It would be a quick needs assessment project so that by next February, the information could be used to inform HIPC allocations decisions once they receive the final award. Today, N. Johns said they would need to discuss distribution and marketing of the survey. She asked that the group brainstorm.

N. Johns brought up the questions and reminded CPC that they created their own questions but also took questions from Medical Monitoring Project (MMP) to compare data. The MMP questions are about clinical outcome questions, demographics, medications, housing, etc. N. Johns reviewed the questions.

C. Steib said that AACO has a PrEP provider monthly meeting. Maybe OHP could get on the agenda to pitch it or ask them to disseminate that information to providers. C. Steib said that he would forward that information to N. Johns.

N. Johns said that 500 responses is the anticipated response rate. K. Carter said that D. Griffin with the Elder Initiative may be a good resource. Maybe they could reach out to the new University of Pennsylvania and Temple LGBTQ Health Centers to help with dissemination.

P. Gorman said that she would be happy to bring back the COVID-19 survey to Cooper Hospital and other providers in NJ to distribute to different agencies. N. Johns thanked her and said assistance of Ryan White providers has been helpful in the past. She added that they are especially trying to reach populations that tend to be under-sampled such as Spanish speaking populations and youth. P. Gorman said that Cooper pediatrics has an HIV program with 50% of patients ages 15-24. She would work to get the surveys completed in that unit. G. Keys offered to put surveys in the health centers.

N. Johns said they would have prepackaged social media text, images, etc. If people wanted to help advertise on social media, they could reach out for the materials. They would also eventually be posted on the website for download.

***—Integrated Plan Monitoring—***

N. Johns reported that Prevention Committee would help with Integrated Plan activities that were relevant to their committee. HIPC and OHP worked together on the Integrated Plan for care and prevention goals in 2016. The 2016 plan was on the OHP website as well as the 2018 update with the baseline data. Due to a lag in data, HIPC reviewed and updated the plan in 2018 once they could properly monitor outcomes. Now that they are in 2020, they can look even further into what they were monitoring. She noted that most of the data comes from the state and AACO. Some of the data can be retrieved easily, but other data take time. There may be a larger delay in data gathering because of COVID-19.

N. Johns said the office would make a data request in the next month or two. As the data becomes available, OHP would bring it to the Prevention Committee and CPC. They would work on the Integrated Plan next year, but in the meantime, they were still awaiting guidance. As the council moves into the Integrated Planning cycle, they will review new data and the EHE plan to incorporate into the Integrated Plan. She said CPC is usually where integrated planning is housed, but duties can be shared evenly between Prevention and CPC.

C. Steib asked if restructuring the Planning Council committees would enable the work to be disseminated better for subcommittees. N. Johns said it depended on how and if the council wanted to restructure. They could look at organizing the committees based on the goals of the plans like EHE's pillars. This may naturally spread out the work if the council based its restructuring on the plan.

M. Ross-Russell added that it may make sense to create balance to get people more involved and interested in some of the discussions which address EHE components. The new Integrated Plan would likely have pieces from EHE as well as the old plan. The EHE plan is structured so half of it is care-related and the other half is prevention-related. Such separations may make the work clearer and the discussions more in-depth. She added that a lot of the needs assessment activities are also going to CPC, so they will have a lot on their plate. C. Steib said that this is a good argument for moving towards restructuring subcommittees. N. Johns said that there is a training session on integrated planning in October which may help to move forward the discussion.

C. Steib asked about the end date for the Integrated Plan. M. Ross-Russell and N. Johns did not know due to the COVID-19 delays.

***—Elders' Needs Assessment—***

N. Johns pulled up the "elder needs assessment slide" which gave a snapshot of what a needs assessment is. Starting, the committee would need to gather information they already know. This includes EPI data, surveillance data, and service data. They would also look into which services people are using, general literature, literature reviews, CSU data around case management, MMP data, NHBS data, national data, and studies from other metropolitan areas such as SF and NY.

N. Johns said that the committee has had many significant conversations around elders' needs. She noted that there was a webinar currently taking place with Dr. Fauci around HIV and aging.

They can gather data about what they currently know about the EMA. The committee could also consider what services are available beyond Ryan White and including Medicaid/Medicare. They could also do their own data collection.

N. Johns read "What do we know?" from the Consumer Survey Report:

> The EMA's RW client population is aging, and many older PLWH have been living with HIV for decades. Age-related non-infectious comorbidities are more common among PLWH than the general population (Guaraldi, et al., 2011). These differences were statistically significant after adjusting for sex, age, and hypertension. Risk factors included prolonged ART exposure and lower nadir CD4 cell count (Guaraldi, et al., 2011). Weiss et al. (201) found that 84% of PLWH at an urban health clinic reported at least one comorbid condition, while 92% of them had at least one chart-documented condition aside from HIV. The highest prevalence conditions were hepatitis C (51.5%), pulmonary disease (28.5%), high blood pressure (27%), high cholesterol (24.5%), and obesity (22.5%). A high number of co-morbidities was associated with older age, being female, and injection drug use as reported mode of HIV transmission. A study of comorbidities among older PLWH found that patients over 60 years old had an average of 4.52 comorbidities (Vance, Mugavero, Willig, Raper, & Saag, 2011). That study also looked at difference in comorbidities and HIV health outcomes between PLWH aged 50-59 an 60 and older. They found that using the age group 50 and older confounded some important differences between 50-50 and 60 and older groups. The number of medications often increases as PLWH get older. This adds complexity to managing their healthcare. However, in this study, older patients had better health outcomes than younger patients, despite complicated treatments (Vance, Mugavero, Willig, Raper, & Saag, 2011). Advancements in HIV treatment mean that people are living decades with HIV, well into old age. Older PLWH are more likely to experience mental health and neurocognitive impairment than their HIV-negative peers. They are also more likely to experience social isolation as a result of decrease social participation and engagement due to social factors like stigma and declining health and mobility (Rueda, Law, & Rourke, 2014). The EMA's service system has to adjust to meet the needs of our aging population. Examples of possible changes in the RW delivery system include home visits by case managers, enhanced personal contact like follow-up phone calls and check-ins about current needs, support groups for older PLWH, and a focus on holistic care.

In summary, N. Johns noted that the older someone gets, the more likely they are to have comorbidities. This is especially true for PLWH. Stigma and other factors also contribute to loneliness and deterioration of mental health. A. Byrd asked if there was any data on elders with diabetes. N. Johns said that from the Consumer Survey, she believed more than a quarter of respondents had diabetes, adding that PLWH are more susceptible to diabetes. N. Johns said that this can be due to several reasons, one of them being access to food. N. Johns said that in general, cancer diagnoses are also higher for PLWH. C. Steib asked if 50+ as "elder age" was for ease of data collection. N. Johns said yes, but they should also be careful because there can be a large difference between someone aged 50 years and someone aged 70 years.

K. Carter asked if they should reconsider the age groupings for data collection. N. Johns said this may be difficult because studies typically go from 50 years old. However, the committee can consider breaking this down. M. Ross-Russell agreed that other EMAs have done needs assessments with "50+" as a category, so in order to compare data, using "50+" might be best.

K. Carter said cities like NY and SF may be ahead of the curve, and their information should be helpful. He added that older individuals who may have had issues with their treatment early on may still be experiencing the effects of that. He also suggested looking into elders and long-term care facilities. K. Carter suggested capturing sexual orientation and gender data for elders as

well. They could retrieve this data through the health department. They ultimately wanted to know how care and provision of services changes depending on these factors.

J. Browne confirmed that AACO collects gender identity and sexuality data. A. Byrd asked how the data is typically collected. M. Ross-Russell said that under normal circumstances, data is collected in steps. First, data would be collected from sources which are known to have reliable data. This could include studies from their own health departments or other health departments. This data and the results are reviewed. After that, they begin to think about how OHP and HIPC want to craft its own needs assessment. If they need to go to the community level for additional information, they will perform a focus group to talk with smaller groups of individuals to uncover more specific needs and whole narratives. Focus groups typically get more substantive information.

K. Carter noted that there are stages of aging – as you age, you need more assistance with care. He suggested looking more into the stages of aging *within* aging. Specifically, how do the needs of the 50+ change over time. He noted that medications can become more complicated for elders and their comorbidities over time. With an increased number of medications, can people stay compliant with their medications?

N. Johns noted that K. Carter's points spoke a lot to health literacy. N. Johns agreed that people may do well with their HIV medications until they add more medications to their routine. K. Carter suggested looking into "blister packing." A. Byrd said that her organization does blister packing, but their organization found that they need an individual to support the client with medication reminders. K. Carter said care structure can change from person to person. His ultimate question was what works best and what is most common structure for people as they age?

K. Carter said neurocognitive issues are also common for PLWH who are aging. How do they research whether people are getting the right mental health diagnoses as they age? A. Byrd said they should look into elders who have not disclosed their status to their families. These individuals may not have families to support their care and emergency contacts who are not family members. N. Johns said this conversation would be around stigma, relationships, and social support.

K. Carter also mentioned elders and affordable housing. Stable housing, he noted, is what keeps individuals healthy and safe. This should be a point of research. He also suggested researching rising STI rates and sexual health of elders and their personal safety measures.

G. Grannan asked how insurance companies look at elders trying to access PrEP. He wondered if people were rejected due to their age. M. Ross-Russell said that she would look into that, but she felt that people were not being rejected. B. Rowley said that as they decided to talk about PrEP in an elder context, they should look at the products out there. Patients need to make decisions with their healthcare provider for their body and health, especially renal function

J. Browne said that AACO heard from providers that Medicare is stricter for STI screenings. K. Carter asked if this included hepatitis tests. He mentioned that they should look into injection

drug use and hepatitis C rates for elders. N. Johns said that hepatitis C is more prevalent among older individuals. K. Carter asked J. Browne about the STI screenings, and J. Browne said she would get back to the group with the information.

K. Carter asked if they wanted to look into glaucoma and cataracts for elders since many insurances do not cover eye health. K. Carter said dental health was also important. N. Johns said that these two things are challenges. She added that they could also see how they can use what they learn to make decisions for how/to whom services should be provided, how priorities should be shifted, etc.

N. Johns said that they will have to patch together different sources and information first and that this was a good start. For focus groups, they should first collect other research. Then, they could look into quality of people's social lives, support systems, and other questions which cannot be answered with yes/no. She said that they could also consider services that they have not funded in the past. C. Steib suggested asking people about what they do for their own self-care to get insight into what care works best and how providers can copy. N. Johns said that this topic may be interesting for Positive Committee to work on.

K. Carter said that they could also get information from THRIVERS and the mayor's aging committee. C. Steib asked whether Siloam was still in existence, and K. Carter said yes. C. Steib said they would be a good resource as well. K. Carter said they could look at governor's aging workgroup, Philadelphia Corporation for the Aging, SAGE, CARIE. M. Ross-Russell said that if anyone knows of organizations working with elder populations, they should email the contact information to OHP. OHP could compile the resources/places so they can start researching and start building their steps. K. Carter said D. Griffin could help and possibly give a presentation. N. Johns said that the more experts in the room, the better. She encourages members to invite others to the future meetings.

N. Johns said that next month, they can pull together information gathered today and see what the next steps would be. M. Ross-Russell said that this would help focus the discussion around the data so as not to overwhelm people with questions they may already have the answer to.

**Old Business:**

None.

**New Business:**

None.

**Announcements:**

K. Carter announced that Positive Committee has changed its unofficial meetings to 5:30 p.m. every other Tuesday. Their next meeting would be in two weeks.

C. Steib announced that the Prevention Committee was meeting on September 23rd at 2:30 p.m.

S. Moletteri announced that OHP now had an Instagram with the handle @hivphilly.

B. Rowley said that Gilead was doing a cultural humility series in four parts over the course of four months. He asked OHP to distribute the information to their meeting list.

**Adjournment:**

G. Grannan called for a motion to adjourn. **Motion**: K. Carter motioned, C. Steib seconded to adjourn the September 2020 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:38 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- September 2020 Comprehensive Planning Meeting Agenda
- August 2020 Comprehensive Planning Meeting Minutes