Philadelphia EMA HIV Integrated Planning Council
Meeting Minutes of
Thursday, January 12, 2023
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Mike Cappuccilli, Keith Carter, Debra D'Alessandro, José de Marco, Lupe Diaz (Co Chair), Alan Edelstein, Monique Gordon, Pamela Gorman, Gus Grannan, Sharee Heaven (Co-Chair), DJ Jack, Gerry Keys, Greg Langan, Lorett Matus, Shane Nieves, Luis Otaño, Erica Rand, AJ Scruggs, Clint Steib, Evan Thornburg (Co-Chair), Adam Williams

Excused: Juan Baez, Jeffery Haskins, Desiree Surplus

Guests: Gracie Borns, Mike Valentin, Mike Frederick, Melissa Hobkirk, Danica Kuncio, Emily McCahery, Ameenah McCann-Woods (AACO)

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

Call to Order/Introductions: L. Diaz called the meeting to order at 2:07 p.m. She asked everyone to introduce themselves in the chat.

Approval of Agenda:
L. Diaz called for approval of the January 12, 2023 HIPC Agenda. C. Steib noted that the committee reports section was missing from the agenda. **Motion:** C. Steib motioned, M. Cappuccilli seconded to approve the amended agenda. **Motion passed:** 12 in favor, 4 abstaining. The amended January 2023 HIPC agenda was approved.

Approval of Minutes *(December 8, 2022)*:
L. Diaz called for approval of the December 8, 2022 HIPC meeting minutes. K. Carter noted there was no excused absence section of the minutes. G. Keys agreed, noting that she was also excused for the meeting. **Motion:** C. Steib motioned, M. Cappuccilli seconded to approve the amended December 8, 2022 minutes. **Motion passed:** 12 in favor, 5 abstaining. The amended December 2022 HIPC minutes were approved.

Report of Co-Chairs:

L. Diaz reported that C. Steib had suggested that she apply to the State of PA's HPG (HIV Prevention & Care Project) so that HIPC would have more representation. She was accepted to the group and would attend her first meeting on Tuesday and Thursday of next week. She would start reporting on the meetings as part of her Report of Co-Chair.

J. de Marco asked about HPG. L. Diaz said that this was the state's version of the Philadelphia HIPC's operations. M. Ross-Russell said that there were various parts of RW (Ryan White). The cities were RW Part A and the states were RW Part B. States were required to have an advisory board, similar to that of HIPC. Since the Philadelphia HIPC covered some counties in two states— PA and NJ—it was good to have representation from HIPC on both the PA and NJ HPGs.

J. de Marco asked if Part B was a separate council. M. Ross-Russell said yes. Initially, the planning group that was referred to was from 20 plus years ago, and was a combined group that included Parts

A and B which consisted of Philadelphia and the four PA collar counties. State HPGs covered the

entire state.

Report of Staff:

S. Moletteri reported that she was also now a member of the HPG. Her application was accepted, and she would be able to represent HIPC/OHP staff during the upcoming meetings. She would be attending virtually this time around since the meeting dates conflicted with CPC's meeting.

Presentation:

—Viral Hepatitis Program—

M. Hobkirk introduced herself as the Viral Hepatitis Prevention Policy and Community Outreach Manager for the Viral Hepatitis Program at the Philadelphia Department of Public Health. D. Kuncio introduced herself as the Project Manager for the Viral Hepatitis Program.

M. Hobkirk said they were finally at the stage where they could share the plan with community members to get feedback and ensure the plan was equitable. As for the background of the plan, there were several other national plans addressing viral hepatitis and eliminating hepatitis B and C.

She looked at the slide titled *Department of Health & Human Services Viral Hepatitis National Strategic Plan*. She said the first plan listed was a great example of a more comprehensive plan with a focus on elimination that took some pointers from the EHE. On the next slide, she explained that the national plans had trickled down into jurisdictional planning. A few elimination plans had come out over the last few years. This was due to new funding from the CDC to focus on hepatitis elimination planning. She noted that PA released a plan in March of 2022.

She next reviewed the slide titled *World Health Organization (WHO) Goals Elimination of Hepatitis B & Hepatitis C*. She said the WHO put out 2020 and 2030 goals to eliminate hepatitis B & C. They were now in the process of working on these. They were trying to achieve a 90% reduction in the number of hepatitis B & C incidents and a reduction of 65% in mortality from these two types of hepatitis. They would be looking at increasing vaccinations and harm reduction services to achieve these goals.

On the next slide, she read the five achievable goals: (1) Prevention of new viral hepatitis infections, (2) improve viral hepatitis-related health outcomes of people with viral hepatitis, (3) reduce viral hepatitis-related disparities and health inequities, (3) improve viral hepatitis surveillance and data usage, and (5) achieve integrated, coordinated efforts that address the viral hepatitis epidemics among all partners and stakeholders.

The next slide had a table titled *Table 3. Priority Populations by Hepatitis Type and Measure*. She explained that a focus on priority populations had not been done in the past. They would look to focus on populations disproportionately affected by hepatitis.

M. Hobkirk looked at the slide titled *Viral Hepatitis Infections* to offer an overview of the hepatitis types. She explained that the focus was on B & C for planning, but they would also touch on types A & D.

Hepatitis A transmission, she said, was fecal-oral, meaning ingesting infected fecal matter. All cases were acute, and people could clear the virus 100% of the time. It was vaccine-preventable and once people got it once, they would be immune to getting it again. There was not much to do to stop the

virus at the time, but they could treat the symptoms as they came about.

For hepatitis B, it was transmitted through blood, semen, and vaginal fluids and was vaccine preventable. Only about 10% of infants, 50% of young children, and 95% of adults would clear the virus. The treatment was supportive and the goal was to reduce the harm to one's liver since it could lead to liver cancer.

Hepatitis C was transmitted through blood and semen. There was no vaccine, but there was a cure. Only 25% of adults could clear the virus on their own.

Lastly, hepatitis D could be transmitted through blood, semen, and vaginal fluids. However, there must be hepatitis B present for transmission to occur. There was no direct vaccine for hepatitis D, but the HBV (Hepatitis B Virus) vaccine could protect people against hepatitis D. Treatment was supportive to reduce harm to the liver, just as hepatitis B.

As for *Testing Recommendations* for B and C, she looked at the next slide. For hepatitis C, she said that people 18+ should be screened for hepatitis C at least once in their lifetime and that there should be continued testing for those at risk (e.g. PWID and those receiving tattoos not from studios). She added that people should also be screened during pregnancy. For hepatitis B, there would be universal screening recommendations for adults. People at risk should continue to be tested as well as pregnant individuals.

Now that they knew that basics of B & C, she wanted to talk about resources and tools available as well as barriers and challenges.

She looked at the *Hepatitis B* slide. She said there was now an effective and universally recommended vaccine. There was effective treatment to extend life expectancy and screening tests that were widely available/billable. However, she said that hepatitis B was highly transmissible with very few symptoms, so most people would not know they had hepatitis B. There was bias/stigma around hepatitis B and vaccine hesitancy within certain populations. There was a cost to patients and a needed blood draw (no rapid test) for diagnosis and treatment. Many people also got hepatitis B when they were younger in other countries, so they would not know they had it. Lastly, hepatitis B required long-term treatment, meaning people could often fall out of care.

As for hepatitis C, M. Hobkirk looked at the tools section on the next slide. There was a cure for hepatitis C that was extremely tolerable at 8-12 weeks. The cure was all-oral with minimal side effects, and many providers were able to provide the treatment. There were universal screening recommendations, and it was easy to screen. Lab tests were common and billable. As for the challenges, hepatitis C was highly transmissible and there was community bias and lack of knowledge around the hepatitis C. There was a blood draw needed for diagnosis and treatment. Additionally, there was a prior authorization process required for Medicaid patients in PA. There was limited access in PA to harm reduction programs and SSPs (Syringe Service Programs). Lastly, many people in key communities were not motivated to be cured and linkage to care after diagnosis fell off.

M. Hobkirk next introduced D. Kuncio to review the successes. D. Kuncio thanked everyone and said that they were here as subject matter experts in some way or another because of their experience

with co-infection and EHE. As a program, they were excited to leverage this knowledge and include this in their planning. She was especially speaking of coinfection of HIV and HCV (Hepatitis C Virus) which was estimated to be about 3,000 coinfected individuals in 2019 for Philadelphia. It was now estimated that about 20% of PLWHA were currently living with or had a history of HCV. They

received funding from the federal government in 2016 for micro elimination.

Back in 2019, she reminded the group that they had seen this slide titled *C-Ya!: Elimination of HCV among HIV/HCV Coinfected Individuals (2016-2019)*. She explained that the goals during this timeframe were to build capacity to test and treat HCV among HIV care providers as well as prioritize HCV among HIV providers through EMR changes and technical assistance. The care continuum chart on this slide showed that people coinfected with HIV and HCV had improved outcomes compared to HCV monoinfected individuals. Therefore, they wanted to build on capacity within HIV care.

On the next slide titled *C-Ya Interventions: Increased HCV Testing and Treatment Capacity*, D. Kuncio explained that they worked to ensure that people received standardized HCV reflex testing, HCV treatment was incorporated into HIV care sites, co-infected individuals and those out of HIV care were identified, and the co-occurring outbreak of HIV among PWUD (People Who Use Drugs) was addressed.

On the next slide titled *HCV Care Continuum Improved*, the green and blue bars were outcomes by the end of the coinfection project in 2019. She said the last set of bars represented those who saw their HCV resolved. By the end of this project, nearly half of the resolved cases doubled. They were hoping to see even better outcomes sooner.

D. Kuncio next looked at the *Considerations* slide. They wanted to build off existing resources for their new plan and tailoring it specifically to Philadelphia. She said a PA-wide plan would not be perfect for Philadelphia, so this sort of tailoring was necessary. What was different than the EHE plan was that no funds were promised for elimination activities, just the planning process—therefore, they were depending on stakeholders and partnerships. They knew their partners had the drive, so they needed to ask for the money and find out what partners needed. The plan, she explained, should be digestible for the public so it could act as a tool.

As for the tentative timeline, they had been working on the plan for over a year and would hopefully release the plan in a couple of months along with surveillance data and an epidemiological report to inform the activities. They would be taking feedback between 2023-3030.

Concerning the plan itself, there were four pillars: (1) Education and Prevention, (2) Testing & Linkage to Care, (3) Care Engagement & Treatment, and (4) Data & Surveillance. These pillars had a focus on health equity, harm reduction, social justice, hepatis A and D, cancer prevention, and social change.

They called for community feedback, D. Kuncio explained, in many ways during many different events and were welcoming more feedback. The form was available in different languages, and she would share the link. She read the list from the *Community of Eliminators* slide of committees that took a role in elimination efforts. She said that people could look to join these if they wanted. The next slide also showed other committees, educational materials, and their monthly newsletter.

D. Kuncio thanked everyone for their time and asked for questions and feedback. T. Dominique asked to the presenters to expound on the graph containing the HCV coinfected care continuum versus monoinfected. D. Kuncio said that this graph was modeled after the HIV care continuum. Each column to the right of the first column (HCV Ab-Positive)—which was at 100%—showed which percentage of those testing positive for HCV were at each stage of the care continuum. For example, in the last column, 15% of monoinfected individuals and 28% of coinfected individuals were cured of HCV out of the total HCV Ab-Positive people in the first column.

D. Kuncio explained that the graph on slide 18 was meant to show progress along the care continuum for 2016 outcomes versus 2019 outcomes. D. D'Alessandro asked if there was an updated continuum since 2019 after stopping the targeted intervention with providers. D. Kuncio said that they had not updated the continuum yet, but they were looking to do so in the very near future. She also noted that they saw improved HCV outcomes, but they also saw improved HIV outcomes along the care continuum. K. Carter asked if people could get reinfected with HCV after being treated. D. Kuncio said they could, but they saw a low proportion of less than 5% of treated individuals becoming reinfected over the last 10 years. S. Nieves asked if they would share the plan. D. Kuncio said they would release and share the plan within the next few months.

T. Dominique asked for more information on the blue column (listed as *Sept 30, 2019 includes new HIV/HCV diagnosis* in the key) for slide 18. D. Kuncio said that this column included the 2,813 people from the beginning of the project, but the blue included additional people diagnosed after Dec 31, 2016, adding up to a total of 3,238 individuals.

D. Kuncio asked if people had any recommendations based on the council's experience with working with AACO on the EHE plan. M. Hobkirk said that if anything came to mind, they could feel free to let them know through the form that they provided.

D. D'Alessandro said that maybe some people would be interested in HepCAP (Hepatitis C Allies of Philadelphia). M. Hobkirk said the coalition was in search of new Steering Committee members (which met about 4 times per year). If anyone wanted to join the coalition (which met 3 times per year) itself, they were also always looking for new members. HIPC should have received an application for this in the meeting invitation.

K. Carter asked if they were linked to the PhillyKeepOnLoving website. D. Kuncio said they did not have an active presence on this website, but they had their own website. They were currently working with the AACO team to ensure they were coexisting, so hopefully there would soon be more information on PhillyKeepOnLoving and on other such HIV-related resources. E. Thornburg suggested it might be beneficial to link to each other's sites. D. Kuncio agreed with this recommendation.

—Clearinghouse/Coordinated Entry—

E. McCahery introduced herself, explaining that she worked for OHS (the Office of Homeless Services) in the office of Clearinghouse. She said she was asked to present on Supportive Housing/Clearinghouse and provide context to Coordinated Entry. There was no visual presentation, but she would be able to offer as much information as the group needed.

E. McCahery explained that OHS was Philadelphia's office for homelessness prevention and diversion efforts. The resources were to prevent homelessness and shelter individuals to meet emergency housing needs. Philadelphia also had short-term transitional housing, rapid rehousing (rental assistance so people could rapidly rehouse in a private market) until people could find an alternative, and permanent supportive housing (for individuals needing more intensive, long-term support).

Several years ago, she said, OHS implemented HUD's (Department of Housing and Urban Development) rules about coordinated entry. In Philadelphia, they call it CEA-BHRS (Coordinated Entry and Assessment-Based Housing Referral System). This meant they worked in a coordinated

way to ensure people in need had access to their services. As for the coordinated entry part, people could call and get a message back, they could engage at access points, or they could engage with someone working on the street as a mobile assessor. As for the assessment-based housing referral portion, once people were considered homeless and needed assistance to attain housing/shelter, they would receive an assessment usually only given once to determine what approach/programs were best for them. This also helped OHS understand high priority populations.

The housing program used to be first-come first-serve, but this did not address many other factors such as behavioral health needs, family, etc. They have now flipped this to address the more vulnerable populations, bumping people up in "line" to avoid negative outcomes. These housing assessments help OHS to do "matchmaking." Those experiencing homelessness could be connected to programs and resources they were eligible for. Programs also input information into the team's system so the team knew which programs were available and had vacancies.

She explained that they did the matchmaking for HUD-funded coordinated continuum of care (CoC) programs, housing with private-market partners, and more recently, the AACO housing waitlist. The team was asked to refer people to HOPWA housing providers using the AACO-housing waitlist and those experiencing homelessness who met the HOPWA housing criteria. When the team first started working with the AACO waitlist, there were still some people on the list experiencing homelessness. They had since made referrals to match these people to HOPWA waitlist vacancies and get them housed. Now, those left on the list were rent-burdened and still eligible for HOPWA housing.

E. McCahery explained that those experiencing homelessness were the highest priority. The only reason they would not be able to offer someone of the highest priority housing, most recently, was often because HOPWA housing providers had larger units for larger households. Therefore, they could not house a single individual and would look further down on the AACO waitlist to find household sizes matching the number of units.

She added that they also had some housing within coordinated entry that was HUD-funded and targeted toward PLWHA. They did not use the AACO waitlist for this because the CoC (Continuum of Care) programs had the basic eligibility requirement that the individual/family must be experiencing homelessness.

J. de Marco asked how many individuals were rent burdened on the waitlist and how long they had been waiting. Additionally, within the shelter system, he asked how many individuals were known to be PLWHA. E. McCahery said for the second question, this was self-reported. If they reported their status, it was recorded, so the team could pull data on this. The last time they looked at this, there were about 45-50 PLWHA who were experiencing homelessness and had a housing assessment done—meaning they were seeking help to resolve homelessness. There were likely some, but not very many, who had HIV/AIDS and were not asking for assistance to resolve homelessness. As for J. de Marco's first question, E. McCahery said there was about 260 households still on the AACO

waitlist under the rent burdened category. The longest wait time on the list was from 2010 or 12 years ago.

J. de Marco asked if there were specific housing providers and how this worked. She said that most providers contracted through the DHCD (Division of Housing and Community Development) while some providers had direct grants with HUD.

K. Carter asked which populations were priority and the most vulnerable. E. McCahery responded that those experiencing homelessness were priority. There was a vulnerability tool used to look at the

assessment. Questions in the assessment included: how many times have you been homeless, have you ever lost housing because of physical or mental health, are there medications prescribed that you do not take, etc. The vulnerability tool was used for the assessment to create a score indicating priority. T. Dominique asked what would happen if people had the same score. E. McCahery said they would look at other factors, such as who had been homeless the longest out of the two individuals and who was unsheltered. They had never gotten to the point of looking at who was sheltered versus unsheltered since there was usually a difference in timeframe of homelessness.

K. Carter asked if people had choice in where they were housed. E. McCahery said there was choice involved, yes. Some of the inventory they had to offer people was place-based. Other subsidies, such as HOPWA-subsidies that were rent-based, meant people just needed to find a renter who accepted the subsidy. If people turned down an opportunity because of legitimate reason e.g., past trauma in the neighborhood, transit for work, etc., this would not affect their stay in shelter. However, if someone turned down the housing opportunity only because of preference, they may be told that needed to leave shelter because they did not have the ability to continually offering different places based on preference.

K. Carter asked if there was competition between the Housing Choice Vouchers from the Housing Authority and HOPWA housing. E. McCahery said there was no competition, and that people could be on both lists. J. de Marco said that most individuals that met the medical requirement for disability likely received monthly disability. He mentioned that rent was very expensive, so he was curious to see how much of housing costs were covered under HOPWA. S. Heaven said that this was based on 20% of income as part of a federal calculation. If a person had zero income, they would calculate this, and the individual would likely receive a utility reimbursement.

S. Heaven said if someone received disability and later got a job, their portion of rent was calculated for the first year based on disability. During the second year, it would be recalculated to base income off the new employment. There used to be a four-year disallowance from HUD—it had since been shortened twice. This was out of Philadelphia's control. She added that failure to report income as it changed would result in termination for the program. Likely, agencies would work with a person so that termination would hopefully not occur.

J. de Marco suggested there needed to be a change in affordability. S. Heaven said this was not necessarily in their control, but lack of affordability was true. She explained that they used two ways to calculate whether a rent amount qualified for the program. At first, they were only using the fair market rent chart, and now HUD allowed them to use the small area fair market rent to look at specific zip codes. Sometimes one was better than the other, depending on the area. Jurisdictions were also allowed to approve 10% of total units above the fair market rent, simply due to lack of affordability.

S. Moletteri asked if there was an idea of how many landlords accepted the HOPWA subsidy. S. Heaven said that landlords had been frustrated because when the city received funding, landlords were not paid on time. They would send out letters to landlords to let them know that payments would go out as soon as possible. She said most of the landlords had been working with the program for years. If landlords stopped working with the program, it was sometimes personal, meaning the landlord had some issues with tenants.

S. Heaven said that they were understaffed, but they were working hard to get people housed as well as the services and safety/security they deserved.

E. McCahery put her email in the chat. D. D'Alessandro asked if being pregnant or with small

children increased the priority score. E. McCahery said that it did and under certain circumstances it would increase people's score by one point. D. D'Alessandro said there was a time where people could be excluded from public housing if any member of their family had a criminal record or was involved in the justice system while in public housing. She asked if this still existed. S. Heaven said this was not the case for HOPWA. E. McCahery said for PHA, there were very specific criminal history rules. Congress, she said, stated that applicants who were lifetime registered sex offenders or if a family member was convicted of methamphetamine production on federally assisted housing property, PHA could not assist no matter what. There were other criminal history requirements from PHA, but people could appeal these and PHA could overturn.

S. Heaven said that Calcutta was currently listed as closed (previously received direct HOPWA funds). PHMC and Congreso also received direct HOPWA funds.

L. Diaz thanked E. McCahery and S. Heaven for all of the information provided.

Committee Reports:

—Executive Committee—

No report.

—Finance Committee—

No report.

—Nominations Committee—

M. Cappuccilli reported that the committee met right before this meeting. They discussed what the next orientation would look like—it would happen on February 9th, right before the HIPC meeting. M. Ross-Russell would cover a portion of orientation during the HIPC meeting.

—Positive Committee—

K. Carter reported that they met on Monday. They met the second Monday of each month. He said they reviewed what RW covered for housing.

—Comprehensive Planning Committee—

G. Grannan reported that the committee reviewed preliminary Consumer Survey 2022 data and discussed HB103. They would meet a week from today at 2:00 p.m.

—Prevention Committee—

C. Steib reported that they did not meet in December, but they would meet on January 25th at 2:30 p.m. He asked new members to join.

Other Business:

L. Diaz thanked everyone for the great meeting and amount of engagement. L. Diaz also thanked D. D'Alessandro for assisting with defining acronyms.

Announcements:

None.

Adjournment:

L. Diaz asked for a motion to adjourn. **Motion:** M. Cappuccilli motioned, D. D'Alessandro seconded. **Motion passed:** general consensus. Meeting adjourned at 3:43 p.m.

Respectfully submitted:

Sofia M. Moletteri, staff

Handouts distributed:

- January 2022 HIPC Meeting Agenda
- December 2022 HIPC Meeting Minutes
- Viral Hepatitis Info
- Steering Committee Member Application 2023