COMPREHENSIVE PLANNING COMMITTEE

MEETING AGENDA

Thursday, September 19, 2019
2:00 – 4:00PM
Office of HIV Planning 340 N. 12th Street Suite 320
Philadelphia, PA

Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*August 15, 2019*)

Report of Staff

Report of Chair

Action Item:

- **Election of Co-Chair**

Discussion Items:

- **Planning for 2019-2020**
  - ❖ **Housing First**
  - ❖ **Syringe Access Programs**

Old Business

New Business

Review/Next Steps

Announcements

PLEASE TURN ALL CELL PHONES TO SILENT.

The next meeting of the Comprehensive Planning Committee is ***October 17 from 2 to 4 pm*** *at 340 N. 12th Street, Suite 320, Philadelphia, PA 19107.* ***Please refer to the Office of HIV Planning calendar of events for committee meetings & updates (www.hivphilly.org). If you require any special assistance, please contact the office at least 5 days in advance.***

Philadelphia EMA HIV Integrated Planning Council (HIPC)
Comprehensive Planning Committee
Meeting Minutes
Thursday, August 15, 2019
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Keith Carter, Mark Coleman, Lupe Diaz, David Gana, Gerry Keys, Clint Steib, Gail Thomas (Co-Chair)

Guests: Jessica Browne (AACO)

Staff: Nicole Johns, Briana Morgan

Call to Order/Introductions:
G. Thomas called the meeting to order at 2:10 p.m. Those present then introduced themselves.

Approval of Agenda:
G. Thomas presented the agenda for approval. **Motion:** G. Keys moved, D. Gana seconded to approve the agenda. **Motion passed:** All in favor.

Approval of Minutes *(June 20, 2019)*:
G. Thomas presented the June 20, 2019 meeting minutes for approval. **Motion:** D. Gana moved, G. Keys seconded to approve the June 20, 2019 minutes. **Motion passed:** All in favor.

Report of Staff:
None.

Report of Co-Chair:
None.

Action Item:

- **Co-Chair Elections**

  N. Johns reported that the committee needed another co-chair. She explained that M. Dias had been elected earlier that year but moved to another city. She noted that committee co-chair nominations were available to any Planning Council member in good standing. The group agreed to table the election until their next meeting.

Discussion Items:

- **Priority Setting Debrief**

  N. Johns reminded those present that they conducted priority setting at their last meeting, and that the results were then approved by the Planning Council. She explained that the group would discuss their process and results *(see – attached handout)*, noting that that any services that were highlighted in yellow had moved at least three slots in the ranking.

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N. Johns asked those present what they liked about the process. G. Keys said that she liked the process and thought it went smoothly. She stated that the scorecards for voting had worked well and prevented any pressure that people should vote a certain way. She said the explanation of the service categories went well. She stated that they wanted the public to come, but that each year, they had attendees who had not been to any previous meetings and interrupted with questions that had been answered before. She noted that she thought this would remain the same in the future. L. Diaz agreed that this could be burdensome. She stated that she did try to remind people that priority setting was part of a larger picture, and that she recommended that people who wanted to be more involved join the Planning Council. G. Keys explained that only coming to the one priority setting meeting made it hard to fully participate.

N. Johns explained that this happened every time they did priority setting, but that the Council kept their meetings open to the public. She said that they could require attendees to come to an additional meeting before they could participate in a decision-making process, which is not something that had ever happened before. She explained that the Planning Council ultimately voted on anything that came through committee, so the committees were open to full participation from community. She noted that any problematic decisions could then be checked by the Planning Council.

M. Coleman asked for the definition of public comment. N. Johns replied that anyone was allowed to participate in discussion in committees, and in the Council. She noted that there was a specific time in the Planning Council meeting that was designated for public comment, and that anyone could address the Council during this time. She stated that co-chairs could limit discussion to keep things on track, based on time and other criteria. K. Carter stated that they were open to hearing from community members, but that they needed to keep things relevant to the discussion. L. Diaz said that part of the job of the co-chairs was to ensure that they address everything on the agenda in order, and to complete their business at every meeting.

The group then reviewed the priority list. M. Coleman stated that there were a lot of people who did not have housing, and that it was important that they prioritize that. N. Johns noted that housing was ranked at #1. D. Gana stated that housing would be better addressed at HOPWA meetings, since Ryan White could not provide permanent housing. K. Carter added that they could only provide temporary housing, up to 24 months. He explained that housing was a constant issue, and that they were doing the best they could with what they had. D. Gana added that the cost of living had been increasing, and HOPWA dollars were not going as far.

N. Johns redirected those present to the list, reminding them that there had been some significant changes. L. Diaz pointed out the rise in mental health and substance abuse services, noting that this made sense since they were in the middle of an opioid crisis. She stated that she liked seeing this, because it reflected the issues they were seeing. N. Johns stated that she had included a sentence in the Part A application about the changes in their priority list due to the opioid crisis and changes in the life cycle of PLWH. L. Diaz stated that she had just noticed the drop in health education/risk reduction. N. Johns replied that they

had talked a lot about definitions, and that it would make sense for a category to fall to the bottom since other services were going up. K. Carter stated that there had been a change in the "community voices" factor, and that they had very specific criteria this time.

L. Diaz stated that child care services had also been dropping lower. N. Johns agreed, noting that it had been toward the bottom for several years. L. Diaz asked if this was because they had never funded the service. N. Johns replied that this service had received two scores of 1 in the Medical Monitoring Project (MMP) and Client Services Unit (CSU) columns. She suggested that they revisit this under the allocations portion of the agenda. L. Diaz noted that care outreach had also dropped a lot, noting that she wondered if the loss of a champion of the service on the Planning Council had made a difference.

K. Carter pointed out that non-medical case management also dropped significantly. N. Johns agreed, noting that they had focused more on the definition this year. She explained the new medical case management model had not yet rolled out at the time of the last priority setting process in 2017. She concluded that they had had a different conversation at the time. G. Thomas asked what health insurance premium/cost-sharing assistance was. N. Johns replied that it was money to pay for health insurance. M. Coleman asked for clarification on non-medical case management. N. Johns explained that this was referrals not focused on medical outcomes, and they did not fund this category in their system. She noted that medical case managers handled anything that non-medical case managers would in the Philadelphia EMA's system.

G. Thomas noted that she needed some helpline cards because other organizations did not have them. J. Browne noted that she could pick them up from AACO.

N. Johns added that priority setting did not dictate funding priorities, but that the priority list did help the Planning Council when they were making decisions about services. She noted that priority setting was a legislatively-required activity of the Planning Council.

- **Allocations Debrief – Identify areas for assessment/inquiry**

N. Johns stated that she would be going through the notes from the allocations meetings, explaining that the group could use this information to inform their meetings and discussions for their next update to the Plan as well as Ending the HIV Epidemic preparations. She went on to say that they had had some extensive conversations about transportation, noting that they wanted to ensure that no one missed a medical appointment due to transportation. She explained that they looked at substance abuse services as well, including syringe access. She added that substance abuse had come up in all the meetings.

N. Johns stated that there had been a lot of concern about access to substance abuse treatment for people who are uninsured, and that there had also been a lot of talk about medication-assisted treatment (MAT). She noted that the Planning Council had also allocated funding to MAT in Philadelphia the previous year. She stated that there had been questions about how transportation was provided in different locations, and concern about the new SEPTA cards making it hard for people to use the system. D. Gana noted that they had been able to get one-way trip cards from SEPTA, which were better than the two-way trips since two-way

trip cards had to be used the same day. G. Thomas noted that she had had experiences where the cards had been used already. N. Johns suggested that she follow up with the organization that had provided the cards.

N. Johns noted that the group in the suburbs talked about difficulty with access to mental health services. B. Morgan added that they had specifically talked about a gap in mental health providers with the ability to prescribe medications, noting that people could often see therapists but did not have access to a prescriber. D. Gana stated that there was also an issue related to access to nutrition counseling in the PA suburbs.

The group then discussed ambulatory care. N. Johns noted that there was not a Ryan White medical provider in Bucks County, nor was there a federally-qualified health center (FQHC). She stated that there was a lack of dental providers who would treat PLWH in the counties. She noted that everyone in the EMA could access Ryan White services anywhere in the EMA.

M. Coleman asked if the counties outside of Philadelphia were aware of the opioid crisis. N. Johns replied that they were aware, although funding for substance abuse services worked differently in these counties, and came through the state. K. Carter noted that there was a lot of conversation about this in Bucks County, and B. Morgan agreed that these conversations had been happening with the general public for several years. The group then discussed contrasts in attitudes to opioids in Philadelphia as opposed to outlying counties.

N. Johns stated that there had been a question about how child care was provided within the EMA, and specifically in Southern New Jersey. She noted that she had done some basic research, and that the provision of child care was provided in an ad hoc process at each organization. She explained that, in some places, someone who worked at a provider would take care of a baby while a parent or grandparent was at the appointment. She noted that she was going to talk to providers who were seeing women of childbearing age to ask how parental responsibilities were affecting access to care.

K. Carter described a play area at an organization in the PA Counties. He asked if there were liabilities involved. N. Johns agreed, noting that there was special liability insurance to get. K. Carter asked if children could go into appointments with their parents. N. Johns replied that it depends on the provider, and that this was not an equitable system. B. Morgan noted that there were a lot of grandparents raising small children, particularly in the face of the opioid crisis, so many older people may require child care as well. G. Thomas noted that public assistance would only provide child care for people who were working. K. Carter asked if they needed to identify the total number of people with HIV who need child care. N. Johns replied that this was part of what they needed to consider. J. Browne stated that AACO did not have complete figures on that, although it might be listed as another barrier to care. N. Johns stated that the consumer survey asked if people support anyone else with their income, but they have never asked about children. K. Carter asked if they could ask about children in future surveys, and N. Johns agreed. N. Johns stated that they could also do a survey just about this topic. K. Carter stated that some people also take care of older relatives. N. Johns agreed, noting that there were existing services for disabled and elderly

people who need care. She stated that they could ask people if their caring responsibilities were preventing them from accessing care. She explained that they could look at the impact of caregiving, although the impact would be different in terms of who they were caring for. J. Browne stated that, in the future, AACO might be able to look to the Data to Care Initiative for relevant data.

K. Carter asked if they were seeing an increase in Hepatitis C among babies. N. Johns replied that there were programs around pregnant people who have Hepatitis C to prevent transmission.

N. Johns stated that they would also get more information about what was being provided under "other professional services."

N. Johns stated that there were also always issues around housing and direct emergency financial assistance (DEFA). She stated that there had also been increases in utilization in oral health care in New Jersey, and that there were only so many providers who would provide the service.

N. Johns stated that they had also talked about access to translation and interpretation in real-time when trying to access services. She noted that interpretation was supposed to be available, but was not always provided. K. Carter asked how this process worked. J. Browne stated that the CSU used Language Line when needed, and that they included preferred languages when referring a new client to a medical case manager. She explained that, ideally, the medical case manager would then use the Language Line or attend the medical appointment with the client. N. Johns stated that a real-life scenario might involve a person coming into an organization, and providers having a difficult time identifying the language that person is speaking. She stated that there could also be issues around whether information is conveyed accurately in medical settings. J. Browne noted that this applied to a small number of clients coming through intake. She added that the Language Line was often hard to figure out. G. Thomas asked if they should do a survey. N. Johns replied that translation of a survey into multiple languages was resource-intensive, and that it can be difficult to reach the populations who would use it.

- **Planning for 2019 – 2020**

N. Johns suggested that the committee use its next meeting to plan for the next year, due to time. She noted that they could consider the true gaps related to a lack of prescribers in mental health services.

M. Coleman asked if care outreach provided funding for organizations to pass out condoms. N. Johns replied that care outreach helped PLWH get into care. She noted that these activities provided through different service categories.

K. Carter stated that they should talk about syringe access and disposal both inside and outside of Philadelphia. He explained that people should be able to pick needles up without a risk of going to jail. N. Johns stated that syringes had to be transported to a location that would dispose of them. G. Keys noted that some people put used syringes in bleach bottles.

K. Carter stated that he also had some questions about safer injection sites. N. Johns noted that she had reached out to Safehouse to see if they would like to come speak with the Planning Council. K. Carter stated that they needed to be able to get people clean supplies to prevent transmission of Hepatitis C and HIV.

Old Business:
None.

New Business:
None.

Review/Next Steps:
None.

Announcements:
M. Coleman announced that Philadelphia FIGHT and partner organizations would be reading names of people who died of overdoses at the federal courthouse the following Monday.

Adjournment:
The meeting was adjourned by general consensus at 4:00 p.m.

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from June 20, 2019
- Philadelphia EMA Planning Council Priority Setting Tool
- 2019 – 2020 Planning Calendar
- OHP Calendar

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For the Comp Planning Group and the HIPC.

Note that all Behavioral Health services funded by RW Part A must participate in Medicaid. In Philadelphia this means they must have a contract with CBH.

Here is information about the smoking issue with Substance abuse treatment.

December 31, 2018
Effective January 1, 2019, smoking and all forms of tobacco use will be prohibited at all residential drug and alcohol treatment programs under contract with the Philadelphia Department of Behavioral Health and Intellectual disAbility Services' (DBHIDS) Community Behavioral Health (CBH) division.
This policy is being enforced as a contract mandate for each of the 80 inpatient addiction treatment programs in the CBH provider network spanning four levels of care including nine detox facilities, 32 short-term rehabilitation programs, 31 long-term rehabilitation programs and eight substance use halfway houses.
Individuals who smoke cigarettes or use electronic nicotine delivery systems and are admitted to any of these facilities for substance use treatment will be offered medication and counseling to manage nicotine withdrawal while concurrently undergoing treatment for their admitting diagnosis. The policy applies to staff and visitors who will also be prohibited from smoking or bringing tobacco products and paraphernalia onto the premises.
Smoking is often part of a drug use ritual and is the leading cause of death and disability among behavioral health populations disproportionately. It is estimated that smoking-related conditions comprise 39 percent of deaths among opioid users, 40 percent among cocaine users and 49 percent among alcohol users.
Additionally, tobacco use kills more people than both opioid overdoses and gun violence in Philadelphia where surveys show smoking use among those with a substance use or alcohol problem to be at around 69 percent and 48 percent respectively. Smoking use among Philadelphians who report not using drugs or alcohol hovers at around 22 percent according to surveys.
Research also shows that people who have an addiction to drugs or alcohol are generally more likely to die from a smoking-related illness than from the other drugs they are ingesting. High smoking rates, frequent smoking and earlier smoking initiation render those with substance use disorder particularly vulnerable to tobacco-related harm.
"People who have a substance use disorder are smoking as much as three times the rate of the general population and, tragically, they are dying 25 years earlier than the general population largely because of smoking-related diseases affecting the lung and heart," said Philadelphia's behavioral health commissioner, David T. Jones. "Providing substance use treatment in a smoke-free environment will not only help us to improve addiction recovery outcomes for people, it will also help us to improve their overall health outcomes – consistent with our population health approach to delivering behavioral health services in Philadelphia."
Quitting smoking while in recovery from drug addiction can increase long-term substance use abstinence rates by 25 percent. Studies show quitting during the recovery process also increases the likelihood of achieving and sustaining long-term recovery. By

comparison, continuing to smoke after addiction treatment increases the likelihood of experiencing substance use relapse.

Data strongly supports the argument that many of those living with substance use disorder want to quit smoking and are more successful in doing so with evidence-based treatment provided by a clinician.

Tuesday's policy rollout comes three years after the same contract mandate was successfully implemented at all acute inpatient psychiatric hospitals under contract with CBH. In both instances, treatment facilities provided input throughout the implementation process and the Philadelphia Department of Public Health and the University of Pennsylvania contributed as partners in the effort.

Comprehensive Planning Committee

2019-2020 Planning Calendar

September	**October**	**November**	**December**
January	**February**	**March**	**April**
May	**June**	**July**	**August**

RAPID RE-HOUSING
RRH

FACT SHEET: HOUSING FIRST

APRIL 2016

National Alliance to End Homelessness

WHAT IS HOUSING FIRST?

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.[i]

HOW IS HOUSING FIRST DIFFERENT FROM OTHER APPROACHES?

Housing First does not require people experiencing homelessness to address the all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing. Housing First does not mandate participation in services either before obtaining housing or in order to retain housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. Supportive services are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.[ii] Other approaches do make such requirements in order for a person to obtain and retain housing.

WHO CAN BE HELPED BY HOUSING FIRST?

A Housing First approach can benefit both homeless families and individuals with any degree of service needs. The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. As such, a Housing First approach can be applied to help end homelessness for a household who became homeless due to a temporary personal or financial crisis and has limited service needs, only needing help accessing and securing permanent housing. At the same time, Housing First has been found to be particularly effective approach to end homelessness for high need populations, such as chronically homeless individuals.[iii]

WHAT ARE THE ELEMENTS OF A HOUSING FIRST PROGRAM?

Housing First programs often provide rental assistance that varies in duration depending on the household's needs. Consumers sign a standard lease and are able to access supports as necessary to help them do so. A variety of voluntary services may be used to promote housing stability and well-being during and following housing placement.

Two common program models follow the Housing First approach but differ in implementation. Permanent supportive housing (PSH) is targeted to individuals and families with chronic illnesses, disabilities, mental health issues, or substance use disorders who have experienced long-term or repeated homelessness. It provides longterm rental assistance and supportive services.

A second program model, rapid re-housing, is employed for a wide variety of individuals and

families. It provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and remain housed. The Core Components of rapid re-housing—housing identification, rent and move-in assistance, and case management and services—operationalize Housing First principals.

DOES HOUSING FIRST WORK?

There is a large and growing evidence base demonstrating that Housing First is an effective solution to homelessness. Consumers in a Housing First model access housing faster[iv] and are more likely to remain stably housed.[v] This is true for both PSH and rapid re-housing programs. PSH has a long-term housing retention rate of up to 98 percent.[vi] Studies have shown that rapid re-housing helps people exit homelessness quickly—in one study, an average of two months[vii]—and remain housed. A variety of studies have shown that between 75 percent and 91 percent of households remain housed a year after being rapidly re-housed.[viii]

More extensive studies have been completed on PSH finding that clients report an increase in perceived levels of autonomy, choice, and control in Housing First programs. A majority of clients are found to participate in the optional supportive services provided,[ix] often resulting in greater housing stability. Clients using supportive services are more likely to participate in job training programs, attend school, discontinue substance use, have fewer instances of domestic violence,[x] and spend fewer days hospitalized than those not participating.[xi]

Finally, permanent supportive housing has been found to be cost efficient. Providing access to housing generally results in cost savings for communities because housed people are less likely to use emergency services, including hospitals, jails, and emergency shelter, than those who are homeless. One study found an average cost savings on emergency services of $31,545 per person housed in a Housing First program over the course of two years.xii Another study showed that a Housing First program could cost up to $23,000 less per consumer per year than a shelter program.[xiii]

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[i]Tsemberis, S. & Eisenberg, R. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. 2000.
[ii]Einbinder, S. & Tull, T. The Housing First Program for Homeless Families: Empirical Evidence of Long-term Efficacy to End and Prevent Family Homelessness. 2007.
[iii]Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes. 2003.
[iv]Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First programs. 2003.
vTsemberis, S. & Eisenberg, R. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. 2000.
[vi]Montgomery, A.E., Hill, L., Kane, V., & Culhane, D. Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH. 2013.
[vii]U.S. Department of Housing and Urban Development. Family Options Study: Short-Term Impacts. 2015.
[viii]Byrne, T., Treglia, D., Culhane, D., Kuhn, J., & Kane, V. Predictors of Homelessness Among Families and Single Adults After Exit from Homelessness Prevention and Rapid Re-Housing Programs: Evidence from the Department of Veterans Affairs Supportive Services for Veterans Program. 2015.
[ix]Tsemberis, S., Gulcur, L., & Nakae, M. Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis. 2004.
[x]Einbinder, S. & Tull, T. The Housing First Program for Homeless Families: Empirical Evidence of Long-term Efficacy to End and Prevent Family Homelessness. 2007.
[xi]Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First programs. 2003.
[xii]Perlman, J. & Parvensky, J. Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report. 2006.
[xiii]Tsemberis, S. & Stefancic, A. Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention. 2007.

From Section I A (Epi) of Integrated Plan Update:

Housing

Rent (and rent as a proportion of income) varies across the Philadelphia EMA. In 2016, median income for Philadelphia renters was $28,463, while median rent was $943 per month.[1] For Philadelphia renters who earned less than $20,000 in the past 12 months, rent alone accounted for 31.9% of household income. By county within the rest of the EMA, this figure ranges from 16.3% – 31%. However, housing as a percentage of median income is even more expensive in the cities of Chester and Camden than in Philadelphia. For households with an income of less than $20,000 per year, rent was 44.9% of income in Camden city and 43.9% in Chester city. These figures demonstrate that there are variations in access to affordable housing throughout the EMA, but housing is particularly unaffordable in cities.

From 2012 to 2016, homelessness increased by 4.1% in Pennsylvania and decreased by 31.7% in New Jersey.[2] By contrast, homelessness decreased by 11.5% nationally. Unsheltered homelessness increased in Pennsylvania, rising by 55.7% from 2012 to 2016. In New Jersey, unsheltered homelessness decreased by 10.2%. National unsheltered homelessness figures decreased by 17.2%.

Philadelphia's Office of Homeless Services has a Continuum of Care Board that addresses homelessness in a number of populations, including people with HIV/AIDS. Their January 2017 Point in Time count identified 5,693 homeless persons in Philadelphia on a given night.[3] Of these, 159 were people known to be living with HIV/AIDS; 108 of these homeless PLWH were sheltered on the night of the count.

From Section I D of Integrated Plan Update:

Housing Insecurity and Homelessness among PLWH

According to PDPH, more than 10.6% (1,779 individuals) of PLWH receiving Ryan White services in the EMA are reported to have unstable or temporary housing. PDPH estimates that there are 2,675 PLWH experiencing homelessness in 2015. Over half of the RW consumer survey respondents (61.6%) reported that they were renting or owned a house or apartment at the time of the survey. However, a substantial proportion of the sample was homeless or marginally housed: 14.5% of the sample were staying with friends or family, 2.1% lived in a shelter, 1.1% said they were in transitional housing (halfway houses or drug treatment program), and 0.8% lived on the street. Rental subsidies supported another 16.4% of respondents: 9% relied on Housing Opportunities for People with AIDS (HOPWA) and 7.4% reported participating in the Housing Choice Voucher Program or living in public housing. Respondents from New Jersey were more likely to rent or own their own home than respondents from Philadelphia and the PA Counties.

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[1] U.S. Census Bureau (2018). S2503 Financial Characteristics [Data]. *2012-2016 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.

[2] National Alliance to End Homelessness (2017). *State of Homelessness in America*. Retrieved from https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/.

[3] City of Philadelphia, Office of Homeless Services (2017). Philadelphia Continuum of Care 2017 Point in Time Summary [Data]. Retrieved from http://philadelphiaofficeofhomelessservices.org/wp-content/uploads/2016/12/pit-count-report-sept-28-2017.pdf.

From Section I D of Integrated Plan Update:

Opioid dependency and other substance use

Although syringe exchange services in Philadelphia have had a dramatic impact on new cases of HIV among PWID in the EMA over the last two decades, there is deep concern about a potential resurgence of the HIV epidemic in PWID due to the escalating opioid epidemic. In 2016 there were over 900 fatal overdoses related to opioids in Philadelphia alone. For 2017, Philadelphia had 1,217 opioid overdose deaths[4]. Philadelphia County had the second highest overdose death rate in the country, with 46 deaths per 100,000[5]. In response to the increasing number of non-fatal and fatal overdoses, the Mayor of Philadelphia appointed a task force to receive community and stakeholder feedback on the opioid epidemic. In May 2017, the task force released their 18 recommendations, which included expanding access to medication-assisted treatment, exploration of comprehensive user engagement sites, and expanding naloxone access throughout the community[6]. PDPH and other city departments and community stakeholders are exploring and implementing many of these recommendations as outlined in the status report from March 2018.[7]

This epidemic is not just a Philadelphia problem. The opioid epidemic is a significant public health challenge for the whole EMA. In the four suburban PA counties, police and EMS workers are reversing overdoses at alarming rates (in Delaware County the police reversed 532 overdoses in 2017[8]), and yet many people are dying from overdose. In 2016, Montgomery County had 230 deaths (rate of 28.75 per 100,00), Delaware County had 206 deaths by overdose (rate of 36.85), Bucks County 168 deaths, and Chester County had 97 deaths. In the suburban New Jersey counties, we see similar numbers in overdose deaths. There were 96 deaths In Burlington County, 200 in Camden County, 88 in Gloucester County, and 18 in Salem County[9]. EMS and law enforcement in NJ reversed thousands of overdoses in 2017: Burlington County 914, Camden County 2,493, Gloucester County 797, and Salem County 147[10].

Meanwhile, opioid overdoses and deaths only tell one aspect of the story regarding the EMA's opioid epidemic. There were also approximately 14,000 persons in treatment for opioid dependence in publicly funded facilities in 2016. In terms of drug use, there were approximately 55,000 heroin users and

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[4]Philadelphia Department of Public Health. Fatal Drug Overdoses in Philadelphia, 2017. CHART 2018;3(1):1-4. http://www.phila.gov/health/pdfs/chart%20v3e1.pdf

[5] Eichel, Karry & Pharis, Meagan. (February 2018). *Philadelphia's Overdose Death Rate Among Highest in Nation.* http://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/15/philadelphias-drug-overdose-death-rate-among-highest-in-nation

[6] The Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia Final Report and Recommendations: https://dbhids.org/opioid

[7]The Opioid Epidemic in Philadelphia Implementation of the Mayor's Task Force Recommendations https://dbhids.org/wp-content/uploads/2018/03/OTF_StatusReport_March2018.pdf

[8] Data on police and EMS overdose reversals by county can be found at the Pennsylvania Opioid Data Dashboard: https://data.pa.gov/stories/s/Rescue/dji6-fb2x

[9] Overdose deaths in NJ by County and Drug http://www.nj.gov/oag/njcares/pdfs/2016-DRUG-RELATED-DEATHS.pdf

[10]EMS and Law Enforcement Overdose Reversals in NJ in 2017 by County http://www.nj.gov/oag/njcares/pdfs/2017-NJ-Naloxone-Administrations-web.pdf

approximately 55,000 persons who misused/abuse prescription opioids in 2016 in Philadelphia. Approximately 150,000 adults in Philadelphia received >1 opioid prescription in the last year.

According to Philadelphia NHBS data in 2015, approximately half of PWID used prescription opioids prior to their first injection but only 23% continued to use prescription opioids at the time of their NHBS interview which confirms that prescription opioid use is a gateway to injection drug use. The median time between the start of using prescription opioids to their first injection was 3 years. In the 2015 Medical Monitoring Project (Philadelphia), 2.0% of PLWH surveyed injected drugs in the last 12 months and 2.0% of PLWH surveyed took a prescription opioid that was not prescribed to them or was prescribed and they took more than directed.

While HIV prevalence in PWID has decreased dramatically based on Philadelphia NHBS data to 4.8% as of 2015, HCV prevalence is high at 81% among HIV positive PWID. Due to high rates of sharing of syringes and works, high rates of exchange sex, low rates of HIV and HCV testing and high rates of HCV transmission, re-introduction of HIV into these high-risk networks could easily lead to an HIV outbreak in Philadelphia as was previously observed in other jurisdictions in the United States. Young white people are the most affected by the opioid epidemic in EMA, in contrast to the older, largely racial/ethnic minority population that comprises the majority of PLWH with PWID transmission.

As of October 2018, PDPH has identified a significant increase in new HIV infections within people who inject drugs, 48% in the previous 12 months[11]. PDPH has formed a response team and experienced community-based organizations and clinical providers are collaborating with PDPH for a robust response.

People Who Inject Drugs (PWID)

In 2015, the average age of participants in the NHBS PWID cycle was 37 (range 19-70), consistent with the underlying population of PWID. The majority of participants were white (65%) followed by Hispanic (20%), and black/African American (13%). Eighty-eight percent of participants injected more than once a day and 97% injected more than once per week. HIV related risk was high with only 37% always using a new sterile needle, 62% using works (i.e. cookers, cottons, or water) after at least one other person and 43% used drugs divided up with a used syringe. Of those that reported sharing needles or works, only 44% and 46% knew their last injecting partner's HIV and HCV status, respectively. Over 40% of female participants and 25% of male participants exchanged sex for money, drugs or other goods in the past 12 months. Despite high HIV risk behaviors, only 55% of participants reported having an HIV test in the past 12 months. Of those tested through NHBS, 4.8% were HIV positive (N=32) which included 14 new positives. By comparison, 81% of participants tested for HCV through NHBS were HCV positive with nearly a quarter being unaware of their HCV status. In summary, PWID in Philadelphia have high rates of sharing of syringes and works, high rates of exchange sex, low rates of HIV testing and high rates of being unaware of sex/needle sharing partners' HIV and HCV status.

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[11] Philadelphia Department of Public Health. HIV Spread Among People Who Inject Drugs. October 2018. https://www.phila.gov/health/pdfs/commissioner/chart/chart%20v3e4.pdf

Objective 2.4: Increase the percentage of PLWH retained in HIV care who are stably housed

Strategy 2.4.1: Continue to support homelessness prevention activities

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH HIPC	Provide direct emergency financial assistance for rent and utilities	RW clients	**# of DEFA units** **# of DEFA- Housing Assistance clients**	**Housing assistance units: 27,060** **DEFA units: 120** **120 DEFA clients**	CAREWare

Strategy 2.4.2: Continue and expand access to transitional and long-term housing for PLWH

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH HIPC DHCD PADOH NJ Dept of Community Affairs	Increase EMA capacity to house homeless and housing-insecure PLWH	PLWH	**# of HOPWA housing slots** **# of RW-funded transitional housing clients**	**655 tenant based rental assistance for Philadelphia, 91 tenant based rental assistance in Camden** **72 clients**	HUD report
PDPH HIPC	Investigate feasibility of RW funded Housing First project	PLWH experiencing homelessness	**Completion of feasibility report**	**To be discussed in 2019**	

Strategy 2.4.3: Provide services that combat economic and individual barriers to housing

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH MCM providers	Ensure medical case managers assess and address housing instability when developing and reviewing care plan	RW client	**% of RW MCM clients with current housing status collected by MCM**	78.4%	CareWare

Strategy 1.2.3 Ensure equitable access to syringe access services, substance use treatment and related harm reduction services

Responsible Parties	Activities	Target Population	Data Indicators	2016 Baseline	Source
HIPC PDPH Substance use service providers	Expand syringe access services throughout the EMA	PWID PLWH with opioid dependency	**# of syringe access sites** **# of syringes exchanged**	**7 sites - 6 in Philadelphia and 1 in Camden** **2.4 million syringes exchanged in Philadelphia**	OHP Prevention Point Philadelphia
HIPC PDPH Substance use service providers	Expand access to medication-assisted treatment for opioid dependency throughout the EMA	PWID PLWH with opioid dependency	**# of persons receiving MAT at RW medical providers offering MAT**	**Data to be reported as of 2018**	RW Medical Providers
HIPC PDPH Substance use service providers	Expand access to and capacity of substance use treatment throughout the EMA	PWID PLWH with opioid dependency	**% of new patients with a diagnosis of HIV who were screened for substance use (alcohol and drug usage)** **# of RW SA units provided**	**92.5% of new RW patients** **10,210 outpatient units (15 min units)**	CAREWare