Meeting Agenda

VIRTUAL:
Wednesday, April 22st, 2026
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes (March 25th, 2026)
- Report of Co-Chairs
- Report of Staff
- Presentation Item
  - Dr. David Metzger: Injection Drugs and HIV Transmission
  - Elizabeth Fischer: Overviewing key demographic, socioeconomic, and health-related factors of the EMA's general population
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Comprehensive Planning Committee/Prevention Committee meeting is on
May 27th, 2026 at 2:30 p.m. to 4:30 p.m.

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Prevention Committee

HYBRID: Prevention Committee
Meeting Minutes of
Wednesday, March 25th, 2026
2:30 p.m. - 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: J. Ealy (co-chair), D. Surplus (co-chair)

Guests: Melissa Hobkirk (PDPH), A. Onorato (Recommended), Jackson Suplita (DHH), Mystkue Woods (DHH)

Staff: Tiffany Dominique, Elizabeth Fischer (Intern), Debbie Law, Sofia Moletteri, Kevin Trinh, Kristin Wilson (Intern)

Call to Order/Introduction: J. Ealy asked for introductions and called the meeting to order at 2:39 p.m.

Approval of Agenda:
J. Ealy referred to the March 2026 Prevention Committee agenda and asked for a motion to approve. **Motion**: J. Ealy motioned; D. Surplus seconded to approve the March 2026 Prevention Committee agenda. Members voted vocally in the room and through Zoom. **Motion passed:** 2 in favor. The March 2026 Prevention Committee agenda was approved.

Approval of Minutes (*February 25th, 2026*):
J. Ealy referred to the February Prevention Committee Meeting minutes. **Motion**: J. Ealy motioned; D. Surplus seconded to approve the February 25th Prevention Committee meeting minutes. Members voted vocally in the room and through Zoom. **Motion Passed:** 2 in favor. The February 2026 Prevention Committee meeting minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
-Viral Hepatitis Program Overview-
J. Ealy introduced T. Dominique gave an update that 25 of the recommended members should be approved by the Mayor's Office on Monday, March 30th. She reported HRSA raised questions about letters and council membership regarding the orientation processes for recommended members, membership drop-off due to wait times, and concerns about the number of members with lived experience on the council. There was a need for more members with lived experience who were not affiliated with a Ryan Part A organization (staff or board). J. Ealy asked if members were required to disclose their HIV status to be on a committee. T. Dominique confirmed you do not have to disclose HIV status. A. Onorato asked if Community Advisory

Members (CAB) were considered unaligned. T. Dominique said CAB membership was considered unaligned and encouraged everyone to apply whether unaligned or not.

J. Ealy asked if there's a demographic preference on residence for the potential members.

T. Dominique said they wanted the council to mirror the epidemic and be representative of the population, regardless of where they reside.

T. Dominique continued that HRSA tied the rent to space usage and she discussed the barriers from the survey with the program officer. The program officer was informed that the space was being used for hybrid meetings every week.

T. Dominique discussed the idea of holding quarterly trainings. The first training, "Show Me the Money," was scheduled for April 29th as a breakfast meeting and will demystify budgeting and spreadsheets in a fun way. While it was math-related content, they will not literally be doing math. A light breakfast will be provided. Future events or trainings were expected to take place in the 5th week of the month, and will take place at a lunch hour or at the end of the day, to be mindful of people travelling.

K. Trinh asked what type of content or training members would benefit from. J. Ealy said he would benefit from learning about the fiscal piece. He also suggested more speakers and a presentation that focuses on the origins of Ryan White for new members.

J. Ealy asked who would be speaking at the April 29th meeting, and T. Dominique confirmed she would be the speaker.

T. Dominique updated members that if they were not present, they would send an email reminder at the start of the respective meeting.

Presentation Item:

M. Hobkirk. She was the viral hepatitis program manager from the Philadelphia Department of Public Health (PDPH). M. Hobkirk explained the different types of hepatitis, which were all categorized as the inflammation of the liver. Hepatitis can be caused by viruses, autoimmune disorders, or alcohol use. The PDPH viral hepatitis program focuses on hepatitis B,8 50C, and D, which were the most common in the United States. The Acute Communicable Disease team at PDPH focuses on hepatitis A. Hepatitis B was preventable through a vaccine, but not curable. Hepatitis C had no vaccine, but it was curable. Hepatitis D was contingent on hepatitis B.

J. Ealy asked if a person fully vaccinated for hepatitis B could acquire hepatitis D. M. Hobkirk confirmed that they cannot get hepatitis D if they were vaccinated for hepatitis B.

M. Hobkirk explained that the Viral Hepatitis Program focused on surveillance and epidemiology, programming, outreach, and prevention. For surveillance and epidemiology, they collected information through labs since hepatitis is reportable.

M. Woods asked for clarification on booster shots for hepatitis A. M. Hobkirk replied that it was recommended to be revaccinated every 20 years, but it was not her area of expertise. J. Ealy reaffirmed it was 20 years.

M. Hobkirk continued, stating that the surveillance and epidemiology informed the programming and outreach while prevention focused on engagement. For surveillance, labs were reported to PDPH and dedicated staff investigated the results. There was follow-up for potentially acute hepatitis B and C, chronic hepatitis B and hepatitis C, potential hepatitis D, and potentially pregnant or recently delivered individuals with viral hepatitis. Follow up consists of patient and provider outreach; they *investigate* the cases, but they do not *navigate* the cases.

To describe the impact of hepatitis, M. Hobkirk explained the populations that were most impacted. In 2023, high rates of reported acute hepatitis B were seen in Non-Hispanic White populations (55%) and populations with a history of substance use (45%). Also, Philadelphia had higher rates than the national average. J. Ealy asked if they have seen a correlation between someone born outside the United States and having hepatitis B. M. Hobkirk confirmed that there were endemic countries for hepatitis B. T. Dominique asked to decipher between acute and chronic hepatitis. M. Hobkirk explained that acute hepatitis occurs when someone tested positive for hepatitis B within a 6-month range, but at 6 months it was no longer detectable. Chronic hepatitis occurs when it was still detectable after 6 months. When looking at case counts of acute hepatitis B, there were small counts because universal testing requirements were new, and people were not getting tested.

J. Ealy asked how hepatitis B was transmitted. M. Hobkirk explained that hepatitis B is transmitted through blood-to-blood transmission, sexual fluids, or vertical transmission (mother to child from birth). Hepatitis B was not transmitted through breast milk. Babies born to someone with hepatitis B can be given a prophylaxis called Hepatitis B Immune Globulin (HBIG) to prevent hepatitis transmission during birth. M. Hopkins explained that PDPH is focused on data-driven, science-based decisions and stood with the CDC and the American Academy for Pediatrics' recommendations for universal birth dose, regardless of hepatitis B status.

M. Hobkirk explained that high rates of reported chronic hepatitis B were seen in Non-Hispanic Black populations (30%) and in people aged 45-54 years old (41%) and 24-44 years old (39%). J. Ealy has seen high rates of hepatitis B in African immigrants. M. Hobkirk explained that the older age groups should have been vaccinated, but did not get vaccinated or have weakened immunity. There were pockets of higher rates in southwest and south Philadelphia. The PDPH found that there were 28,828 people (1.6%) of Philadelphia residents who are living with chronic hepatitis B. There was a study with Prevention Point and repeated with Hepatitis B Foundation that found pockets of PWID and people who were not vaccinated that have high rates of hepatitis B. K. Wilson asked if the cases coincide with other sexually transmitted diseases. M. Hobkins said there were reports on the connection between hepatitis B, deaths, HIV, hepatitis C, syphilis,

and other conditions. T. Dominique asked why there was a higher prevalence in the ZIP code 19107 (Center City). There was a discussion from members about the possible reasons for higher rates in this area. J. Ealy noted this could be due to more testing sites in Center City, D. Law explained it could be because people may use the clinic address as a placeholder to avoid using their home address. T. Dominique noted that there were many homeless shelters in the ZIP code. She also noted that with HIV epidemiology, high rates are in a "J" shape, with higher rates along Broad Street, southwest Philadelphia, and a hot spot near the prison.

Compared to hepatitis B, M. Hobkirk explained that acute hepatitis C counts were much higher. Someone exposed to hepatitis C can typically fight it off, but they can be reinfected. Testing includes an antibody test to look for active bodies, or an RNA test, which is a blood draw. J. Ealy asked if there was credible data about unsafe tattooing and hepatitis. M. Hobkirk responded that there was not much data on this area, but hepatitis C can live on the ink, blotting clothes, on the needle, etc. T. Dominique asked how long hepatitis C could live on surfaces. M. Hobkirk responded that it could live up to 69 days on surfaces. J. Ealy asked if tattooing in prisons had driven increased hepatitis acquisition. H. Hobkirk believed tattooing, along with drug injection, were two contributing factors to hepatitis acquisition. She continues that there is a shift from the baby boomer generation to 30-39 year olds having higher rates of hepatitis C, which is driven by injection drug use. K. Trinh asked how the opioid epidemic affected hepatitis. M. Hobkirk explained that it may have caused an increase in viral hepatitis. She also explained that HIV has paved the way for how to work with linkage to care and care coordination and informed how we work with people living with hepatitis C and surveillance.

M. Hobkirk explained that chronic hepatitis C affected people aged 30-39 (27%) and 60+ (28%), and non-Hispanic White (39%). J. Ealy asked to clarify if chronic means people living with hepatitis C, which M. Hobkirk confirmed it was correct. She noted that the hepatitis C care continuum can be difficult to navigate, as individuals may enter care, receive treatment, and be cured, then exit the system. T. Dominique asked why people under 30 are being tested for hepatitis C. M. Hobkirk clarified that the CDC recommendation changed to universal testing for any adult over 18 years old and for anyone who has ongoing risk factors such as substance use. J. Ealy asked if the reason people aged 15-29 have high rates is because they were following the guidelines. M. Hobkirk suggested it was because services are available for this age group to get tested.

In terms of the prevalence of hepatitis C, M. Hobkirk explains how 51,490 people have had chronic hepatitis C since 2013. Currently, because of treatment and natural clearance, 23,396 people were living with chronic hepatitis C (1.5% of Philadelphia residents), with the Kensington area having a higher prevalence.

M. Hobkirk shared that the World Health Organization had a plan to eliminate viral hepatitis by 2030, though it was not public. They were on track with goals to decrease newly reported cases

of chronic hepatitis B/C by 90% and decrease the percentage of people with hepatitis B/C who died prematurely by 65%.

For prevention and outreach, M. Hobkirk explained that they use the surveillance data to inform their activities such as educational materials, social media, vaccine clinics, health fairs, and community-based presentations. They offer limited, free vaccine clinics to increase access to care since hepatitis vaccines were not covered by many insurance policies. K. Wilson asked why the vaccine is not covered. J. Ealy suggested that the Affordable Care Act paid for hepatitis B and hepatitis A, but does not currently cover it. For specific questions, M. Hobkirk suggested talking to your provider to find the best option for you. She explained that HEPLISAV-B is a two dose vaccine series that was more effective, but insurance inconsistently covers the cost. Her program was experiencing vaccine hesitation in clients due to the COVID-19 aftermath and the administration. M. Hobkirk asked the audience what can we do to fill gaps, to which J. Ealy responded that misinformation causes vaccine hesitancy and that the best approach was to talk to people and spread accurate information. Philadelphia has a program with adults at risk for hepatitis, CFAR, where clinics can receive free vaccines to give out, but they are no longer accepting any new clinics since there were limited funds. K. Wilson asked if they do a risk assessment before giving patients the vaccine due to the limited vaccines. J. Ealy would ask his network and reach out with an answer. M. Hobkirk also emphasized their continuing education opportunities for providers for stigma reduction, testing, and result interpretation.

M. Hobkirk shared their online presence where you can follow the program on Twitter/X and Instagram @HepCAP, Facebook @PhillyHepCAP, LinkedIn @Philly-Hepatitis, and their websites phillyhepatitis.org and hepcap.org. Through these sites, you can request materials, newsletters, and presentations.

The Viral Hepatitis Program is also involved with coalitions such as Hep C Allies of Philadelphia, Hep Free PA, and Hep B United Philadelphia (sister organization to Hep CAP). M. Hobkirk also highlighted that May was Hepatitis Awareness Month.

With the community support and data to back it, M. Hobkirk explained that they were currently offering a variety of programs. These included the Perinatal hepatitis B and hepatitis C programs that identify pregnant/postpartum people, follow the birthing person and infant until 27 months of age, and support provider communication and intervention/testing support.

Another program they provided was HCV/SUD Navigation that launched in 2020 for HCV and SUD treatment which prioritized co-located and coordinated treatment. They identify persons from surveillance and perinatal HCV care/treatment and offer linkage for SUD and HCV care. This was used to identify barriers to maximize success of referrals. M. Hobkirk mentioned the biggest barriers experienced include transportation, office location, office hours, and mental health and the services desired onsite was behavioral/mental health, case management, lab onsite, and pharmacy onsite. Ultimately, they want it to be a one-stop-shop.

They were also partnering with PDP and Philadelphia FIGHT on an HCV program in Philadelphia prisons. The prisons provided opt-out testing for hepatitis C, but frequently, they don't receive results. So, the program called and sent letters to individuals diagnosed with HCV in prisons who were released prior to being told to support navigation to care. They were hoping to improve this program in the future with communication and transportation.

M. Hobkirk also described Philadelphia's Integration Program, Philly InSync. There were two components including technical advisory committee (TAC) quarterly and enhanced technical assistance. TAC was invited only for clinical providers and offers support for vaccine availability, billing issues, contact information, mobile units, etc. For the enhanced technical assistance, the program completed a need assessment for sites and partners with Change, a third-party that adapted hepatitis C integration models for behavioral health. J. Ealy asked a question regarding the ability to incorporate Federally Qualified Health Centers (FQHC). M. Hobkirk explained that they have worked with Philadelphia FIGHT, Spectrum, and DBCH. The group discussed the importance of active and constant communication because it can easily be overwhelming for community members to find care.

M. Hobkirk continued to discuss the coordinated provider and care provision outreach, which prepares healthcare providers to address HIV and viral hepatitis, as well as substance use. These include the HIV Data 2 Care Project, Low Threshold Sexual Health Sites, HCV Treating Provider Preceptorship Model, Performance Measures for Ryan White, and Philly InSync.

M. Hobkirk explained the program's patient education aspect, which included a website to share links and content, relinking coinfected individuals to care, and participating in events. In terms of coordinated epidemiology, they have started reporting coinfection in Philadelphia, which helped identify new coinfections for enhanced outreach. Other coordinated efforts included monthly surveillance data matches, syndemic EIS officer, NHBS, PWID, Trans cycles including HCV testing and extensive drug use related questions, and special projects looking at HIV and HCV care continuums among coinfected individuals. All of these efforts worked to inform epidemiology and programming.

M. Hobkirk explained a jurisdictional approach to curing HCV among HIV/HCV co-infected people of color. This was a 3-year HRSA/SPNS cooperative agreement from 2016 to 2019. They found improved diagnosis of HCV in people with HIV (PWH), improved HCV treatment access and success among PWH. The trainings developed in this program were used to inform the hepatitis C trainings outside of HIV providers. These training activities emphasized harm reduction and strategies to treat PWID.

M. Hobkirk described the study "People With HIV Are More Likely to Clear Hepatitis C: Role of Ryan White Services, Philadelphia, Pennsylvania, United States", which looked at HCV mono-infection and HCV-HIV coinfection using surveillance data to find out who had better

health outcomes. The results showed that the more Ryan White activities led to better outcomes including health outcomes, social outcomes, and cures.

J. Ealy asked if hepatitis A was classified with programming involving STI-related outreach. M. Hobkirk explained that it was not because it was grouped with acute communicable diseases. There was no intervention other than immunization. J. Ealy asked if hepatitis C was transmitted mostly by blood. M. Hobkirk confirmed it was transmitted through blood and through sexual fluids. She also noted that PWH were more likely to transmit hepatitis C through sexual activity. K. Wilson asked if hepatitis A was a one-and-done infection. M. Hobkirk confirmed that it is a one-and-done infection. K. Wilson asked why there was no vaccine for hepatitis C. J. Ealy explained that the reason there was not a vaccine was that doctors can't find a drug that covers all seven genotypes of hepatitis C. T. Dominique added that if you look at worldwide data, hepatitis has a greater prevalence than HIV because it is more communicable than HIV, because it lives on surfaces. Despite this, it was given less funding than HIV. M. Hobkirk explained that the Viral Hepatitis Program was one of the smallest programs in PDPH, but was one of the largest in the United States. J. Ealy explained that there was stigma for HIV and hepatitis due to substance use. He also discussed the idea of hepatitis A being transmitted through water that was contaminated with fecal matter, as well as through anal sex. M. Hobkirk explained how the Viral Hepatitis Program had trainings on hepatitis A, where they discuss prevention through sexual behaviors.

Other Business:
None.

Announcements:
T. Dominique said many members were at Harrisburg to take action on HIV decriminalization, hence why there were few members in attendance. She announced information will be sent out for a seminar, Transition to Adulthood, hosted by CHOP and CFAR that discussed the barriers young people faced when transitioning from pediatric HIV care to adult HIV care on April 23rd. There will also be a CROI update next week that includes a mini seminar.

K. Trinh announced there was a webinar on March 26th, at 12PM, The Power of Partnership, that featured panelists sharing their experiences with local and state departments on best strategies for public health.

Adjournment
J. Ealy called for a motion to adjourn. Motion: J. Ealy motioned, D. Surplus seconded to adjourn the March 2026 Prevention Committee meeting. Motion passed: Meeting adjourned at 4:15 p.m.

Respectfully submitted,

Elizabeth Fischer, staff

Handouts distributed at the meeting:

- March 2026 Prevention Committee Agenda
- February 2026 Prevention Committee Meeting Minutes