Illinois HIV Planning Group (ILHPG)/Ryan White Advisory Group Integrated Meeting Minutes

February 16, 2017, 9:30 am-12:00 pm

- Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)-
  The meeting formally began at 9:30am. Janet Nuss, the Integrated Group Co-chair, welcomed everyone to the first Integrated Meeting of 2017. She introduced herself and Jeffrey Maras as the Integrated Group Co-chairs. She also introduced the meeting facilitator and presenters. She led the group in a moment of silence for all people living with HIV past and present and for all people working to end the HIV epidemic.
- Review agenda
  The Co-chair reviewed the meeting agenda (see presentations below). She noted that the new "talking bubble" icon on the agenda helps participants identify which National HIV/AIDS Strategy goal(s) and/or Step(s) of the HIV Continuum of Care each presentation addresses. She thanked the ILHPG Evaluation Committee for recommending this update to the agendas.
- Webinar process; Attendance; Announcements; Updates (15 minutes)
  - Webinar meeting, online meeting survey, and online discussion board instructions- Participants were instructed on how to interact with the meeting facilitator, presenters, and other participants on the webinar interface. An active discussion board for this meeting will remain open until February 23. Meeting evaluation surveys will be received through February 23 as well. Both the discussion board and the evaluation are available at http://ilhpg.org/webinar
  - Attendance will be taken by tracking/announcing members logged in, taking roll call of voting members, and sign-in sheets from host sites- The Co-chair led a roll call of ILHPG and RW Advisory group members logged in to the call. She also announced members identifying as participating from a host location. She recognized that there was a number of guests on the call and ensured them that their attendance was being logged.
    - Review meeting objectives and Concurrence checklist- The Co-chair reviewed today's meeting objectives and reminded the group of its primary goal of guiding the content, discussion, and activities that assure the development of a comprehensive HIV care and prevention plan that can achieve the goals of NHAS. She reiterated the importance of the community's voice and input in this process. She hopes to achieve this goal by focusing on more discussion-based presentations this year.
    - Announcements- The Co-chair reminded participants that all 2016 recorded webinars and supplementary materials are still available on at ilhpg.org. She also encouraged anyone who still wanted to contribute to the Spring 2017 ILHPG newsletter to submit their articles to the Community Planning Intern as soon as possible.
    - She also informed the group of changes to the current ILHPG/ Joint ILHPG/RWBP Advisory Group schedule. Because of delays in securing a contract, it will not be possible for the groups to meet face-to-face on May 11th and 12th as tentatively planned. These meetings will now we conducted via webinar from 9:30am-12pm on both dates. Because there will not be enough time to cover all topics intended for the face-to-face meetings, another webinar is tentatively being planned for April 13 (also 9:30am-12pm). She will

continue working on revising the schedule and will release it once it is finalized. She hopes that the August meetings as well as the December meeting can be conducted face-to-face and will continue to keep members updated to the best of her ability.

- Update/Input on Development of Preliminary Plans for Structure and Composition of Integrated Planning Group – (20 minutes)
  Jeffery Maras, IDPH Ryan White Part B Administrator, Integrated Planning Steering Committee Co-chair
  Janet Nuss, IDPH HIV Planning Coordinator, Integrated Planning Steering Committee Co-chair

  Janet presented updates on the work of the Integrated Steering Committee 2 to the full group so they could be informed of the committee's current progress and could give input on its next steps. She began by reporting on the committee's first two meetings. They included finalizing the committee work plan (available in meeting materials); reaching consensus on a new name for the group: Illinois HIV Integrated Planning Council (acronym pronounced as I-HIP-C); reviewing current ILHPG documents to determine modifications and needs for the new group; reviewing CAHISC bylaws and group structure for guidance/ ideas; and revising the ILHPG Bylaws for IHIPC purposes. The committee is currently tasked with revising the ILHPG procedures.

  Janet continued by reminding participants that starting in 2018 the new integrated planning group will function as the advisory body to IDPH as described in both CDC guidance and HRSA legislation. Therefore, the group will embody responsibilities across Prevention and Care which include the following: providing input on prioritized populations for prevention services; participating in Statewide Coordinated Statement of Need activities; informing the development of the state's integrated plan; and developing and monitoring the stakeholder engagement process. In order to achieve this, the committee has proposed that the IHIPC be composed of 25-35 voting members that represent a wide variety of HIV prevention and care providers as well as community members (please see presentation or IHIPC model document for specific targeted composition). In addition to these members, the committee has proposed that three IDPH HIV Section representatives as well as agency liaisons also be voting members. These members, especially those from the HIV Section, will refrain from voting on concurrence and priority setting in order to prevent a conflict of interest issue. Additionally, non-voting IDPH support staff, community members, and professionals in the field will continue to be encouraged to regularly attend meetings. Janet also reviewed the new committee structure, which reflects NHAS goals (please see presentation or IHIPC model for details on committee structure). At the end of the presentation, she thanked the committee for their great input thus far and reminded participants that input in this process from all integrated planning group members is welcomed.

  - Questions & Answers, Discussion, Input – (10 minutes)
    - Question: Julio asked "How will the committees of IHIPC be different than current ILHPG committees?"
      - Janet answered this by explaining that many of the functions of the committees will be similar to their current functions but will differ in light of the committee's new emphasis on integrated care and prevention planning and reaching NHAS goals. The new IHIPC Membership Committee will take on the roles of both the current ILHPG Membership and Evaluation Committees. The new IHIPC Epi/NA Committee will take on the current roles of the ILHPG Epi/NA Committee with primary emphasis on identifying HIV disparities. The IHIPC Primary Prevention Committee will take on the roles of the ILHPG Interventions and Services Committee with additional responsibilities in reviewing HIV incidence trends and disparities for use in developing recommendations. The Linkage/ Retention/ Reengagement/ Antiretroviral Therapy/ Viral Suppression Committee will take on some of the planning responsibilities of the RWBP Advisory Group as well as Interventions and services Committee functions relevant to prevention for positives and will focus on making recommendations that will improve efforts in the corresponding steps along the HIV Continuum of Care. Janet hopes to see coordination and collaboration among the committees, especially when it comes to data/ epi specific projects. Janet mentioned that some current RWPB committees like the project directors, consumer and case manager group calls will stay in place for program purposes beyond planning.

- Question/ Comment: Jill said "I like the committee structure. How is the collaboration going to work between committees if there are no face-to-face meetings?"
  - Janet responded by explaining that she hopes that some face-to-face meetings will be possible during 2018 when the IHIPC is fully established and running. Break-out committee groups/collaborations can be conducted at those meetings. If for some reason face-to-face meetings will not be possible or if there is not adequate time for the committees to collaborate face-to-face, joint committee meetings can be scheduled as needed and conducted by conference call. The group will do its best to implement, evaluate, and modify these collaborative efforts.
- Question: Lexie asked "How will this group differ from others? Will there be two integrated groups?"
  - Janet responded by explaining that the IHIPC will be a fully integrated group. In 2018, the ILHPG and RW Advisory Group will no longer be functioning as hybrid/joint group like it currently is. There will only be one group that takes the place of our current state CDC and RW Part B planning groups and will assume the CDC and HRSA planning body functions and responsibilities.
- Comment: Julio said "This is very interesting to me, because the work that I am doing now is all about linkage, retention, etc."
  - Janet responded by saying that many people and agencies are adopting an integrated approach to their work so she thinks the planning group is headed in the right direction.
- Question: Reggie asked "Is there a need to discuss budgeting issues with stakeholders and how it is impacting the groups?"
  - Janet responded by saying a more in depth discussion on this can be scheduled for the future. We have been challenged with not being able to plan for face-to-face meetings for over a year so that issue is not new. The current issue is not relevant to lack of a state budget since we have allocated federal funds for planning group support. We have also been assured that the IDPH Office of Health Protection supports our planning groups having two face-to-face meetings this year. It is more the process associated with state government regulations and changes to those regulations that have caused a great challenge in securing a contract. This issue is also not specific to the HIV Section or the planning group. She and other staff in the HIV Section are working as diligently as they can to get this resolved. If the issue isn't resolved, we will schedule a group discussion with HIV section leadership.

- Overview of Current HIV and HIV/STD Co-infection Epi Profile - (50 minutes)

  : NHAS Goal 1(Reduce New HIV Infection), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All steps

  Cheryl Ward, IDPH HIV Surveillance Administrator

  Cheryl presented an overview of Illinois Statewide HIV Epidemiological Trends as a reference for future planning group activities (priority setting, monitoring, evaluation, etc.). The presentation included "Illinois excluding Chicago" data and "Chicago only" data in order to highlight differences in HIV trends in the separate jurisdictions. She also told participants that regional data was not included in the presentation but is available upon request.

  Cheryl reviewed different sets of HIV data dated 2006-2015. Data sets included HIV diagnoses by jurisdiction, sex, race/ ethnicity, sex & race/ethnicity, age, and sex & transmission category. Of these categories, the following groups saw rising HIV trends: Hispanics (Illinois excluding Chicago), people 20-29 years of age (Illinois excluding Chicago and Chicago), MSM (Illinois excluding Chicago), and Black & Hispanic MSM (all of Illinois). Cheryl also reviewed trends in late diagnosis and mortality of people living with HIV. Illinois HIV prevalence by sub-category was also made available during the presentation.

  Next, Cheryl reviewed the 2015 Illinois unmet need assessment (data set included 2004 and 2007-2015), which was conducted in October 2016. She explained that there has been a considerable drop in unmet need from 2004-2015 (55.3% to 36.8%, respectively), but

efforts still need to be made to lower this rate. Unmet need rates by type of HIV diagnosis (AIDS v Non-AIDS), sex at birth, race/ethnicity, age, transmission category, and region were included in the analysis. Cheryl noted that regional data should be interpreted with caution as data reporting in some regions, particularly for Region 2, is incomplete because of lab reporting issues. IDPH is working to resolve this problem and will release more complete data when it is available. Cheryl continued by doing a brief review of the Illinois Continuum of Care (2015) and noted engagement trends by sex, race/ ethnicity, age, and transmission category.

In conclusion, Cheryl noted that overall Illinois has made progress in lowering HIV diagnosis rates as well as using Continuum of Care data to direct HIV treatment strategies. However, challenges associated with gender, race/ethnicity, and age disparities still exist, and data collection for some special populations (i.e. transgender people) is limited. She encouraged participants to continually use this and other HIV data to guide their planning and service efforts.

- Questions & Answers, Discussion, Input - (10 minutes)
  - Question: Casey asked why there were differences in prevalence numbers in the presentation (i.e. prevalence slide v continuum of care data).
    - Cheryl explained that two separate data sets were used for these calculations: Continuum of Care data includes diagnosis only through 12/31/14 and the prevalence slide is data through 2015. Incomplete lab reporting at the time of data pulls may have also contributed to the differing numbers.
  - Question: Julio asked if limitations in transgender data exist because of a lack of ability to enter gender identity information on report forms.
    - Cheryl explained that providers are able to include this information on case report forms because there are questions on both gender at birth and current gender. She said that overall, transgender data is better reported in Northern Illinois. She is not sure why this is the case, but thought that it may be correlated to a health provider's willingness and ability to talk about gender identity with patients.
  - Question: Dwight asked "Is the reduction in new infections a result of PrEP, Treatment as Prevention (TasP), or both?
    - Cheryl said that this could be the case, but that there is not surveillance data to support this since PrEP data is not captured in eHARS. Janet said that she believes we will see a greater impact of PrEP in the future. Other strategies that may have contributed to reduction of new infection may include High Impact Prevention, efforts that have led to a significant reduction of HIV among PWID, overall earlier HIV disease diagnoses, and higher rates of viral suppression.
  - Comment: Scott said that even though there are some issues with incomplete lab reporting, it is much better than it has been in the past.
    - Cheryl agreed and explained that today, nearly 98% of all labs are reported electronically. The reduction of processing paper labs has made this much better. She also anticipates data being more accurate after reports from Region 2 and surrounding areas is appropriately transferred/recorded.

Lesli Choat, IDPH STD Coordinator

Lesli reported on Illinois and national trends in chlamydia, gonorrhea, and syphilis. Unlike HIV trends, STD cases in the US were at an unprecedented high in 2015 and are continuing to rise. She reported that Illinois STD numbers increased from 2014-2015, especially in Chicago. Lack of funding and reduced services may be responsible for the spread of these curable and preventable infections.

Lesli stated that according to national data, STD disparities exist among people aged 15-24, minorities, and MSM. Syphilis rates among MSM are especially concerning as they account for nearly 82% of cases where the gender of the sex partner is known. HIV/syphilis coinfection rates among MSM remain at approximately 50% nationally and in Illinois. Unlike syphilis, limited data is collected on the gender of sexual partners for gonorrhea and chlamydia. A small national sample collected by CDC SSuN grant recipients, however,

suggests that MSM have higher rates of gonorrhea when compared to men who have sex with women (MSW) as well as women. Rates of chlamydia in MSM also surpass MSW and women in older age categories (>=30 years of age). In light of these statistics, Lesli reiterated the importance identifying STDs in MSM and getting the message of PrEP to those who are HIV-. Lesli also noted that rates of STDs are considerable higher among HIV+ MSM in comparison to HIV- MSM. She noted, however, that only 36% of people receiving HIV medical care received comprehensive STD screening in 2013. She stressed the importance of continually working to improve this number to reduce, identify, and treat STDs among people living with HIV.

Lesli noted a number of additional challenges that may be contributing to rising rates of STDs. They include, but are not limited to, antibiotic-resistant STDs, introduction of more pharyngeal and rectal gonorrhea and chlamydia testing, anonymous sex, and lack of education. She challenged participants to think about how current practices can be modified to better serve disproportionately affected populations.

- Questions & Answers, Discussion, Input - (10 minutes)
  - Question: Jeffrey asked Lesli to address the new law (Administrative Code Rule 693) that allows HIV and STD programs to share information.
    - Lesli stated that new Illinois Law allows the STD section to share STD diagnosis information with state HIV programs as well as lead agents outside of the agency. She hopes that this new data sharing will allow for better care. Jeffrey continued by saying that the Ryan White program will be working to incorporate this data into Provide™ so that case managers can see STD diagnosis history regardless of disclosure. This should help case managers address partner notification and prevention with clients for the future.
  - Comment: Candi said "I think one of the things that would help is support to do rectal and pharyngeal GC/CT testing"
    - Lesli responded by saying that Champaign has done a great job of implementing this. Unfortunately, the state lab does not run these tests at this time. Lesli said that she will revisit this issue with the lab.
  - Question: Silas said "I am curious if there has been a conversation about the rise in STDs and the ACA with people gaining insurance coverage and getting STD tested for the first time ever or for the first time in a while. It is alarming to see the increase- however I am curious how many are new infections and how many may be late infections. I know you can easily tell the difference between early/late diagnoses with syphilis."
    - Lesli confirmed that syphilis is staged by estimated time of infection, but that there is no easy way to tell when gonorrhea or chlamydia infections occur. She also agreed that there may be a correlation to screening and increased access to health care. Although there are good screening programs out there, there is a need for more routine testing due to the asymptomatic nature of some STDs.
  - Comment: Reggie said "Comprehensive Sexual Health Education is having a positive impact on students in grades 6-12. I work with 10 Priority School Districts in Illinois and our efforts in working with these school districts have shown to be helpful in holding the line on teen pregnancy and to some extent STIs."
  - Comment: Debbie said "Partner notification and follow up is very difficult because of anonymous sex.
  - Question: Mark asked "My agency is considering implementing STI testing. Are there similar (blood) testing devices to rapid HIV Testing?"
    - Lesli stated that although there is a rapid blood test for syphilis, it is not purchased by IDPH due to high false positive rates. Syphilis testing is done by blood draw, and gonorrhea and chlamydia testing are typically done with a urine sample.

- Comment: Tina said "Region 4 Ryan White Lead Agency is presenting an idea to our local HIV advisory group regarding a greater focus on STDs/co-infections and collaborating with our Communicable Disease staff and STD community partners in our discussions and planning. This presentation certainly helps prove the need."
  - Lesli thanked Tina for her comment and welcomed her to ask for assistance from the STD section if needed
- Question: Steven asked "Why is there a limit on State labs processing specimens? This is a big barrier. Will this possibly change in light of this huge increase in cases?
  - Lesli explained that limitations to lab processing are in place due to financial limitations. Federal funding sources direct state departments to use fewer dollars on direct services because FQHCs and greater access to health insurance can pick up some of these expenditures. That is why there are limits on tests per site. Lesli said that she is happy to work with sites to see if there is a need to change/increase their allotment.
- Comment: Jill said "We have seen that MSM will test for STDs if they are in a safe, affirming space that literally celebrates rectal swab tests! Also, clients do not understand that pee in a cup is not systemic, just site specific."
  - Lesli agreed and said that there is a need to train STD providers in cultural competency. She said that the STD section will be doing a webinar on ally-ship and cultural competency in April.
- Question: Jamie asked "What about large broad-based public education and awareness campaigns targeting youth and using social media platforms to highlight the importance of STI screening as demonstrated by various HIV Step up and Getting Tested campaigns?".
  - Lesli said that work is being done with school health centers to address STDs and barriers among youth. CDC also has their Get Yourself Tested campaign. Their website helps identify free testing sites and provides STD education. Despite these efforts, Lesli said that she believes that more must be done to hit home with youth populations. Cynthia said in regards to social media, there is a Chicago-based campaign funded by CDC called Project Elevate. It targets STI messaging to adolescent cis and transgender females. Lesli asked for more information on this project.
- Question Tina asked "What do we know about Truvada making men susceptible to syphilis?"
  - Lesli said that several articles have recently been released on this topic. They state that antiretroviral medication can affect the immune system of some individuals and can make them more vulnerable to syphilis. Despite this, there is still a large need for antiretroviral medication and PrEP. As more information is released, we can begin to address it. She said that if anyone is interested, an article on this is available at bodypro.com. Lesli said that her biggest takeaway from this information is to reiterate the need for comprehensive STD screening among people living with HIV and among PrEP users.

- Addressing HIV Disparities among MSM of Color, Women of Color, Youth, and Transgender People- (20 minutes)

  : *NHAS Goal 1(Reduce New HIV Infection), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All steps*

  Janet Nuss, IDPH Illinois HIV Planning Coordinator

  Janet presented information on HIV disparities among special populations. She explained that this information is important not only for participants to consider for planning purposes but also to continually work towards achieving the disparity related goals and indicators in NHAS. She noted that information on national data in this presentation was provided by the National Quality Center. They are currently conducting the end+disparities Learning Exchange in order to reduce HIV disparities in the following populations: MSM of color, African American and Latina women, youth aged 13-24, and transgender people.

  Prior to the presentations of disparities among the four subpopulation groups, polling questions were asked of participants to ascertain their knowledge about the extent of the disparities. First, Janet addressed disparities regarding MSM of color. She stated that it is

estimated that 1 in 2 black MSM and 1 in 4 Latino MSM will be diagnosed with HIV in their lifetime. Additionally, black MSM in the United States have lower rates of success along the continuum of care in comparison to white MSM. Illinois data on HIV diagnosis among MSM by race/ethnicity was also included in the presentation. Next, Janet addressed women of color. She stated that in the United States, black women are 18 times more likely to be diagnosed with HIV than white women, and Latina women are 4 times more likely to be diagnosed with HIV than white women. Similar rates and disparities were identified in Illinois data. Next, Janet addressed disparities among youth. In the United States, it is estimated that over 50% of youth are unaware of their HIV status. Additionally, it is estimated that only 6% of youth in the United States (aged 13-24 years) who are living with HIV are virally suppressed. Illinois data on HIV incidence and prevalence among youth by subcategory (gender, transmission category, and race) was also included in the presentation. Lastly Janet addressed HIV disparities among transgender people. In the United States, it is estimated that approximately 28% of transgender women are living with HIV. Transgender women are also 49 times more likely to be diagnosed with HIV when compared to cisgender adults.

After identifying disparities among these groups, Janet spoke of how efforts can be made to address these issues in Illinois. Some strategies included addressing disparities at planning group meetings, through adhoc work groups, and through committee objectives, working to spread information about best practices among vulnerable populations, and working to enhance existing Care and Prevention service models to better address disparity related needs at local, regional, and state levels. She asked for continual input from the group in these endeavors. Janet also encouraged participants to visit the end+disparities website as it has a variety of resources on this topic, including recently conducted webinars. She and the Community Planning Intern will continue to participate in these webinars and relay important information to the planning groups at meetings.

- Questions & Answers, Discussion, Input - (10 minutes)
  - Comment: Lesli stated that she thought this was a great presentation and liked the visual aspects of it.
  - Comment: Scott said that he appreciated the interactive quiz questions dispersed throughout the presentation. He hopes that future presentations will also include quizzes.
  - Comment: Marleigh said that she would be picking up on HIV disparities among transgender people with a presentation at the ILHPG meeting on 2/17. Everyone was invited to attend.
  - Question: Cynthia asked "What can we do as community planners to ensure that we are including social determinants of health as part of our tools/interventions? We must address the "whole" person to best achieve optimal benefits and health equity. Great job."
    - Janet responded that our planning group committees need to continue to consider social determinants of health. Currently, the Epi/Needs Assessment Committee and Interventions and Services Committee address them in several of their objectives, but more can be done. Input from direct providers is also very important in understanding how social determinants of health affect outcomes. Janet challenged the Epi/Needs Assessment Committee to take the lead on continuing this conversation. She will also talk to Jeff to see if there is any information on Ryan White Part B Program initiatives addressing disparities and/or social determinants that can be added to our group discussions of disparities.
  - Comment: Mark said "We offer in-house testing, we utilize our mobile unit, and we accept request for tests in the community. The most important thing is that we listen to the people we test and follow through with their suggestions."

- Public Comment Period/Parking Lot - (10 minutes) - There was no request for public comment and no parking lot items.
- Adjourn- The meeting formally adjourned at 12:05pm.

: *Planning Group presentations/ discussions are designed to be centered on Planning Group functions/processes and the goals/ indicators of the National HIV/AIDS Strategy (NHAS) and/or the steps of the HIV Care Continuum. This symbol, followed by its description, indicates the focus of the presentation in relation to NHAS or the HIV Care Continuum.*