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

August 18, 2016, 10:00 am-12:30 pm Minutes

- Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)- *The meeting formally began at 10:00 am. The Co-chairs, webinar facilitator, and presenters were introduced. Special recognition was also given to the Integrated Planning Steering Committee for all of their commitment and hard work that ultimately made this meeting's presentations and objectives possible. Then a moment of silence was acknowledged for PLWH, past and present, and all those working in the field that bring high quality HIV services to communities and are diligently working to end HIV.*
- Review agenda- *The agenda for today's webinar was reviewed. It was noted that many agenda items were relevant to the Illinois HIV Integrated Care and Prevention Plan. All voting members were given access to the final draft of the Plan in advance so that they could review it before the today's meeting.*
- Webinar process; Attendance; Announcements; Updates (15 minutes)
  - Webinar meeting, online meeting survey, and online discussion board instructions - *An active discussion board for this meeting will remain open until August 25. Meeting evaluation surveys will be received through August 25 as well. Both the discussion board and the evaluation are available at ilhpg.org/webinar.*
  - Attendance will be taken by roll call, tracking of members logged in and sign-in sheets from host sites- *Voting members were tracked by webinar logins. Their names were announced. Roll call was taken of other voting members and their presence was announced as they either raised their hand to be unmuted or sent a message via the chat feature. Quorum was achieved.*
  - Review meeting objectives *The Co-chair reminded the group of the purpose of the Integrated Planning Group and the importance of community input into the integrated planning process and the Integrated Plan itself. She thanked everyone for their input and commitment to the Integrated Planning group during this pilot hybrid meeting process. The objectives for the day's webinar were reviewed.*
  - Announcements
    - *The Co-chair reminded everyone that recordings of all 2016 ILHPG/Integrated Planning webinars were available for viewing at ilhpg.org/webinar. The attendance log, minutes, evaluation results, and the voting log for this meeting will be made available sometime in late August.*
    - *The Co-chair reminded participants that abstracts for poster submissions for the HIV/STD conference are due on August 31. The conference is October 26-27; there will be pre-conference seminars on October 25 from 1-5.*
    - *Face-to-face ILHPG/ Integrated meetings will be held in Springfield on the morning of October 25 prior to the pre-conference seminars. The ILHPG business meeting is scheduled for 8-9:15am, and the integrated meeting is scheduled for 9:30am-12pm. These are important meetings as it will be the groups' first chance this year to meet face-to-face and build relationships. Team building and interactive evaluation of the integrated process will be conducted during the integrated meeting.*
    - *The Co-chair noted the slide that named 92 people (other than the regular ILHPG and RW Advisory Group members and IDPH staff who routinely participate in meetings) and their agency affiliations who have participated in ILHPG and Integrated Planning Group meetings by webinar since the first of the year. This demonstrates that the webinars have significantly enhanced community engagement and has created opportunities to collect input from new stakeholders.*

- Acknowledge Integrated Planning Steering Committee leadership- *The Co-chair formally recognized each member of the Integrated Planning Steering Committee and thanked them for their commitment and hard work. They are: Jeffrey Maras (Co-Chair), Janet Nuss (Co-chair), Valerie Johansen, Marcy Ashby, Steven St. Julian, Chris Wade, Susan Rehrig, Joe Trotter, and Tobi-Velicia Johnson.*

- Overview of Final Integrated HIV Prevention and Care Plan, Implementation Plan, Monitoring Plan, Resource and Workforce Assessment – 20 mins.
  Jeffrey Maras, IDPH Ryan White Part B Administrator
  Janet Nuss, IDPH HIV Planning Coordinator
  Janet presented an overview of the Illinois integrated planning process and the 2017-2021 Integrated Plan. She explained that the planning process and the development of the Integrated Plan would not be possible without input from program areas and community representatives. She thanked everyone who has been involved in the process. Jeffrey also mentioned that feedback from all Ryan White Parts (A-F) had been solicited for the plan and that this process has aided in breaking down silos and building collaborations. Janet continued by explaining the importance of the hybrid integrated meetings of the ILHPG and the RW Advisory group in the integrated planning process. These meetings allowed both prevention and care representatives to participate in reviewing needs assessments; identifying gaps, barriers, challenges, and successes in breakout discussions; and suggesting collaborative recommendations and strategies to address these challenges. Although the hybrid meeting process in 2016 did not go as originally planned due to discontinuation of face-to-face meetings in 2016, the integrated group was still able to successfully function and complete its tasks through quarterly webinars.
  Janet then reviewed the contents of the Integrated Plan. The Plan consists of four main sections: Introduction and Overview; Statewide Coordinated Statement of Need (which includes the updated Epidemiological Overview, HIV Care Continuums, the Financial and Human Resource Inventory, and needs assessments); Integrated HIV Prevention and Care Plan (which include goals, strategies, and activities, all of which are in alignment with NHAS); and Monitoring and Improvement (which includes how goals will be accomplished through the use of data). Janet also reviewed the Integrated Plan Appendices. This list included documents that have already been published by IDPH or other agencies as well as several new documents like the IL 2016 HIV Resource Inventory, the 2017-2021 Integrated Plan Activities Chart, and the NHAS and Illinois 2020 Indicators Baselines and Monitoring Plan.
  Janet concluded the presentation by thanking everyone involved. She said that this is Plan is something to be proud of and will be used as a road map in future program planning to address the HIV epidemic in Illinois. Jeffrey said that collaboration brought on by development of the Integrated Plan has allowed many HIV stakeholders and bodies to come together and appreciate each other's roles in Prevention and Care. It has also allowed programs to become responsive to challenges and barriers identified through community input. He also said that the development of the Integrated Plan has taken HIV Integration in Illinois to the next level and that these collaborative efforts will continue in the future.
  - Input, Questions & answers (10 minutes) - *There were no questions or comments at this time.*

- Summary and Demonstration of Linkage between 2017 Prevention and Care Grant Applications, Budgets, Program Legislation/Guidance and the Integrated Plan– 50 mins
  Jeffrey Maras, IDPH Ryan White Part B Administrator
  Curt Hicks, IDPH HIV Prevention Administrator
  Jeffrey began this presentation with his overview of the Ryan White Part B (RWPB) Program. He explained that the RWPB Program offers 17 core medical and supportive services, but not all are available in each region as determined by needs assessments. Eligibility for most services is set at 500% Household Family Poverty Level, but there is no income limit on medical case management. Jeff then reviewed the Federal requirements of the RWPB program. They include the following: that the RWPB Program is the payer of last resort for HIV services, that services are funded by category, that at least 75% of funding be spent on core services and up to 25% on supportive services, that clients be recertified in the program every six months, that performance measures on multiple services be conducted and monitored, and that the program submit a Statewide Coordinated Care of Need. Jeffrey also recognized

the importance of collecting input from grantees, stakeholders, and PWLHA. The RWPB program collects information through monthly lead agent calls, the ADAP Medical Issues Advisory Group, Quarterly RWPB Advisory Meetings, and RWPB Auxiliary Committees.

Jeffrey continued by presenting the breakdowns of RWPB funding for FY16 (4/1/16- 3/31/16). Jeffrey informed the group that the program received its full federal award at the end of June. This award was approximately $41.5 million. 43% of funds are allocated for medication assistance, 29% for premium assistance, and 21% for the RWPB program's Lead Agent Consortia. Other federal allocations include funding for Corrections, HOPWA, and the Minority AIDS Initiative. Additional funding for the RWPB program is made available through State General Revenue Funds (GRF) and through medication rebates. Jeffrey presented all funding streams and allocations in a bar graph, but noted that the rebate amounts are estimates and the GRF dollars included in the graph only represent allocated funds through December. Jeffrey then explained how regional allocations are determined based on utilization reports, needs assessments, and regional epi. A fiscal breakout of funding allocated for each service core and supportive service category was also included in the presentation.

Curt presented on IDPH's HIV 2017 Prevention Plan and Grant Application (CDC PS12-1201). Curt began by informing the group that the Prevention Program is requesting allocations of approximately $1.9 million and $600,000 for Categories A and B, respectively, for FY17.Category A helps fund Regional Grants, while Category B funds routine testing. He then presented a bar graph that shows past allocations for Categories A, B, and C. He noted that the drop in Category A funding was due to a new CDC formula that is based on HIV/AIDS prevalence instead of AIDS prevalence alone. This shifted more federal dollars to Southern States. With this in mind, Curt explained that General Revenue dollars have become the main source of funding for regional prevention grants. In recent years, there have been some challenges with the grant. These include changes associated with fee-for-service, the budget impasse that resulted in destruction of infrastructure, and a cut in funding in the current FY16-17 GRF appropriation.

Curt continued by reviewing the 2017 Regional Prevention Awards. He explained that 13.5% of funding was allocated to lead agents (each received a $25,000 base award with additional awards based on epi distribution), and 86.5% was allocated to Program (calculated based on epi distribution only). The total grant award is approximately $4 million. Regional breakouts that compared CY16 and CY17 awards were presented in pie charts and bar graphs.

Curt then presented on break outs of Service Class Allocations. They are as follows: 10% risk reduction for positives, 20% surveillance-based services, 50% HIV testing, and 20% risk reduction for negatives. The yearly gap analysis has been conducted to identify where gaps in services exist among priority populations among all HIV prevention grants. This analysis will be used in 2017 to target HIV services to underserved populations. Curt continued by presenting on reimbursable Interventions and Strategies for 2017. This includes comprehensive prevention for positives; program coordination and service integration (includes testing for HCV, GC/CT and Syphilis as well as HAV, HBV, and HPV vaccinations); and evidence-based interventions for highest risk HIV-negatives. Reimbursement for unvetted or unsupported interventions will be discontinued, but the I&S Committee will be developing some guidance for providers on approved interventions that could substitute as viable ways to implement group prevention support and risk reduction activities. Curt then discussed some policy initiatives that are being pursued. They include, but are not limited to, seeking federal funds for syringe exchange, creating nPEP protocols and trainings, reimbursement of testing for unlicensed providers' HIV services, condom access in correctional settings, and more care and prevention planning on linkage and retention in care interventions.

Other than the changes described above, Curt reported others changes in the Regional Grants (Category A). They include, but are not limited to, increasing funds for capacity building and supplemental services and reducing funds for epi-proportioned services, addition of bonus payments for prompt positive follow- up service, data unit modifications to simplify Provide® billing, reimbursement for external lab Western Blot confirmations, increased percentages of HIV tests using 4th Gen technology, SBS case referrals sent with updated information, and electronic Linkage to Case Management to be built into Provide®.

Curt explained that Category B will continue predominantly as a third-party billing project. Only STD clinic will bill under Category B and additional capacity building that allows routine testing providers to conduct testing through insurance billing will be provided. Curt finished by explaining how all of the work and strategies included in his presentation will help prevention efforts align with NHAS goals.

– Input, Questions & answers (20 minutes)

There were no questions for Jeffrey about the RWPB Program at this time. The following questions were in regards to Curt's Prevention Presentation:

- *Question: Why was there a significant drop in federal dollars from 2012-2013?*
  - *Answer: New federal formulas implemented by the CDC caused changes in funding. Initially, Illinois was going to get one large cut in funding, but the CDC decided to phase this in over several years. Less Category A dollars were seen in regional funding during that time because the HIV Section had been instructed to move IDPH staff salaries to federal funding. At the time that that decision was made, there was enough GRF funding to keep the funding stable.*
- *Comment/ Question: Thank you for funding continued Orasure® confirmation when phlebotomy is not available. Will each agency need to locate a lab or will the Department specify a lab to use? Also, how will the bill be reimbursed?*
  - *Answer: External labs can be scanned into Provide® and there can be a flat fee paid out of supplemental services. Regional Lead agents will need to identify labs that still conduct Western Blot testing. Jamie Gates at IDPH is also trying to identify some options.*
- *Question: When and how will IDPH have all these new payment/bonus structures in place in Provide® for Category A/RIG grants while making billing simpler? When will agencies be trained in these new interventions over the next 6 months?*
  - *Answer: Proposed bonuses are not for new interventions or services. Diligent agencies will now be rewarded for prompt work that they are already doing (i.e. different bonuses for Linkage to Care within 30, 60, or 90 days).*
- *Question: Will PrEP Activities fall under the fee for service structure in the next funding cycle?*
  - *Answer: PrEP counseling, assessment, and linkage to access will come out of funds for testing and effective risk reduction activities. CRCS can be used for PrEP case management as it addresses both biomedical and behavioral components.*
- *Comment: IPHA has contracted with a lab out of Texas. Set up can be obtained by reaching out to Mike Kossman 888-858-8663, ext 214. $10 4th Gen contracted cost.*
  - *Answer: The above lab has discontinued Western Blot Testing.*

- Integrated Plan Concurrence Checklist, Concurrence Overview, Discussion, and Vote – 10 mins

Janet Nuss, IDPH HIV Planning Coordinator

Janet presented an overview of the 2016 Integrated HIV Prevention and Care Plan concurrence process. She reminded participants that at prior meetings, a Concurrence Checklist was presented and made available to voting members. This checklist was used as a tool to help members identify CDC's and HRSA's expectation of IDPH and the Integrated Planning when preparing for and voting on concurrence and to help voting members understand how their input was used in the development of the Plan. Next, Janet listed the steps in the concurrence process. Step 1 is that the Integrated Plan has been informed by, reviewed by, and explained to the Integrated Planning Group and demonstrates that programmatic activities and resources are being allocated to the most disproportionately affected populations and areas that bear the greatest HIV disease burden. Step 2 is that a letter is drafted and signed on behalf of the Integrated Planning Group stating that the Plan sent forward by IDPH demonstrates a collaborative and coordinated approach to HIV prevention, care, and treatment and ensures that services and resources are directed to areas with the greatest HIV disease burden. Janet explained to members that three types of letters that are possibilities based on the vote of the planning group: Letter of Concurrence (which means that the group has informed and reviewed the plan and that the plan describes how HIV care and prevention programmatic activities and resources are allocated to populations and areas with the greatest burden of HIV disease); Letter of Concurrence with Reservation (which means that the group generally agrees with the Plan but has some concerns/ issues with it); or Letter of Non-Concurrence (which means the groups did not inform or review the Plan nor does

the Plan describe the allocation of HIV prevention and care programmatic activities and resources). She also explained the consequences that IDPH and the Integrated Group might face if a letter was not submitted to CDC and HRSA.

- Discussion, Questions & answers, Vote (10 minutes)

  There were no questions about the presentation at this time.

  With no questions, the Co-chair entertained a motion to concur, concur with reservations, or not concur with the proposed Integrated Plan. Steven St. Julian made a motion to concur with the Integrated HIV Prevention and Care Plan as presented, which was seconded by Pam Briggs. With no discussion, a vote was taken and the following was announced:

  The motion carried with 36 votes in favor, 0 opposed, and 0 abstentions *(Note: After the meeting, Debbie Starnes and Charaine Boyd, both voting members, informed the Co-chair that they had experienced technical difficulties during the webinar, but both voted in favor of the motion. The vote count above reflects their added votes).*

  The Co-chair once again thanked everyone for their participation in the Integrated Plan. Eduardo Alvarado, HIV Section Chief, also congratulated the group and looks forward to continuing partnerships and collaborations.

- Public Comment Period/Parking Lot (10 minutes) – *No Public Comment requests were received. No items were in the parking lot.*
- Adjourn- *The meeting was formally adjourned at 12:30pm.*