Illinois HIV Integrated Planning Council (IHIPC) Webinar – Minutes
Thursday, February 21, 2019, 9:30 am – 12:30 pm

9:30 am: Welcome; Introductions; Moment of Silence

The Co-chairs, J. Nuss and M. Benner, welcomed all participants to the meeting. Webinar instructions were reviewed, and the IHIPC leadership and the webinar facilitator were introduced. Participants were led in a moment of silence for all people living with HIV past and present as well as for all those working to end HIV in Illinois. M. Benner stressed the need for and value of community input during IHIPC meetings, especially from people living with HIV and from people who represent communities that are most affected by HIV. He encouraged everyone to comment and participate in discussion so that all input can be heard and considered in planning efforts.

9:35 am: Meeting Process/Instructions

» Take attendance of voting members; Roll call of those not logged on; Brief introduction of new members

M. Andrews-Conrad conducted roll call by recognizing voting and at-large members that were logged into the meeting. Members who were not logged in were also announced and given opportunity to make their presence known. Although other participants were not announced, it was noted that their attendance was being tracked and recorded.

» Review of agenda, Meeting objectives, IHIPC purpose, Announcements, Updates

The meeting agenda, meeting objectives, and concurrence checklist were reviewed. The following announcement and updates were also made:

- Meeting surveys can be submitted until February 28.
- In 2018, 88 new community/ agency representatives participated in IHIPC webinars/ meetings.
- Orientation has been completed by all new IHIPC members.
- All new members should complete the Illinois Open Meetings Act by March 31 if they have not already.
- Results of the Member Demographic Surveys will be used to guide our membership gap analysis and new member recruitment for 2020.
- The link to the IHIPC webpage was shared. Participants can access at IHIPC documents and meeting registration links/recordings at http://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg . Two 10-minute tutorials will be added to the website soon: IHIPC website tutorial and Webex™ tutorial.
- The Spring IHIPC Newsletter is in its final editing stages. Articles for the Summer Newsletter can be submitted through May 15th.
- In 2019, each Region will be holding Integrated Prevention and Care Community Engagement/ Needs Assessment Meetings. The tentative meeting dates are: Region 1- October 8; Region 2- October 15; Region 3: August 22; Region 4- August 28; Region 5- September 17; Region 6- June 20; Region 7- July 24; and Region 8- September 4.

9:55 am: Efforts to Prevent Hepatitis A Outbreak in Illinois/ Q&A, Discussion/Input

Dawn Nims, IDPH Communicable Diseases Data Coordinator/Epidemiologist

D. Nims presented information on trends of Hepatitis A in Illinois. Characteristics of Hepatitis A, including symptoms and modes of transmission, were reviewed. It was noted that outbreaks of Hepatitis A have been declared in specific areas and among specific risk groups in Illinois, including PWID, MSM, homeless individuals, and people who have been incarcerated. Specific demographic/geographic information about outbreaks in Illinois were shared, including HIV/HAV co-infection information.

D. Nims shared that IDPH has been working to promote a Mass Vaccination Campaign for Hepatitis A among at-risk populations through local health departments (LHDs). The goal of the Campaign is to partner with providers/ agencies that already serve at-risk populations so that individuals can access the vaccine where they are already receiving social/medical services (please refer to the slide set for details). Access to Hepatitis A factsheets/ infographics/ and resource documents was shared at the end of the presentation.

D. Nims stressed that vaccines can be ordered by all LHDs, and community organizations can partner with LHDs to provide the vaccine to their served populations. Overall, the initiative is in need of vaccinators and field workers/ agencies that have established relationships with hard to reach priority populations.

Q&A, Discussion/ Input

Q: What does "attack rate" mean?

A: Attack rate refers to the speed of the spread of a disease in a risk population. It estimates how many individuals within the community will acquire the disease once it is introduced.

Q: Are there costs for using the mobile units for vaccination event?

A: Mobile units sponsored by the Center for Minority Health are free to use. It is not known if a driver is included with use of the unit or not. Please reach out to D. Nims or the Center for Minority Health (dph.cmhs.info@illinois.gov) for more information.

Q: Are sex workers included as a risk population? Their work could expose them to fecal matter.

A: Sex workers are not included as a stand-alone risk group at this time. They might identify in other populations (incarceration or drug use), and they might come in contact with other individuals that belong to risk groups. If this is the case, they would be prioritized for the vaccine.

Q: Are there any Hepatitis A social media campaigns (sponsored by IDPH or nationally) that can be used to recruit clients?

A: IDPH has worked with Grindr to endorse pop-up ads statewide, although most ads are targeted by geographic location of identified outbreaks. Each ad contains a list of health departments that provide the vaccine and other information through links. In regards to other platforms like Facebook or Instagram, there has not been a campaign developed. The public IDPH link with resources can be shared on these sites. The Vaccine Campaign is open to ideas. The best scenario that IDPH's Communicable Disease Section envisions for the Campaign is that agencies that have already reached and built rapport and trust with risk group populations partner with LHDs to help as many people access the vaccine as possible. This has been a struggle working with LHD nurses alone as they often work to combat diseases that affect the general public. IDPH has tried to lift as many restrictions as possible to make the process feasible and encourage LHDs/ agencies to be creative in their local initiatives.

Q: Are Hepatitis A vaccinations provided at Summit of Hope events?

A: Yes, the Communicable Disease Section has partnered with M. Gaines to provide Hepatitis A vaccines at Summits of Hope. CPDH is supported Chicago-based Summits of Hope in the same way. LHDs are contacted when a Summit of Hope is scheduled in their area so that they can plan to attend.

Q: Besides vaccination, what are some other prevention methods?

A: Limiting risk behaviors associated with transmission is one way, but we know that it not always feasible. Beyond that, the best two practices for prevention include the vaccination and practicing good hygiene, such as hand washing.

Q: Are their limitations to performing vaccinations?

A: Yes, one must be a licensed medical professional (nurse, physician, pharmacist, etc.) to administer vaccines. Community health workers/ HIV testers without medical licensing are not allowed to administer vaccines. One good way to recruit vaccinators is to contact local hospitals when looking for volunteers. Sometimes, volunteering is a requirement of a medical professional's job.

Q: What is the regimen for the vaccine? Is it a series? How often should someone get it?

A: This outbreak vaccine is intended to consist of two doses six months apart. The first vaccine, however, is 95 percent effective for 10 years. Therefore, one vaccine per person is adequate to stop or prevent an outbreak. If an agency works with regular clients, there is more potential to be connected to the second dose.

Q: How much does the vaccine cost at Walgreens or CVS?

A: It is not known how much the vaccine could cost in a retail setting, especially depending on insurance status. People with insurance would most likely be able to bill the cost of a vaccine towards it, especially if they identify with a risk group. LHDs also have regular vaccine stock for Hepatitis A. Clients are usually charged on a sliding scale in this circumstance.

10:15 am: Update on Illinois HIV Epidemiological Profile and Trends /Q&A, Discussion/Input

Cheryl Ward, IDPH HIV Surveillance Administrator

C. Ward presented information on Illinois's HIV Epidemiological Profile and Trends. Information included Illinois HIV incidence and prevalence data by gender (including data for transgender people), race/ethnicity, age, HIV transmission category, and geographic distribution (demonstrated by rate on county maps). Late diagnosis data, HIV/HCV co-infection data, and mortality data was also reviewed (please refer to the slides to review specific data in more detail).

. The following summarizes recent HIV trends in Illinois:

- Since 2008, HIV diagnoses in Illinois are down an average of 2.5 percent per year.
- New diagnoses among females in Regions 1-8 declined an average of 7 percent each year since 2008.

- The proportion of cases testing late in Regions 1-8 are down 25 percent since 2008.
- All genders, ages, racial/ethnic groups, and geographic regions are affected by HIV, but not all are affected equally:
    - New diagnoses among 20-29 year-olds in Regions 1-8 significantly increased.
    - The rate of new HIV infection among African Americans is significantly higher compared to other racial/ethnic groups.
    - The proportion of cases "testing late" (AIDS diagnosis at or within one year of HIV diagnosis) in Regions 1-8 are down 25% since 2008.
    - Roughly one-half of males with infections attributed to heterosexual contact and persons over the age of 40 tested late.

C. Ward also introduced nucleotide sequence reporting/ cluster detection and response (previously known as molecular HIV surveillance) as part of the presentation.

Q&A, Discussion/ Input

Q: Regarding HIV/HCV co-infection, the typical statistic is that about ¼ of all people with HIV are co-infected with HCV. It is surprising to see only a 3 percent co-infection rate. Could this be due to significant underreporting?

A: Although there is some suspicion that there is underreported of HCV, the 3 percent co-infection rate refers to all people ever diagnosed in Illinois (about 66,000 individuals) since reporting began. It is also not limited to when HCV diagnoses occurred (either before or after HIV diagnosis). We could do further analyses to determine co-infection rates in which diagnoses of HIV and HCV occurred within the same year. There is a report of HIV/HCV matched data within the Integrated Plan (http://www.dph.illinois.gov/sites/default/files/publications/090216-OHP-Illinois-HIV-IntegrPlan-and-Appendices.pdf : Appendix E) that can be viewed for more information. It is our intent to update this within the next year.

Q: Please reiterate the new name for molecular HIV surveillance.

A: CDC is steering away from language that is jargon or could be misinterpreted as charged or stigmatizing. Nucleotide sequence reporting refers to Surveillance Unit activities and cluster detection and response refers to Prevention activities (such as surveillance based services).

Q: Great information. There is a need, however, to further discuss nucleotide sequencing data.

A: CDC has been hosting webinars on this information. Some webinars were open to community members. Announcements of these were communicated by J. Nuss. There will be future meetings sponsored by CDC as well. Announcement of these will also be communicated through J. Nuss. Additionally, there are plans to more fully discuss and get community input on this when the State's Cluster Detection and Outbreak Response Plan is reviewed at the June IHIPC face-to-face meeting.

Q: Can you again share the number or rate of those who are undiagnosed?

A: There are approximately 7,600 cases unaccounted for in prevalence totals. It is estimated that 16 percent of people who are living with HIV who are undiagnosed.

Q: We have moved on from the period where Illinois didn't have a budget, which resulted in an overall decrease of prevention efforts. Can any of this decrease in cases be attributed to decreases in prevention activities during that period?

A: The Surveillance and Prevention Programs believe that the recent decline in HIV infections is true and accurate. We are confident that the decline is not attributed to budget issues. The Prevention Program can speak to this in more detail.

Q: With transgender reporting, are gender non-conforming or non-binary persons being reported? How does this happened if only transwomen and transmen are counted?

A: At this time, the ability to report gender non-conforming or non-binary gender identities are limited by eHARS -included fields ask for sex at birth and current gender identify (both have male and female options only). This data may be able to be supplemented by Prevention and Ryan White data.

Q: How is PrEP uptake considered/ integrated into this data? This could help use to determine which communities are accessing PrEP and which communities are still experiencing barriers to it.

A: PrEP use is not tracked by Surveillance, but C. Hicks or E. Alvarado might have more information on how this is tracked by Prevention programs. PrEP uptake data is also available by state on AIDSVu (https://aidsvu.org/resources/deeper-look-prep/).

Q: There have been a lot of conversations around nucleotide sequence reporting. Issues around privacy, confidentiality, and ethical matters are of concern to people living with HIV. To what extent can health departments share personally identifiable data, especially with non-public health government entities like law enforcement?

A: The Surveillance Unit can assure all people living with HIV that personally identifiable data is not being shared unless it with a LHD or community-based organization to inform them of cases that need services (i.e. surveillance-based services), it is authorized by an individual (i.e. insurance purposes), or if it is ordered by a judge (although this is very rare). Data will never be shared with any other entity. This has been the law for many years.

10:55 – 11:00 am: Short break

11:00 am: Update on Illinois STD Profile and HIV/STI Co-infections/Q&A, Discussion/Input

Lesli Choat, IDPH STD Coordinator

L. Choat presented Illinois's STD Profile. She began by reviewing strategies and activities that are conducted under the STD Section's Prevention and Control for Health Departments (PCHD) grant. She also covered other information that drives STD Section activities, including collection of sexual orientation/ gender identity (SOGI) data through new morbidity report forms. L. Choat shared resources, including National STD Treatment Guidelines, which can be used by local programs to guide STD activities.

L. Choat presented data/information on trends in chlamydia, gonorrhea, and primary, secondary, and congenital syphilis, all of which have been increasing in Illinois or the nationally since 2013. Illinois trends in chlamydia, gonorrhea, and primary & secondary syphilis were reported by age, gender, and jurisdiction (Chicago or Illinois excluding Chicago). Additionally, gonorrhea and syphilis were reported by race/ethnicity and sexual orientation (men who have sex with men v. men who have sex with women). HIV/STD co-infection data was also reviewed. All data can be reviewed in detail in the presentation slides. She also discussed action steps being taken by IDPH and providers to reduce new STD cases.

L. Choat ended the presentation by urging participants to keep the rise of STDs in the forefront of their HIV work. She challenged them to think about why increases in STD rates are occurring while HIV rates are decreasing and encouraged them to think of ways to effectively incorporate STD prevention and treatment into HIV-related activities. She also announced that April is STD Awareness Month, and the STD section will be hosting a series of lunch-time webinars in April to commemorate this. More details about the webinars will be forthcoming.

Q&A, Discussion/ Input

Q: Was the slide that showed increasing congenital syphilis nationwide or statewide data?

A: The slide with the infographic (slide 63 of the presentation slide set) is national data. Slides 67 and 68 include both National and Illinois data.

Q: Is the increase in gonorrhea cases among males consistent across sexual orientation/ behavior reported?

A: CDC reports only an increase in males (19 percent nationally) that does not account for sexual orientation. They recognize, however, that there has been an alarming increase in gonorrhea among MSM. This is supported by slide 72, which shows that rates among MSM are rising, while other rates among MSW are steady and low.

Q: Do you think the increase of diagnoses of gonorrhea in males v. females is attributed to extra-genital testing?

A: This might be a factor, but the STD Section encourages that everyone (not just men, or specifically men who have sex with men) be tested at all sites of exposure. The Section is working on collecting this data and will analyze it by gender, age, and other factors when it is available.

Q: Is there any gonorrhea breakdown for the Latino population in IL?

A: Although this was not included in the presentation, L. Choat provided the following information after the meeting: "Gonorrhea rates disproportionally affect the black non-Hispanic population more than any other group. In 2017, the gonorrhea rates were 723.9 per 100,000 population in black non-Hispanics, 265.3 per 100,000 population in American Indian/Alaskan Native non-Hispanics, 202.0 per 100,000 population in other non-Hispanics, 99.9 per 100,000 population in Hispanics, 56.1 per 100,000 population in white non-Hispanics, and 32.4 per 100,000 population in Asian/Pacific Islander non-Hispanics. Many gonorrhea cases are reported without a race/Hispanic ethnicity with 14.0 percent (3,337) of cases reported unknown in 2017." More information on this can be found in Illinois's 2017 STD Surveillance Report (http://www.dph.illinois.gov/sites/default/files/publications/publicationsohpt2017-il-std-surveillance-report.pdf) on page 11.

Q: Is Expedited Partner Therapy (EPT) limited to any number of sexual partners?

A: Illinois law says that EPT can cover treatment of gonorrhea and chlamydia in any number of partners that are reported to have been exposed in last 60 days.

Q: Do we envision any work around LGV (lymphogranuloma venereum) in the next year or more?

A: LGV, which is a complication of chlamydia, is not specifically tracked or reported.

11:40 am: Brief Update and Discussion: 2019 IHIPC Needs Assessment Activities/IHIPC RECAP and Illinois GTZ Plan Recommendations

Janet Nuss, IDPH HIV Integrated Planning Administrator

Cynthia Tucker, AIDS Foundation of Chicago

Candi Crause, Champaign-Urbana Public Health District

C. Crause reviewed the process in which the draft Getting to Zero (GTZ) Plan Recommendations had been developed through various stages of community input. She thanked everyone who participated in GTZ events/ activities for their thoughts and recommendations. C. Crause continued by explaining the main forces that drive the Plan, which include PrEP uptake and increase viral suppression (U=U). Anticipated challenges in rolling out and implementing the Plan include getting information and services to communities most vulnerable to HIV; addressing barriers to community knowledge and access to services, including messaging to clients and providers; ensuring

that messages and services associated with PrEP and U=U are not stigmatizing; and finding ways to increase access to HIV testing. She encouraged participants to discuss challenges, ideas, and other considerations that can be better incorporated into the Plan.

C. Tucker reviewed the structure of the Plan, which is organized by six domains: Workforce, Health Care, Equity, Efficiency, Linked Conditions, and Surveillance (WHEELS). She also made several announcements: the final plan should be released in the spring; the Plan is intended to a five year plan (2019-2023) which can be updated/ changed as needed; and new committees will be formed for plan implementation and community engagement purposes. All are encouraged to participate in these committees once they are more formally announced.

J. Nuss then reviewed action steps that had been recommended through several IHIPC needs assessment activities in 2018 (please see slide set for more details). Each action step was accompanied by information that demonstrated how they again with the GTZ domains. It was noted that planning for/ implementation of the actions steps that will be taken on by the IHIPC over the next 2 years has been/ will be addressed by the IHIPC Steering Committee. Recommended Action steps that require actions on the part of the state, regions, or providers have been provided to HIV Section Program administrators for their consideration.

Q&A, Discussion/ Input

Q: L. Choat mentioned that an LHD had recently reached out to her about PrEP and U=U, asking if PrEP really worked and if U=U was true. This is a reminder to that even if messages are shared many times, they don't always reach everyone, especially when there are high staff turnover rates at service facilities. Although this felt like a big wake-up call to L. Choat, it was also a great opportunity for her to speak on it and share information.

Q: The IHIPC is always enhancing engagement of all medical and service providers that work with shared HIV prevention or care clients through updating its extensive email distribution list. If anyone would like to add organizations/ collogues to this list, please contact J. Nuss.

Q: Has the IHIPC formally endorsed Getting to Zero?

A: Not formally because we have been waiting for the final Plan to be released. When the Plan is released (anticipated to be this spring), it will be sent to the IHIPC for review. A brief discussion on the final plan and formal vote can be scheduled to occur at the June meeting.

C: The linkages between the domains and the IHIPC action steps are much appreciated.

12:10 pm: Public Comment Period-

M. Williams, Co-Chair of the Membership Committee, spoke of behalf of the Membership Committee. He stated that the Committee recently reviewed the results of the IHIPC End of Year 2018 Survey. It was noted that there was some dissatisfaction with "providing opportunities for input and participation for PLWH and those vulnerable to HIV in the planning process". The Membership Committee will continue to discuss and strategize about ways to ensure voices can be better heard. He ensured participants that the Committee is listening to feedback and doing the best that they can to address identified issues. He completed his comments by thanking everyone for their valuable input and encouraged participants to continue to use their voices during planning meetings and activities.

12:20 pm: RECAP (Review, Evaluation, Challenges, Actions, Preview) Discussion

J. Nuss led participants in a RECAP activity, briefly reviewing the key takeaways from each presentation. She encourage participants to continue to give feedback on meetings, presentations topics, and materials so that the IHIPC can continue to make meetings as understandable and engaging as possible.

The following open discussion occurred as part of the RECAP activity:

Q: What is the possibility of holding a summit to educate LHDs, FQHCs, and medical society leaders about GTZ, PrEP, and U=U?

A: This idea can go back to IDPH leadership. C. Tucker also noted that GTZ will be having more engagement meetings as the Plan is implemented.

A: MATEC would like to offer support for these meetings if they would be led by IDPH.

Q: Thanks for the great information about GTZ: it is good that it encompasses all areas of state. As it is launched, please recommend that activities/ events encompass all parts of the state as well.

A: C. Tucker stated that this is the intent of the Plan. They would also like people from across the state to be a part of upcoming committees.

Q: The LHD administrators are part of state and regional associations/consortia (such as NIPHC – Northern Illinois Public Health Consortium) that meet on a regular basis. There might be an opportunity to introduce GTZ at those meeting.

A: C. Tucker will work with S. Semelka (GTZ Program Manager) to make sure she has this information. This is a good way to ensure that every region is informed of and involved in the process.

12:30 pm: Adjourn – The meeting adjourned at 12:25pm**.**

2019 Illinois HIV Integrated Planning Council (IHIPC) Voting Log : February 21, 2019 Meeting

Member Name	Member Type	Date: Jan. 4, 2019 Time: 12:30 pm **Motion 1:** A motion was made by Mike Maginn at 11:45 am on Jan. 4, 2019 to adopt the agenda for the Feb. 21, 2019 IHIPC meeting approved by the IHIPC Steering Committee. The motion was sent to the full IHIPC at 3:05 pm on Jan. 4, 2019. Members were given until 12:00 pm, Jan. 11, 2019 to submit their votes.	Date: Jan. 10, 2019 Time: 10:50 am **Motion 2:** A motion was made by Scott Fletcher and seconded by Janet Nuss at 10:50 am on Jan.10, 2019 to adopt the revised agenda for the Feb. 21, 2019 IHIPC meeting approved by the IHIPC Steering Committee. The motion was sent to the full IHIPC at 10:50 am on Jan. 10, 2019. Members were given until 12:00 pm, Jan. 16, 2019 to submit their votes.
IHIPC Voting Members			
Benner, Mike	Voting	Y	Y
Bradley, Wendy	Voting	Y	Y
Charles, James	Voting	X	Y
Choat, Lesli	Voting	Y	Y
Crause, Candi	Voting	Y	Y
Dispenza, Jill	Voting	Y	Y
Erdman, Jeffery	Voting	Y	Y
Filicette, Joe	Voting	Y	Y
Fletcher, Scott	Voting	X	Y
Frank, Stephanie	Voting	Y	Y
Gaines, Michael	Voting	Y	Y
Gassett, Dwight	Voting	Y	Y
Guzman, Lisa	Voting	X	X
Hendry, Chad	Voting	X	Y
Holmes, Nicole	Voting	X	Y
Hoots, Cheri	Voting	Y	Y
Hunt, Don	Voting	Y	Y
Johnson, Rashonda	Voting	X	Y
Jones, Shanett	Voting	Y	X
Laskowski, Casie	Voting	Y	Y
Lewis, Karen	Voting	X	X
Maginn, Mike	Voting	X	Y
Meyer, Len	Voting	Y	Y
Nuss, Janet	Voting	Y	Y
Olayanju, Bashirat	Voting	Y	Y
Paesani, Trish	Voting	Y	Y
Reed, James	Voting	X	Y
Rehrig, Susan	Voting	Y	Y
Roeder, Lisa	Voting	Y	Y
Stevens-Thome, Joan	Voting	Y	Y
St. Julian, Steven	Voting	Y	Y
Tucker, Cynthia	Voting	Y	Y
Williams, Mark	Voting	X	Y
Williamson, Mildred	Voting	Y	Y
Zamor, Sara	Voting	Y	Y

Type of Vote: Hand Count, voice, electronic		**electronic**	**electronic**
Results: Carried/Defeated		**carried**	**carried**
Results: Vote Count		**25 in favor , 0 opposed, 0 abstentions, 10 members absent or "no vote cast/received"**	**32 in favor , 0 opposed, 0 abstentions, 3 members absent or "no vote cast/received"**