Illinois HIV Integrated Planning Council (IHIPC) Meeting Minutes

October 21, 2019, 11:00 am – 4:30 pm

11:00 am: Working lunch: Welcome; Introductions; Meeting process/instructions; Review of agenda/meeting objectives; Moment of silence

Co-Chairs J. Nuss and M. Benner welcomed all members/guests to the meeting. Webinar and housekeeping instructions were reviewed. Following this, the group was led in a moment of silence for all people living with HIV past and present and for all those working to end the epidemic in Illinois.

All in-person participants introduced themselves, and webinar participants were announced.

The following announcement were made at the meeting:

- Member updates: J. Kowalsky is the new Substance Use and Prevention and Recovery liaison. He has finished new member orientation and is officially a voting member.
- The Fall issue of the IHIPC newsletter should be released soon.
- Most voting and at-large members have completed the 2020 High Impact Prevention and HIV Care Interventions training. Follow up is occurring for those who have not completed it.
- The series of focus groups for at-risk populations started with a focus group for black women in Region 4 in September.
- The Regional Community Engagement Meetings will conclude in November. A full report will be compiled and shared when available.
- As of June 2019, 51 community/ agency representatives have participated in IHIPC meetings and trainings this year.
- All documents for the October 21-22 meeting are posted on the registration page: https://www.regonline.com/october2019ihipcmeetings.
- Meeting surveys for the October 21-22 meeting can be submitted until Tuesday, October 29 at the following link: https://www.regonline.com/IHIPCmeetingsurvey .
- All IHIPC documents, including full body and committee meeting agendas and minutes, are available on the IHIPC website: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg.

After Announcements, the Co-Chairs reviewed the meeting objectives, meeting agenda, and the IHIPC concurrence checklist.

11:30 am: Community Services Assessment: Regional Care and Prevention Lead Agent Brief Reports to the IHIPC/Discussion - (30 minutes)

Each Prevention and Care Lead Agent gave a brief regional report:

Region 1: Care report from C. Boyd: The Region 1 Community Engagement Meeting was on October 8 and went well, with many participants from diverse fields and expertise. A Summit of Hope was held in Region 1 in August, where HIV testing and Hepatitis A vaccinations were conducted. Prevention Report from M. Maginn: With the Prevention grant year beginning on July 1, five Region 1 providers have been conducting HIV services (i.e. testing, linkage and partner services for two new positive individuals) and STI testing. The next Regional RIG meeting will be November 15.

Region 2: Care report from P. Briggs: The Region 2 Community Engagement Meeting was on October 15 and produced good conversations and discussion. PrEP activities have been conducted in the region, including the addition of new primary health care providers prescribing PrEP. One challenge that the region identified is the inability to use ADAP services to provide short term coverage for people discharged from the hospital or going into a nursing home. Prevention report from M.

Maginn: There are five agencies in Region 2 conducting HIV services (testing, identification of one new positive individual) and STI testing. The next Regional RIG meeting will be November 13.

Region 3: Care report from M. Ashby: New case managers have been hired and are in training. All case managers are working on the region's Stigma Project and are trained in trauma informed care. A Region 3 Care and Prevention Service Cooperative has been established, and the region recently hosted their 4th client retreat. Prevention Report from J. Erdman: C. Wade is the new prevention lead for Region 3 as of August. C. Wade has been conducting site visits and has been getting to know his organizations. There are four agencies in the region, and two new positives have been identified thus far. The next meeting Region 3 RIG meeting is November 14.

Region 4: Care report from S. Rehrig: Region 4 has continued their collaboration with SIHF and Madison County Health Department on the social media/marketing project "Metro in the Know". Region 4 is now fully staffed with case managers, but they need to fill two client representative positions. Currently, the region is planning for a focus group on HIV decriminalization, has a thriving support group, and has a successful consumer advisory committee. Prevention Report from J. Erdman: There are eight agencies in Region 4 where seven new positives have been found (five of whom were found through routine testing). The Region 4 Community Engagement Meeting was held in August and went well. The next Region 4 RIG meeting is in November.

Region 5: Care report from S. St. Julian: Region 5's Community Engagement Meeting was held in September and was well attend with 40 participants from diverse backgrounds. A hot topic at this meeting was discussion around the aging population, particularly around education about HIV for nursing home staff and issues around medication gaps for clients. The PrEP clinic in the region remains successful. Prevention Report from M. Maginn: C. Wade is the new lead agent in Region 5. There are two providers in this region. Although no new HIV+ individuals have been found in this quarter, the region has found many new STI cases through testing efforts. The next RIG meeting in Region 5 will be on November 12.

Region 6: Care report from C. Crause: The region has recently hired two new staff. Prioritized trainings for all staff include topics such as Gender Inclusion and Undoing Racism . The region is also prioritizing messaging around U=U with providers and the community. Prevention Report from J. Erdman: There are five providers in Region 6. One new positive individual has been identified. The Region 6 Community Engagement Meeting will be on November 14 at C-UPHD.

Region 7: Care report from B. Olayanju: There have been many conversations in Region 7 around resources as there has been changes in the funding landscape in the area. Open enrollment has also been discussed so that all staff and clients understand the enrollment process. Collar County Advisory Board meetings (collaboration with Care and Prevention providers in the region) have been ongoing. Prevention Report from J. Erdman: There are eight funding providers in Region 7. Eight new positives have been identified this year. The next RIG meeting will be in November. The Region 7 Community Engagement Meeting was held in July and went well.

Region 8: Care report from B. Olayanju: Site visits with grantees are now ongoing. The Region has released and collected information from a case manager survey. Barriers and successes have been identified and will be followed up on. As in Region 7, discussions about resources considering changes in funding in the area have been important. The region will also be having a Case Manager Appreciation Day on November 1. Prevention Report from W. Allen: There are fifteen providers in the region, where fifteen new positives have been found (two through risk-based testing and thirteen through routine testing) . The Region 8 Community Engagement Meeting was held in September and went well. The next RIG meeting will be on December 6.

There were no questions following these reports.

12:00 pm: IHIPC Appointed Liaison and HIV Section Updates - (30 minutes)
IDPH HIV Section leadership; IHIPC Appointed Liaisons

Each liaison gave a brief report:

Chicago Area HIV Integrated Services Council report by C. Tucker: At the September CAHISC meeting, M. Williamson provided a health equity training which included information on social determinants of health, race, and inequality. The latest grant awards were also reviewed at the meeting. In October, CAHISC will be voting to elect a new liaison for the IHIPC. The Housing Committee will be conducting a needs assessment for the 5-year Housing Plan.

IDPH IDOC Corrections Project report by M. Gaines: The Summits of Hope have continued with the most recent being in Chicago in July, in Rockford in August, and in Rock Island in October where HIV and HCV testing were conducted. Planning for Summits in late 2019 and 2020 is ongoing. There have been ongoing discussions with the Department of Juvenile Justice to bring back "First Step" events, which are youth events based on the Summit of Hope model. The Illinois Department of Corrections has hired two new HIV coordination positions that will be working on opt-out testing efforts. The Community Reentry Project had its annual conference in October.

Illinois Primary Health Care Association report by C. Hoots: IPHCA represents 48 community health centers as members, with 385 clinic locations. The IPHCA Annual Leadership Conference was held in October and included HIV clinical sessions. IPHCA is preparing to write their HRSA community health center grant application. Ending the Epidemic is a priority of this grant, so IPHCA will be providing technical assistance and guidance around this to their members. They will be looking to partner with already established HIV entities in those efforts.

IDPH STD Section report by L. Choat: The finalized national STI data for 2018 was recently released by CDC. The report focuses on the increase of syphilis, including congenital syphilis. All STIs have increased over the last five years and are now at an all-time high. Illinois numbers also reflect this trend. It is promising that the Getting to Zero-IL Plan emphasizes STI testing, treatment, and prevention. 2020 new counselor trainings dates are March 24-27 and September 15-18.

St. Louis Area HIV Services Planning Council report by W. Bradley: Five counties in Illinois are funding through St Louis TGA Ryan White Part A funding. The grant application was submitted and is currently being routed through the appropriate channels. St. Louis is looking to restructure their case management model. The first meeting around this topic will take place on October 29. RFPs for 2020 services should be released soon.

Illinois Department of Human Services, Division of Substance Use Prevention and Recovery report by J. Kowalsky: No report was given.

IDPH Centers for Minority Health Services report by R. Wheeler: The Minority AIDS Initiative grants will begin on November 1. Six agencies have been selected for funding this year. The first grantee meeting will be held shortly after initiation of the grant.

IDPH HIV Section report by A. Danner: Care: The Ryan White Program has been conducting Pre-Open Enrollment Webinars to prepare all case managers and clients for this process. Plan are yet to be selected as the Department of Insurance has not released plan options. Plans will be announced as soon as they are available. Prevention: The Prevention Program, in collaboration with the Surveillance Program, successfully submitted the PS18-1802 funding application in September. Prevention has also recently gained several new staff members. The RIG, Direct, and Quality of Life Grants have been renewed within their respective cycles. An updated risk assessment form will be tentatively available on December 1. There will be webinar trainings around this form and any related changes in Provide ™ before and after the form release. The next FIM-R meeting will be held on October 31 in Chicago. The 3rd Party Billing project is working on training around PrEP costs, and the Routine Testing grant will be reestablished and open for competitive bid in November 2020. Training: A new Training Administrator has been hired. There are several trainings left in 2020 that have openings, including HIV Navigation Services and Motivational Interviewing (October 29-31: Springfield) and Surveillance Based Services (December 3: Elgin). On November 13, Dupage County Health Department will hold a U=U, Getting to Zero, and PrEP training in collaboration with IDPH and CDPH. There are plans for an upcoming training newsletter and training calendar on the IDPH website. PrEP: There will be a PrEP Summit on March 31 in Springfield. Almost all PrEP sites have submitted workplans for this year. This project has been very successful.

Discussion:

Q: How can we receive a full list of trainings and special events/ presentations?

A: We will be scheduling trainings for 2020 in the next few weeks and have plans to implement a quarterly newsletter which will include upcoming training events. We will also be adding the class list to our training page on the website as well.

12:30 pm: Community Services Assessment: Results of 2018-2019 Needs Assessments of Youth and Young Adults; Q & A, Discussion, Input - (30 minutes)
Marleigh Andrews-Conrad, IDPH HIV Community Planning Program Specialist

M. Andrews-Conrad presented the results of the 2018-2019 Needs Assessments of Youth and Young Adults. Needs assessment activities were conduct in juvenile detention centers, at an LGBT support group, and at a Summit of Hope. Tools used for the activities included a youth survey and a focus group protocol (including HIV/STI/ HCV education information and focus group questions). Survey and focus group procedures and content were explained in depth. Survey and focus group findings and recommendations from the activities were shared with participants. Participants were then asked to give their input about the recommendations and other ideas/ strategies for serving youth and young adults.

Discussion:

C: I would be cautious about curriculums when it comes to comprehensive sex education. There are very few CDC- approved curriculums, and the ones that exist are old, outdated, and do not address today's youth in an effective way. I think there are innovative ways to incorporate comprehensive sex education into curriculums without using those as they seem limited.

C: This is a great time to have this conversation as October is Let's Talk month, which is meant to bridge the gap between parents and children in conversations about sex and sexuality. Advocates for Youth has a free sexual health curriculum called the 3 Rs: Rights, Respect, and Responsibility (https://3rs.org/3rs-curriculum/) . This is a good resource. There is also an organization called Sex Positive Families, which helps families have healthy discussions about sex and sexuality that often goes beyond school curriculums.

Q: Was there any discussion about consent at the focus groups? How does consent fit into these recommendations?

A: M. Andrews-Conrad responded: We did not ask any questions about consent and I don't believe it came up in conversation. I think it is a great thing to consider for our next needs assessment cycle.

Q: You said that stigma was high in the Juvenile Detention Centers. Is that something that we should include in education and training recommendations? When it comes to the Juvenile Detention Center, I think the environment pushes stigma. I also think that its not just the youth: it is also the staff. They need training as well because they have the power to push that culture. Another way that we can try to educate youth is through the Juvenile Courts. They often have training programs for youth that can be terms of their release (similar to anger management). Training courses on this topic could be delivered in a similar way.

A: M. Andrews-Conrad responded: Yes, that is a great point. The integration of stigma into education is very important. Also, the idea around training through Juvenile Courts is great and something to consider.

Q: You said that you talked to the youth about using PrEP, but did you also discuss the long-term side effects? This includes kidney disease and bone disease. It is important for them to know this before making a choice.

A: M. Andrews-Conrad responded: Yes, some youth did ask about side effects, which were briefly discussed. However, we recommended to the youth that they talk to a health professional about this in detail if they were to choose PrEP. Thank you for bringing this up as transparency is important in all that we do.

C: There are high schools in Suburban Cook County where Aunt Martha's provides a sexual health program. I agree that some curriculums are limited, so it is essential to think outside the box to make sure the youth are getting this information. Another issue around sex education in high school is that students take health classes only for one semester. There are not other opportunities for them to continually learn about sexual health. In terms of PrEP, I believe we really need to push this among youth, not only to protect them from HIV but also to familiarize them with affirmative health care.

C: I agree that Advocates for Youth has a great curriculum. I believe you said that the majority of youth would feel comfortable talking about sexual health with a provider, but many providers are not opening the door for this type of conversation. I think there has to be a better emphasis on sexual health when it comes to the training of providers, especially those in family medicine and pediatrics. One thing Cook County Health is trying to push forward is PrEP training modules for adolescent and infectious disease providers. We need to push this forward, however, with all family health providers. I think the long-standing emphasis of HIV in infectious disease settings has caused a deemphasis of sexual health in other medical specialties. Because of this , there is a need for full saturation of PrEP into primary care. This includes training primary care providers on taking an appropriate sexual health history for patients of all ages, but especially youth. I also think there is an opportunity for us to work with science and health teachers to identify strong youth that can be trained to teach these topics to their peers. Advocates for Youth resources could be used to implement a train the trainer type program for this, and youth should be given some sort of educational credit for participating. This could be done on an even larger scale at colleges and universities.

C: I want to echo that the Advocates for Youth 3Rs curriculum is very comprehensive and free. It is a K-12 curriculum that is authored by the same group that published the National Sexuality Education Standards. We have been advocating for all of our school districts to implement this. I also wanted to mention that although providers should be educating people on PrEP side effects, quarterly labs help us to monitor any unwanted physical side effects. PrEP is very effective and protects people from HIV transmission. We should educate clients on all of these components so that they are fully equipped to make a decision.

C: I also agree that more work needs to be done educating primary care and pediatric doctors on this topic. Sexual health affects all stages of life, so it is essential to introduce education as early as possible with patients/ clients.

Q: The participant sample for these activities was only from two counties. Should more activities be done so that we have a better statewide perspective from youth, rather than just from a few areas?

A: M. Andrews-Conrad responded: The activities presented today represent the entirety of the youth needs assessment process conducted by the Integrated Planning Program. However, all agencies are invited to view and use the survey and focus group tools if they are interested in completing similar activities in their areas. Please reach out to me if you would like to access those. If activities are completed by agencies, we would ask that the results be shared for continuity purposes.

C: I want to address reaching college and university systems. There are some people who are not exposed to sexual health education in their adolescent or teen years, so it is vitally important to continue this education into college curriculums. Also, the HIV/ STD hotline can be used as a resource for any student to ask questions that they might feel uncomfortable about in a school setting. Finally, if we are talking about sexual health education for youth, we must incorporate discussions about pleasure into the conversation.

C: Another important thing to address is trust in the health care system, especially for young MSM of color. It is evident in the findings that youth know where services are but are not accessing them. An impactful way to address this is to acknowledge mistrust of the system and continue to talk about it. If this is not addressed openly, education efforts might not work.

C: Considering the survey results of youth reported fear of their parent's reactions to an HIV diagnosis, I think that community outreach to parents and primary caregivers of children would also be a target group to educate about sexual health.

C: We need to be mindful that workforce development and structural interventions are important in increasing health outcomes. This is true for youth and adults.

C: In Peoria, Holt Center provides comprehensive sex education in District 150 of Peoria. The FLASH training curriculum is free from King County Health Department in the state of Washington. It can be found here: https://www.kingcounty.gov/depts/health/locations/family-planning/education/FLASH.aspx .

1:00 pm: Community Services Assessment: Barriers/Challenges to HIV Prevention & Care in Rural/Migrant Communities; Discussion, Input - (45 minutes)
Janet Nuss, IDPH Integrated Planning Program Administrator/IHIPC Coordinator
Steven St. Julian, Jackson County Health Department Prevention Services Coordinator

J. Nuss presented Barriers/ Challenges to HIV Prevention and Care in Rural/ Migrant Communities. The presentation began with an introduction to rural and migrant communities in Illinois, specifically the unique factors that may make HIV prevention and care challenging in these communities. S. St. Julian then gave his perspective and opinion on the topic as a rural provider. Recommendations and strategies for combatting barriers in rural and migrant communities were then introduced, followed by a discussion on the topic. It was announced that all feedback and information from this presentation would be reviewed by the Epidemiology/ Needs Assessment committee for continued research and work on developing recommended strategies to address the issues.

Discussion:

Q: Under the current administration, I have heard that they are saying that testing positive for HIV is a reason that people can have residency or green cards denied. Additionally, if an undocumented person applies for Medicaid, they may be found to be a burden on society, which is another reason that residency can be turned down. So even if we are identifying at-risk and/or HIV+ people in these communities, they often won't engage in prevention or care services due to fear of being denied in the immigration process.

A: J. Maras responded: I would like to respond to how the Ryan White program serves undocumented populations and people with green cards who are not yet eligible for Medicaid. The Public Charge Act is a critical issue when it comes to this topic. Anyone working within the Ryan White system should be informed of and sensitive to public charge. At this time, there is an exemption on public charge, so policies and information about this have recently changed. On the Ryan White Open Enrollment webinars, public charge was addressed. The program has never required undocumented clients to submit proof of Medicaid denial in order to receive Ryan White services as they would not be eligible. For these clients, the Affidavit of No Insurance can be used. In recent years, the Ryan White program has offered "sister plans" at open enrollment that allow clients to enroll for coverage without proof of citizenship. They will again be offered this year. These are all things that the program has done to serve these clients while being cognizant of the unique barriers that these clients face.

C: I think employment in these areas is also another issue that relates to this topic. For example, if there is a prison in a rural area, many people will seek employment there. Stigma is often perpetuated in prisons, which can then cultivate in the communities of the employees.

C: I appreciate J. Maras's comments about public charge. Public charge is somewhat of a moving target. There is a reprieve at this time, and that is due to the work of the human service and legal communities. One thing that could be very helpful on this topic would be a training or webinar from legal entities such as the Legal Council for Health Justice or the Legal Assistance Foundation. Through the Cook County Health System, services have always been available to undocumented people, and many who come for services express fear and anxiety around this topic. People do not want to put their family members at risk. Keeping up on this information is so important so that we can best serve clients. Regarding general rural health care, I think we need to better explore opportunities with telemedicine. Several rural states

have very strong HIV telemedicine programs as they often partner with federally qualified health centers to reach individuals. This is very promising and could be successful in our rural regions.

C: It would be good to know how these populations use and perceive medical providers /services outside of HIV.

1:45 -2:00 pm: Break

2:00-3:30 pm: Panel Discussion: Current and Future Efforts to Collaborate/Align our Programs with GTZ-IL – (90 minutes)
Dave Kern, Chicago Department of Public Health/Chicago Area HIV Integrated Services Council
Jeffery Maras, IDPH Ryan White Part B Administrator
Curt Hicks, IDPH HIV Prevention Administrator
Mike Benner, IHIPC Community Co-chair

J. Nuss facilitated the panel discussion: Current and Future Efforts to Collaborate/ Align our Programs with the Getting to Zero Illinois Plan. Each of the panelists (named above) gave a brief review of the ways that their respective programs/entities/ groups are supporting the Getting to Zero Plan through various efforts. Discussion about the programs and their ability to collaborate/align to reach the goals of Getting to Zero followed.

Discussion:

Q: In the PrEP housing that was discussed (for State prevention programs), are their certain contracts/ grants that are eligible for this or is this for anyone on PrEP? At our CBO, we do bill PrEP services to insurance. We would like to build a status-neutral model around our PrEP clients and would be interested in learning more about how we could participate in these types of housing opportunities. If you would share your model, that would be helpful.

A: This question was misheard by C. Hicks at the meeting. The following response is a correction to the initial response: The Chicago Department of Public Health is developing a program to be funded by city corporate funding to provide housing for some HIV-negative clients taking PrEP. This innovative pilot program is limited to eligible residents of the City of Chicago. Given that the holistic needs of vulnerable Illinois residents greatly exceed limited State HIV funding and that many other programs provide housing for low income persons on a status neutral basis, IDPH has ranked housing for HIV-negative clients as a lower priority than its current prevention investments covering the costs of PrEP medications, PrEP insurance copays, PrEP medical services, PrEP linkage services, PrEP marketing, and PrEP training and capacity building throughout the State of Illinois. Prevention providers are required to screen for a client's housing status and to make individually appropriate referrals. Options include homelessness prevention assistance, emergency shelters, transitional housing, recovery homes, youth housing supports, HUD subsidized apartments, public housing, independent living centers, rural rental units, and low income housing tax credits. The following websites list federal and state housing programs available to eligible Illinois resident on an HIV-status neutral basis: https://www.hud.gov/states/illinois/renting ; and https://www.dhs.state.il.us/page.aspx?item=29723 .

C: I have found the Community Engagement Meetings to be very helpful. In Region 2, there were representatives from the Supportive Housing Providers Association. They will have a Getting to Zero presentation at their upcoming conference. I say this because I think these are opportunities for us start broadening our networks outside of our HIV resources.

Q: With the implementation of the new portfolio in Chicago, I have heard some concerns about services within the African American community and services for women not being funded. What is being done to make sure that people are not falling through the gap?

A: D. Kern responded: With the implementation of the portfolio, there were 26 different funding opportunities released over a 1.5-year period. These opportunities were designed to accommodate different kinds and sizes of agencies. For example, the community development projects are specifically meant to focus on working with communities to define problems, find solutions, and then implement structural interventions around them. For other projects like the population-centered health homes, those are meant for the delivery of health care. This diversity in opportunities was identified as an important component in our engagement process, and we believe that we lived up to this commitment in our funding opportunities. Despite efforts to design funding opportunities with integration of input from the engagement process, the outcomes of any funding process unfortunately cannot always be predicted. Regarding this portfolio, there are several agencies that have expressed concerns about funding. However, when we look at an analysis of our resources, we see them following the geographical trends of HIV in Chicago (services available on the South and West sides) and that many services are EMA-wide. Given the size and complexity of the portfolio, the outcomes show that there are organizations who are smaller

communities agencies and larger systems that are distributing resources and services throughout Chicago. Should additional resources become available, we will look for opportunities to fund services that are expressly targeted to non-clinical, non-medical organizations.

C: I think that something to take into serious consideration is that despite the shift to biomedical interventions, there is still a need to address structural inequality of organizational strength, community status, and legacy issues around smaller organizations. We must consider the unintended consequences that this might pose for them. In terms of Getting to Zero, focusing on outcomes is very important. But within the context of that, we must involve organizations from oppressed communities so that they end up stronger and not more precarious. I think we could use some quality time to talk about root causes analyses and power dynamics of organizations that have lost funding. Efforts should be made to address those causes with these organizations whenever possible. Every organization does not have the same strengths horizontally and vertically, and government entities above these agencies need to be careful in considering this.

Q: There was mention in C. Hicks's presentation that to get to zero new diagnoses, over 6,000 people would need to be identified and linked to care this year. How would this happen under a fee-for-service model? Fee-for-service gets in the way of making "touches" needed to find new diagnoses. This type of reimbursement also only allows for certain allotments of services. An agency is not paid for any services done beyond those allotments under this model.

A: C. Hicks responded: I don't think that all this work should be done through the fee-for-service model or risk-based testing. For this scale, routine screening would be essential in achieving this goal. An example of this is opt-in screening in prisons. An example recommendation would be for colleges and universities to make HIV testing a health standard for all students, which might help us identify more positives among young adults. Still, additional efforts would need to be made to address transmission elimination efforts among people living with HIV who have fallen out of care and/or do not have a suppressed viral load.

C: I very much appreciate the Undoing Racism Trainings that have been sponsored by IDPH and CPDH. I think we need to continue these efforts very strongly. If we don't continue these conservations and work through some of the feelings that this training has brought up, we are doing a disservice to those populations that we represent at this table.

A: J. Maras responded: The Section found the Undoing Racism Workshops profoundly important. Knowing that this training is not an ultimate solution to racism, there is an ongoing commitment and discussion around continuing these conversations so that we do debrief and then move forward. These plans will be forthcoming. Within the Minority AIDS Initiative grants, there has been a substantial shift in how the grant is targeting minority populations. MAI and ADAP have a very good partnership, and there has been a major overhaul to the MAI program to be more successful in the next portfolio. These changes will allow for more effective targeting of minorities who are already diagnosed and have been in the Ryan White system but are now lost to care and not virally suppressed. ADAP has the ability to identify these clients through their own records and surveillance data, but now, through this new system, MAI will be responsible for reengaging these individuals. It will be exciting to see how this initiative will help us get to zero.

C: I attended the Undoing Racism Workshop, which I think empowers staff to address the power dynamics of racism.

Q : I enjoyed all the reports. Is there anywhere online that these reports will be posted?

A: Please find all meeting slides and reports on the meeting registration page: https://www.regonline.com/october2019ihipcmeetings.

Q: Regarding strengthening and building the workforce, will there be any new initiatives that help clients re-enter the workforce? Some clients are becoming well enough to work but may not have the training or education needed to acquire a job. What can we do to assist these clients?

A: J. Maras responded: From the Ryan White perspective, this is a challenge for us as career development is not a HRSA-authorized service, so federal dollars cannot be used to support this. The Department, however, has had preliminary discussions about how this might be possible outside of Ryan White funding. In my opinion, one of the greatest needs that needs to be addressed among our clients is poverty. HRSA, however, does not use this as an indicator for guiding funding. Career development and career engagement for clients who have moved to self-sufficiency is very important and should be addressed through a model that uses alternate funding. Initiatives around this might not be ready for the next grant year, but it is being discussed.

A: D. Kern responded: With the new Ending the Epidemic initiative, more funding is becoming available for prioritized areas, which includes Cook County. CDPH recently submitted an application for additional funding to look at aging, and one of the topics under that umbrella is helping people return to work and helping clients manage other age-related conditions and issues related to social isolation. We are hopeful that we will be funded and look forward to partnering in this endeavor.

A: C. Hicks responded: Each Prevention region is funded to hire and train Black and Latino MSM for peer outreach. This is an opportunity for them to re-enter the workforce. If you know a client who might be interested, please reach out to the prevention lead agent in your area to see if there are any needs/ openings at this time.

Q: One thing I noticed in the presentations is that Chicago is taking a very comprehensive approach to prevention and care services, and J. Maras also mentioned that the Ryan White program has comprehensive components such as using funding for Hepatitis C treatment and other medication needs. Is IDPH looking at how

disease specific dollars (i.e. HIV, STI, Hepatitis C, PrEP) can be used as a combination package to help providers better create health home models for clients? Care coordination for primary care for clients is also something to consider. I would like to ask IDPH leadership to continue to push and find ways to introduce more comprehensive packages through multiple funding streams.

A: C. Hicks responded: Grantees have the ability to apply for a variety of grants and a variety of services within those grants, which can help agencies offer many services like screening, linkage to care, Hepatitis C testing, vaccinations, etc. This bundling has been built into the HIV infrastructure for this reason.

A: J. Maras responded: Regarding PrEP, there are several funding sources that support this. Medical cost can be covered, and the cost for labs and auxiliary work that must be done can be covered through the local Health Protection Grants. From a Ryan White perspective, we will be focusing on quality initiatives that ensure that case managers are talking to their clients about PrEP for partner use. We must find resources that allow for this type of education not only for Ryan White clients but also for PrEP users themselves as navigation of health insurance plans for PrEP can be difficult and overwhelming. We must also continue to do a better job to elicit partners so that all of these pieces fit together comprehensively.

C: I think that bundling services is very important for getting to zero. Funding structures need to be re-evaluated in order to align with the GTZ Plan. Specifically, the fee-for-service model with very narrow scopes is not feasible for agencies. It is difficult for agencies to be successful under this model because the deliverables are too specific. Maybe there should be a committee that looks at the funding to see how it aligns with the GTZ Plan.

A: C. Hicks responded: It is important to remember that targeted testing must be coupled with routine testing in order for us to get to zero. Routine testing is not a fee-for-service model. I would like to reiterate that the Routine Testing grant is being reestablished in 2020.

A: D. Kern responded: If we are looking to end the epidemic, I think that we must think outside the box and not continue programs for the sake of maintaining them. Because of this, it is important to do those deep dives into funding to determine how it can be used most effectively. It might be a long process, but it is worth doing and is possible to integrate funding for status neutral services through community engagement and input.

C: We must remember that bundled packages of funding are easier to implement in large areas. This integrated funding could cause new challenges for rural areas.

C: I was on CAHISC while the portfolio was being planned and worked through. I agree that ending an epidemic takes a different mindset than maintaining programs. We had to remain focused on populations driving the epidemic. For agencies that were built in response to trauma and hatred around HIV, it is very difficult to have conversations about where funding can be most efficiently allocated, especially if it is means their funding is cut or reduced. We don't want to lose these vital community organizations. CAHISC tried to honor the fact that biomedical services should be at the forefront of our work while being supported by behavioral interventions. I think the State needs to look at this model and consider how their funding follows the priorities of targeting the most at-risk populations while also ensuring that all people are virally suppressed.

C:I come from the health care system, and I want to say something about financial viability. Value-based care transitions within delivery models are something we need to be talking about with people who represent the healthcare system outside of our current grants. It's important to understand what population health metrics are and how they relate to outside partnerships within healthcare systems. It's also important to understand that grants are not the only answer to serving our clients. There are many ways that agencies can partner with healthcare delivery systems that are beneficial to both parties.

3:30 -4:30 pm: Gender Language Training

Len Meyer, Planned Parenthood of Illinois Downstate Community Engagement Manager

L. Meyer presented the Gender Language Training. Training topics included review of gender-related terminology, proper use of pronouns, other gender-related language, gender diversity, and ways to be a gender-affirming advocate, especially in health care setting. Myths and facts about the transgender/ gender diverse community were discussed, and participants were challenged to discuss what they could change at personal and organizational levels to better serve transgender/gender diverse clients.

At the completion of the training, the Gender Language Workgroup shared information about their work on creating recommendations for the incorporation of sexual orientation/ gender identity data into IDPH HIV Prevention and Care forms (i.e. eligibility assessments for Care, risk assessments for Prevention). A draft of these recommendations was shared with an opportunity for participants to provide and submit written input for the Workgroup's consideration.

Discussion:

C: Personally, I would like to focus on changing some of my language to be gender neutral. I have used terms like " you guys" and never thought that it was offensive until it was brought to my attention. I was not aware of that and I apologized for having said it. It is a culture change that I have accepted and continue to work on. It is something that has become engrained into our language. Now, I hear others say it a lot and I educate them on this, even if they don't understand at first.

A: L. Meyer responded: Yes, I think many people say things like "hi guys" or "bye ladies". We should try to change this by using gender neutral language. You can use "y'all", "friends"… whatever works for you.

Q: There was a phrase that you used earlier: "dead named". Could you expand on this?

A: L. Meyer responded: Dead naming means that someone uses a transgender person's birth name to address them. Many transgender people do not use their birth names and don't associate with it, so this can be very triggering.

C: I would like to be mindful about everyone's personal experiences and address them appropriately. I've encountered more transgender or non-binary people in my life recently, and it feels very new to me to understand the experiences of people who identify differently than me. I want to make sure that I am being cognizant of that.

Q: At our agency, I was working to develop a policy that includes pronouns on name badges for all employees. We have received pushback, however, on this as people feel they are being forced to do it and might not understand the cultural importance behind it. What are your thoughts on this?

A: L. Meyer responded: I think pronoun use is very important, but I also want to be respectful of people's thoughts. Before any decisions are made, I would want to ask people who are resistant to it about their thoughts. Why is it an issue for them? Maybe they don't understand what it means. Get involved and get curious as to why people are thinking this way. If it is out of disrespect for trans people, then I think there is a need for more education. If they can understand that this is a good way to advocate for patients, it might be easier to get them on board. If you need this type of education at your organization, please email me (lenm@ppil.org) and I or someone else at Planned Parenthood can come do a similar presentation for your staff.

Q: I think people should have the choice to not disclose pronouns if they don't want to. If you force people to have them on their name tags, you are putting them into a restrictive situation. It doesn't mean that they have anything against transgender people, but not all people want to use them. I think sometimes we try to put forth too much by making people do something they don't want to, even when there is not a negative connotation behind it.

A: L. Meyer responded: I would challenge that person to think about how this choice is helping or hindering them from advocating for their client. Using correct pronouns is the first step to advocating for transgender people. Without pronouns, assumptions about gender identity can be very harmful to clients. It is triggering and can cause anxiety. We cannot assume that everyone is binary in their gender identity. If someone doesn't want to display their pronouns on a name tag, maybe they'd agree to phrases like "ask me my pronouns" or "anything used respectfully". Then people are not forced into it, but it is a signal to clients that they are still an advocate.

Q: In one of the statements, it said to apologize if you mis-gender someone. I wanted to add to that saying "thank you for the correction" might be good also so that the responsibility of responding to the apology is not put back on that person.

A: L. Meyer responded: Thank you. If you mis-gender someone and apologize, please do not go on or make a big scene about it, and do not make the conversation about you. This can traumatize transgender people by making them feel that they have upset you.

C: I wanted to reiterate the importance of the relationship of sexual orientation to gender identity. In the presentation, one example said that a transman who is attracted to women is heterosexual. This is the same in the reverse: a ciswoman attracted to transmen is also a heterosexual. This is important to remember this when talking with clients and when generally educating the public on this topic.

Q: Could you explain the term "tokenism", especially when referred to in the workplace?

A: L. Meyer responded: Tokenizing in the workplace means that an organization hires one transgender person and then thinks they are diverse or have met requirements because one transgender person is on their staff. It might "check a box" for the organization, but one person cannot speak for all transgender people.

4:30 pm: Adjourn – There were no announcements at this time. The meeting adjourned at 4:34pm.

4:30-5:00 pm: Break with Refreshments/Appetizers

5:00 -6:00 pm: Committee Breakout Meetings/Provide Input on Committee Objectives for 2020

The four standing committees of the IHIPC met in-person during this portion of the meeting.

2019 Illinois HIV Integrated Planning Council (IHIPC) Vote Log _ October 21-22, 2019_updated 10.30.2019

Member Name	Member Type	Date: August 15, 2019	Date: Oct. 22,2019	Date: Oct. 22,2019	Date: Oct. 22,2019	Date: Oct. 22,2019	Date: Oct. 22,2019	
		Motion 1: A motion was made by Janet Nuss on 8/7/19 at 2:23 pm and seconded by M. Benner at 3:35 pm to adopt the agendsa for theOct. 21-22, 2019 IHIPC meeting as approved by the Steering Committee. The motion was sent to the full IHIPC at 2:48 pm on Aug. 8, 2019. Members were given until 5:00 pm on Aug. 15, 2019 to submit their votes.	**Motion 2:** At 10:50 am, a motion was made by D. Hunt and seconded by S. Fletcher to accept the proposed changes to the I&S Guidance for 2020 as recommended and presented by the LRAV and PP Committees.	**Motion 3:** At 11:03am, a motion was made by L. Roeder and seconded by D. Hunt for the IHIPC to continue its support of the existing letter of concurrence.	**Motion 4:** At 12:35 pm, a motion was made by S. Fletcher and seconded by C. Hoots to adopt changes to the IHIPC By-laws as recommended and presented by the Membership Committee.	**Motion 5:** At 12:40pm, a motion was made by N. Holmes and seconded by R. Wheeler to adopt changes to the IHIPC Procedures as recommended and presented by the Membership Committee.	**Motion 6:** At 1:05pm, a motion was made by J. Erdman and seconded by S. Jones to accept the slate of new at-large members for 2020 as recommended and presented by the Membership Committee. A ballot was distributed to voting members. Members were asked to cast their votes.	**Y: In favor; N: Opposed; A: Abstain; X: Absent or No vote cast/received TS: temporarily suspended**
IHIPC Voting Members								
Benner, Mike	Voting	Y	Y	Y	Y	Y		
Bradley, Wendy	Voting	X	Y	Y	Y	Y		
Charles, James	Voting	X	Y	Y	Y	Y		
Choat, Lesli	Voting	y	Y	Y	Y	Y		
Crause, Candi	Voting	y	Y	Y	Y	Y		
Dispenza, Jill	Voting	Y	Y	Y	Y	Y		
Erdman, Jeffery	Voting	y	Y	Y	Y	Y		
Filicette, Joe	Voting	Y	X	X	X	X		
Fletcher, Scott	Voting	y	Y	Y	Y	Y		
SUPR Liaison	Voting	y	X	X	X	X		
Gaines, Michael	Voting	Y	Y	Y	Y	Y		
Guzman, Lisa	Voting	y	Y	Y	Y	Y		
Hendry, Chad	Voting	X	Y	Y	Y	Y		
Holmes, Nicole	Voting	Y	Y	Y	Y	Y		
Hoots, Cheri	Voting	Y	Y	Y	Y	Y		
Hunt, Don	Voting	y	Y	Y	Y	Y		
Johnson, Rashonda	Voting	y	Y	Y	Y	Y		
Jones, Shanett	Voting	X	Y	Y	Y	Y		
Laskowski, Casie	Voting	Y	Y	Y	Y	Y		
Lewis, Karen	Voting	X	Y	Y	Y	Y		
Maginn, Mike	Voting	y	Y	Y	Y	Y		
Meirick, Andrea	Voting	y	Y	Y	X	X		
Meyer, Len	Voting	Y	Y	Y	Y	Y		
Nuss, Janet	Voting	Y	Y	Y	Y	Y		
Olayanju, Bashirat	Voting	y	Y	Y	Y	Y		
Paesani, Trish	Voting	y	Y	Y	Y	Y		
Rehrig, Susan	Voting	Y	Y	Y	Y	Y		
Roeder, Lisa	Voting	y	Y	Y	Y	Y		
Stevens-Thome, Joan	Voting	y	A	Y	Y	Y		
St. Julian, Steven	Voting	X	Y	Y	Y	Y		
Tucker, Cynthia	Voting	y	X	X	X	X		
Wheeler, Rose	Voting	X	Y	Y	Y	Y		
Williams, Mark	Voting	X	X	X	X	X		
Williamson, Mildred	Voting	y	Y	Y	Y	Y		
Zamor, Sara	Voting	y	Y	Y	Y	Y		
Type of Vote: Hand Count, voice, electronic		**electronic**	**voice**	**hand**	**voice**	**voice**	**ballot**	
Results: Carried/Defeated		**carried**	**carried**	**carried**	**carried**	**carried**	**carried**	
Results: Vote Count		**27 in favor , 0 opposed, 0 abstentions, 8 members absent or "failed to cast a vote"**	**30 in favor , 0 opposed, 1 abstention, 4 members absent or "failed to cast a vote"**	**31 in favor , 0 opposed, 0 abstentions, 4 members absent or "failed to cast a vote"**	**30 in favor , 0 opposed, 0 abstentions, 5 members absent or "failed to cast a vote"**	**30 in favor , 0 opposed, 0 abstentions, 5 members absent or "failed to cast a vote"**	**27 in favor , 2 opposed, 1 abstentions, 5 members absent or "failed to cast a vote"**	