Illinois HIV Integrated Planning Council (IHIPC) Meeting Minutes

October 22, 2019, 8:30 am – 1:30 pm

8:30 am: Welcome; Introductions; Review of agenda/meeting objectives; Moment of silence

Co-Chairs J. Nuss and M. Benner welcomed all members/guests to the meeting. The Co-Chairs reviewed webinar instructions and housekeeping instructions. 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 Co-Chairs reviewed the meeting objectives, meeting agenda, and the IHIPC concurrence checklist.

8:40 am: Updated State and Regional HIV Care Continua; Discussion (40 minutes)
Fangchao Ma, IDPH HIV Section Epidemiologist

F. Ma reported on the the recently updated Statewide and Regional HIV Care Continuum. Steps of the Continuum (linkage to care, engagement in care, retention in care, and viral suppression) and their respective definitions were reviewed. Several data limitations were disclosed. This year, the Continuum of Care data was compiled from both eHARS and Ryan White data systems. F. Ma reviewed linkage to care, engagement in care, retainment in care, and viral suppression data by year (2013-2018), and then by sex at birth, age, race/ethnicity, transmission category, and region for 2018 only. Main findings from the presentation included the following:

- The increasing trend in linkage to care (LTC) within one month of new HIV diagnosis since 2012 peaked in 2017, and was flat in 2018;
- Males had greater LTC rate within 30 days of diagnosis than females in 2018 (80.0% vs 75.8%);
- Older patients (ages >=65) and MSM/IDU had lower rates of LTC relative to their counterparts; Hispanics had highest LTC (87%); still regional differences in LTC;
- Rates of engagement in care, retained in care, and viral suppression increased dramatically in 2018; and
- Regional differences seen in 2017 for treatment cascades has reduced greatly.

Discussion:

Q: Regarding the engaged in care, retained in care, and viral suppression cascades, how can we know if people are virally suppressed if they are not retained in care? Is the viral suppression data taken from their first engagement only?

A: F. Ma responded: Both engagement in care and viral suppression data is based on one medical visit only. For retention in care, there must be evidence of two visits that are three months apart to apply. The viral load information can come from clients who are either engaged or retained in care. If we were to look at viral suppression among people who were retained in care only, that number is close to 90 percent.

Q: Is the denominator for each level of the cascade based on the total number of people living with HIV, or are they determined based on the previous level (example: is retention in care a proportion of those engaged in care only?).

A: F. Ma responded: The denominator for linkage to care is all new diagnoses in 2018. The denominator for engaged in care, retained in care, and viral suppression is all people living with HIV in Illinois. None of the proportions shown here today are subsets of one another.

C: A lot of medical practices only see patients once a year. This makes the calculation for retention in care hard to evaluate because people might be in care, they just aren't getting two visits per year.

A: F. Ma responded: People who are retained in care must also be engaged in care. If we were to look at the proportion of those engaged in care who are also retained in care, the number would be about 60 percent. We could also look at the proportion of viral suppression among those engaged in care v. those retained in care. Among those retained in care, it is about 90 percent. For those engaged only, it is below 80 percent. We can consider doing further analysis on this next year.

A: C. Ward responded: I would like to reiterate that the data shown today for engagement, retention, and viral suppression is based on all living cases or prevalent cases. The data could be examined in many ways as needed.

Q: In the presentation, you said there are a significant number of eHARS cases that have no risk reported/ no identified risk. What is the percentage of those cases?

A: C. Ward responded: At this time, about 25 percent of prevalent cases are missing risk information, but this is partly because many cases from the 1980 and early 1990s are missing information. Apart from this, missing data has trended downward each year. CDC has required jurisdictions to prioritize the collection of this information: we must ensure that 85 percent of cases identified in the previous year have a risk identified. This standard has been met by IDPH in recent years. Of course, we would like to have risk reported for all cases, but it is not always possible. We are always trying to ascertain this data through local health departments, physicians, and the Care program.

Q: Does this data include correctional cases?

A: F. Ma responded: Yes, correctional cases are included in this data. In the future, I would like to analyze the continuum of care for correction cases only so that we have a clearer picture of this population.

9:20 am: Overview of NHAS Indicators and Update on Illinois' Progress (40 minutes)
Patricia Murphy, IDPH HIV Evaluation Administrator

F. Ma presented an Overview of the NHAS Indicators with an update on Illinois's progress on behalf of P. Murphy. Each of the 13 NHAS indicators was presented with the following information: Illinois baseline data for measuring the indicator as well as yearly outcomes, targets, and overall goals through 2020. Each indicator was also accompanied by points of consideration for future progress on the goal. Please see the presentation slides for specific information about each indicator.

There were no questions or comments on this presentation.

10:00 am: Break

10:15 am: Proposed Changes to Interventions and Services Guidance for 2020; Vote (45 minutes)
Jeffery Erdman, IPHA, IHIPC LRAV Committee Co-chair

J. Erdman presented Final Recommended Changes to the 2020 I&S Guidance on behalf of the LTC, RRC, ART, VS and Primary Prevention Committees. It was noted that a similar presentation was conducted at the June meeting, but further recommended changes to the Guidance have been proposed since that time. The final recommendations for changes to the 2020 Guidance are as follows:

- Waiting to incorporate CDC's new "Ending the Epidemic" plan into the document until final guidance from the CDC on how best to do this is released;
- Adding an HIV Care "Best Practices" Compendium as a complementary document to this guidance;
- Adding three new strategies/interventions to the guidance: Couples HIV Testing/Testing Together, Taking Care of Me, and STEPS to Care;
- Removing the unsupported TWISTA intervention and adding the CDC-supported TWIST intervention to the guidance;
- Adding a Structural Interventions section to the guidance; and
- Ensuring that gender-inclusive language is incorporated into the guidance and into IDPH data collection forms.

Discussion:

Q: I feel there are a lot of behavioral interventions on this list. I know there are a lot of resources that can support some of the trainings for these interventions, but practically, the Training unit can only support so many trainings. We can always reach out to make requests for additional trainings and technical assistance, but I wonder if we can talk about scaling this list of behavioral interventions back. The biomedical interventions are effective and thank you for working to include Care best practices, but I am concerned about the number of approved behavioral interventions. Behavioral interventions that have online trainings or are not counselor-based (i.e. waiting room videos) are good to add to the mix, but I just think that this is a very large list. I would like to get input from the group about if we need to approve these many interventions. I think we should be cognizant of behavioral interventions and what their purposes is. I know they have a place, but I question how effective they are at times. The biomedical interventions are the push these days. Thank you to the committees for all the work they have done on this.

A: J. Erdman responded: The reality is that although approved, many of these interventions are not implemented across the state. Only a handful of these interventions are actually being done by providers. The most popular interventions include Medication Adherence, HIV Navigation Services, MPowerment or D-Up. Additionally, a lot of the trainings for these interventions are available online. CDC did a rehaul of all the trainings several years ago to add PrEP components into the curriculums. It is also important to note that within High Impact Prevention, CDC prioritizes biomedical interventions but also emphasizes that a combination of behavioral and biomedical interventions is needed to best serve clients. We could probably prioritize a list of the most impactful behavioral interventions, but CDC does stress a combination is needed to get to zero.

A: J. Nuss responded: It is important to remember that the I&S Guidance is an IDPH guidance document. The IHIPC provides recommendations as to what additions or changes it proposes. IDPH still has the final say. Also, just because all of the interventions that have been approved by the CDC and adopted by IDPH are listed, it does not mean they are all implemented. It is up to the Prevention program to work with the RIG lead agents and the grant monitors to determine which interventions will be conducted based on the needs of the regions and targeted populations and then prioritizing which trainings grantees need. That means that training don't need to be provided for all interventions just because they are on the list.

C: Thank you for the information. I would like to suggest that there be behavioral interventions for the corrections and re-entry populations. In my work, I see people who are being released with suppressed viral loads but are then lost to care once their transitional housing support runs out. There are also needs to consider like the opioid epidemic. For the corrections population, I think it would be beneficial to do more collaborating.

A: J. Erdman responded: It wasn't covered in the presentation, but it was in the HIP Training. There is a behavioral intervention specifically for individuals leaving corrections called Project Start. As part of the intervention, they meet with a prevention specialist before release so they have tools for successful re-entry. They also meet several times after release to ensure sustainability and self-sufficiency.

Q: Do we know if the interventions that Prevention is using correlate to the Getting to Zero Plan? Do regions have an obligation to explain how those interventions are reaching the Getting to Zero objectives?

A: J. Erdman responded: Yes, most of the interventions were overhauled by CDC to add PrEP and viral suppression elements, so they support the pillars of Getting to Zero. I also want to say that I agree with J. Nuss' comments. When the lead agents work with providers at the beginning of the year, we strategize with grantees to select interventions that will be most impactful and cost effective. Usually, agencies are picking a small set of the behavioral interventions. An agency typically has 1-2 interventions to conduct. Additionally, they are focusing on PrEP counseling and testing, so these behavioral interventions are a small component of all the work that is being done. All work is targeted to the agency's capacity and their population. There is a lot of thought that goes into this process.

A: C. Hicks responded: I would like to mention that each agency that receives grant funding is allotted capacity building dollars. These dollars can be used for trainings. If an agency selected a behavior intervention that was less commonly used, they could use capacity building dollars to send staff to out of state for trainings as needed. All behavioral interventions have gone under rigorous testing by the CDC to prove effectiveness. Many also address other health and wellness topics beyond HIV, so they are important to our work.

C: I wanted to comment on Steps to Care. We made a collaborative effort with other agencies to identify needs in training and intervention gaps. Steps to Care has a great dashboard to help in the planning and implementation process. Many things can be accomplished through these resources.

Vote: 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. The motion carried with 30 in favor , 0 opposed, 1 abstention, and 4 members absent or "failed to cast a vote".

11:00 am: Integrated Plan Concurrence Overview, Discussion, and Vote (30 minutes)
Mike Benner and Janet Nuss, IHIPC Co-chairs

The IHIPC Co-chairs presented the Integrated Plan Concurrence Overview, Discussion, and Vote. They began by briefly reviewing the 2019 updates to the Integrated Plan which had been presented previously and at this meeting. With these updates completed, they discussed the IHIPC's role in the Integrated Plan's concurrence process. Through review of the concurrence process, participants were reminded that concurrence letters from planning groups are only required with the submission of a new Integrated Plan (concurrence letter for 2017-2021 plan was submitted in September 2016), or if major changes are made to the Integrated Plan mid-cycle. J. Nuss then asked IHIPC members to discuss if they believed that a new concurrence letter related to this year's updates was necessary.

There were no questions or comments at this time.

Vote: 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. The motion carried with 31 in favor , 0 opposed, 0 abstentions, and 4 members absent or "failed to cast a vote".

11:15 am: Lunch and Membership Recognition Presentation –
In-person participants were dismissed for lunch. Before starting the next presentation, four voting members whose terms will end in December 2019 were recognized for their services to the IHIPC:

- 2018-2019 Member Awards: T. Paesani, J. Stevens-Thome, and C. Tucker.
- Lifetime Achievement Award: S. St. Julian.

12:15 pm: Presentation/Discussion/Vote on Proposed Changes to IHIPC Bylaws and Procedures (30 minutes)
IHIPC Membership Committee Co-chairs
Marleigh Andrews-Conrad, IDPH HIV Community Planning Program Specialist

M. Andrews-Conrad presented the proposed changes to the IHIPC Bylaws and Procedures for 2020 on behalf of the Membership Committee. It was explained that the Membership Committee had completed their yearly review of the Bylaws and Procedures and were proposing changes on the following topics: At-large membership, agency affiliations, new member selection, and attendance procedure. Each proposed change was explained in depth and read aloud during the presentation.
It was noted that in order to adopt the new recommendations, Bylaw revisions required a 2/3 vote, and Procedure revisions require a majority vote.

Discussion:
Q: If a committee meeting time or day is moved and a member has a conflict, does this count as an absence?
A: J. Nuss responded: If the committee decides to move their meeting in a specific month, attendance would still be taken as usual, so it would count as an absence for a member who had a conflict.
Q: It was noted that anyone who is going to miss a committee meeting should communicate with the co-chairs. If communication is made, does this still count as a miss, or does informing the co-chairs excuse the absence?
A: M. Andrews-Conrad responded: Informing the co-chairs of the expected absence is to be done out of courtesy. The member would still be counted as absent for the meeting.
A: J. Nuss responded: Even though the procedure is that a member miss no more than three committee meetings a year, that really turns out to be more like 3 out of 10 rather than 3 out of 12 because committees typically cancel an average of two meetings each year. Those cancellations would not count against a member.
C: Please be cognizant about the procedure stating that appointed members aren't included in agency affiliation counts. I know they're here to represent a specific group or expertise, but we could end up having an overabundance of members from one agency because of this. I wouldn't change the procedure, but I just want to raise the concern.
Q: Regarding committee meeting absences, if a day or time of a person's committee meeting no longer works for them, what should they do?

A: M. Andrews-Conrad responded: We always ask members to request a change in committee assignment if their schedules have changed and can no longer accommodate their current committee's call. We'd also work with the member to see if there were other things we could do to help them maintain consistency in attendance.

Q: For new members, are there trainings or webinars that they can do to help them in their role as a member?

A: M. Andrews-Conrad responded: Yes, each new member is required to attend new member orientation, and to take trainings on IHIPC meeting procedures as well as use of epidemiology in HIV planning. All of these items are recorded and available to all IHIPC members and the public on the TRAIN site. There are also several short tutorials on our website for using Regonline, Webex, and navigating the IHIPC webpage. J. Nuss, M. Andrews-Conrad, and mentors for new members can also be reached out to for assistance.

Q: There is a substantial amount of time being spent by some members on Workgroup calls. If someone is participating in several workgroups, this could be an additional commitment of 3-4 hours per month to the IHIPC. A lot of change and decisions are being made on the workgroups, so participation on them is very important. If a person misses a committee meeting, but is committed to workgroup calls, is there a way that their attendance on the workgroups can be counted for committee attendance?

A: J. Nuss responded: Because the standing committees are part of our public body, we must have quorum on the committee meetings in order to conduct business. If members only attend the adhoc workgroup calls, quorum might not be reached. While we really appreciate the work of the workgroups, we do need to require attendance on the committee meetings.

Q: What is a quorum?

A: J. Nuss responded: It is a majority of members.

Vote: 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. The motion carried with 30 in favor , 0 opposed, 0 abstentions, and 5 members absent or "failed to cast a vote".

Vote: 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. The motion carried with 30 in favor , 0 opposed, 0 abstentions, and 5 members absent or "failed to cast a vote".

12:45 pm: Results of 2019 IHIPC Membership Recruitment/Vote on 2020 New Member Selection (30 minutes)
IHIPC Membership Committee Co-chairs

M. Andrews-Conrad presented the 2020 IHIPC Membership Applications Review, Ranking, and Selection Process on behalf of the Membership Committee. Participants were reminded of the 2020 Membership Gap Analysis process and the identified priorities:

- Highest priorities: Region 1; MSM of "other" or multiple races; young adult (aged 18-24)
- Other priorities: Black and Hispanic MSM; Hispanic PWID; Please who are Black, Hispanic, or of "other" race; Region 2,4,5,6, and 7

After the application and scoring process was reviewed, the recommended slate of six new at-large member for 2020 was presented. The following is true of the proposed members in the slate, thus fulfilling several identified gaps:

- All are people of color:
  - Two identify as more than one race.
  - Two identify as Hispanic.
  - Three identify as Black.
- Four identify as members of a prioritized population.
- Four fill regional gaps: 1, 4, 6, and 7.
- One is a young adult.

Gaps not filled by these proposed members will be prioritized in 2020.

Discussion:
C: In Region 1, recruitment could be done at Northern Illinois University for new, young members.
Q: Is there a consideration for formally incarcerated people?
A: M. Andrews-Conrad responded: This was not a consideration in this process, but it is something that the Membership Committee can look into for next year.

Vote: 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. The motion carried with 27 in favor , 2 opposed, 1 abstention, and 5 members absent or "failed to cast a vote".

1:10 pm: Public Comment Period – There were no public comment requests submitted for this meeting.

1:15 pm: Adjourn – An announcement was made regarding election of leadership at the December meeting. The positions that will need to be filled are the Community Co-Chair Elect, the Parliamentarian, and the Secretary. If any members have questions about these positions, please contact J. Nuss. Final announcements about submitting surveys and travel announcements were also shared. The meeting adjourned at 1:15pm.

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"**	