IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

IHIPC
Illinois HIV Integrated Planning Council

Monday, October 29, 2018 Illinois HIV Integrated Planning Council (IHIPC) Meeting Minutes _Draft
IHIPC Committee breakout meetings/Working lunch: 11 am – 12 pm
IHIPC Business Meeting: 12:00 - 4:30 pm

11-12 pm: **Working lunch/IHIPC Committee Breakout Meetings to Recap 2018 Year Outcomes and to Finalize Draft 2019 Objectives**
Facilitated by Committee co-chairs

The IHIPC's four standing committees spent the first hour of the meeting reviewing 2018 activities and outcomes as well as finalizing objectives for 2019.

12:00 pm: **Meeting process and instructions** (10 minutes)

- Welcome; Introductions, Moment of silence

» The co-chairs welcomed all members and guests to the meeting and introduced themselves, the IHIPC leadership, and the webinar coordinator. Co-chair M. Benner led the group in a moment of silence for all people living with HIV (PLWH) past and present and all those working to end the epidemic in Illinois.

- Roll call attendance of voting members, announcement of non-voting members and others, including those participating remotely

» J. Nuss reminded everyone that the meeting was being recorded and reviewed webinar participation instructions for those who were joining the meeting remotely. Remote participant will be included on the meeting attendance list and are able to participate in meeting discussion by phone/ webinar interface.

» Each in-person participant was asked to introduce themselves by name, agency, and preferred pronoun if desired. Remote participants were announced by the webinar coordinator.

» It was noted that all meeting materials were available on the meeting registration website: https://www.regonline.com/october2018ihipcmeetings . Meeting recordings will be made available on the ITrain website.

» Housekeeping information regarding facility rules, lunch & breaks, and review of Respectful Rules of Engagement/ Robert's Rules of Order were reviewed. Participants were informed that only one microphone was available for discussion and were reminded to wait for the microphone before speaking.

- Review of agenda, Concurrence checklist, Meeting objectives; Announcements

» Co-chair M. Benner reviewed the objectives of the meeting and agenda topics/ discussions. Printed copies of the agenda were made available in the meeting packet. The goals of the IHIPC were reviewed, including integration of National HIV/AIDS Strategy (NHAS) goals into IHIPC's purpose and work.

» The following announcements were shared with participants: T. Markovich left her voting membership position as of September 2018; the IHIPC Steering Committee is in the process of selecting a new appointed liaison to fill the vacancy previous held by R Patterson at Illinois State Board of Education (ISBE); all members fulfilled the High Impact Prevention training requirement; the Fall Newsletter has been published and articles/information for the Winter newsletter can be submitted to M. Andrews-Conrad.

12:15 pm: **IHIPC Appointed Liaison and HIV Section Updates** - (45 minutes)
Eduardo Alvarado, IDPH HIV Section Chief
IDPH HIV Program Administrators

E. Alvarado, HIV Section Chief, provided an update. He first introduced H. Clark, the new IDPH Division Chief of Infectious Diseases, who was present at the in-person meeting. He announced that all GRF appropriations for FY19 had been secured and will be appropriately distributed through grants. He encouraged everyone to continue to promote PrEP awareness and availability to all in the state. He also gave updates on the expansion of Hepatitis C (HCV) testing, accessibility to HCV treatment for dually-diagnosed client through ADAP, and new avenues to be explored with new FDA guidelines for

Gardasil vaccinations. Lastly, he encouraged community stakeholders to participate in the Getting to Zero (GTZ) dinner that was to be held later that evening. He thanked all community partners for their ideas and recommendations and encouraged all participants to ask questions if desired.

A. Danner, HIV Section Assistant Chief, provided an update on the PrEP project. She reminded participants that the PrEP project is incorporated in the Local Health Protection Grants. Sixteen sites are part of the project. The project is in its second year with goals to increase PrEP provider networks through recruiting; to partner with universities to establish clinics and coordinated services; to partner with harm reduction sites and treatment centers to recruit clients; and to educate and assess all clients for PrEP services. Aside from the PrEP project, A. Danner encouraged all participants to continue to access and promote PrEP4illinois as a source of financial assistance for Truvada.

J. Gates provided an update for the Surveillance Unit. As of June 2018, approximately 39,390 PLWH reside in Illinois. There were approximately 1,366 new HIV cases in Illinois in 2017, which is consistent with decreasing incidence trends since 2013. The Surveillance Unit is working on publishing new reports on people who inject drugs (PWID), stigma among PLWH, social determinants of health, hospitalizations among PLWH, community viral loads, and opioid overdose among PLWH. These reports will be made available on the IDPH website. J. Gates reported that the Surveillance Unit will be publishing a new online training on case reporting. The training will be made available on ITrain and should be disseminated widely among health departments and medical providers.

C. Hicks provided an update for the Prevention Unit. He reported the following personnel updates: S. Grundy and J. Woker will be leaving their positions, and L. Jadama was welcomed as a new staff person The following updates on the Prevention grants were provided: AAARA and the Direct Grant are currently in their final stages of execution; the 3rd Party Billing grant will be renewed for calendar year 2019 and has produced webinars to educate providers on billing for testing, vaccinations, and other services; the Perinatal Enhanced Case Management grant will be available for competitive bid for 2019-2022, with funding moving to the RW grant; the Regional Implementation Grants (RIG) have been executed, and sub-grantees are now being set up in Provide ™; and the routine screening grant will be reestablished in July 2019. It was also noted that the GTI contract is currently suspended, and the HIV section is working establish a new grant for database services.

J. Maras provided an update for the Care Unit. Open enrollment is currently underway for Medicare Part D, and Marketplace open enrollment will begin Nov 1. He announced which plans will be accepted for premium assistance through ADAP and provided flyers with this information. He noted that all current clients have been sent this information, and all case managers have been made aware of the open enrollment execution process for ADAP clients through webinar trainings (recordings are available on the IDPH website). He announced that S. Rehrig has taken on the position of Care Project Director in Region 4. He also noted that his program had recently undergone a federal site visit, which resulted in instructions to set an FPL limitation on case management. More information on this will be announced as it develops.

D. Tiburzi provided an update for the Training Unit. A capacity-building assistance (CBA)-sponsored HIV Navigation Services training has been circulating through the state. Upon its completion, IDPH will be developing its own HIV Navigation Services training, which will be paired with motivational interviewing. The unit is creating a series of online trainings that can be viewed by providers at any time. Lastly, a training needs assessment survey is being developed and will be distributed by email/Survey Monkey to selected providers.

IHIPC Appointed Liaisons

L. Choat provided an update for the IDPH STD Section. On September 25th, National STD data for 2017 was released and showed sharp increases in chlamydia, gonorrhea, and syphilis for the fourth year in a row, with Cook County being in the top ten counties for highest reports of new cases for each STD. L. Choat urged that, due to dual infections of HIV and STDs, providers must continue to collaborate to decrease infections and ultimately get to zero. In November, she plans to attend the National Coalition of STD Directors in Orlando where she will present on Illinois' implementation of PrEP in STD clinics.

J. Reed provided an update for the IDPH Center for Minority Health Services. He stated that the Center is currently in the process of issuing grant agreements that will increase STD testing and HIV prevention and testing services among minorities in Illinois. Although grants are closed for bid at this time, he encouraged all participants to continually check eGRAMS for new opportunities as the Center is always looking to expand their grantee network.

M. Gaines provided an update on the HIV Section's Corrections Project. He reported that the IL Department of Corrections (IDOC) has recently established a permanent team of staff persons focusing on HIV testing and care within facilities. He also reported the following IDOC data for 2018: 16, 830 individuals were tested for HIV upon intake, 4 of which were newly diagnosed and 115 found to be previously diagnosed; and of 148 HIV + individuals released, only 22 were missing to care but are being accounted for (IDOC is working on identifying tracking issues such as violating at the gate, moving to county jails, immediately moving out of state upon release, etc.). Summit of Hope events have concluded for the year and were successful in finding several new positives through testing efforts. Distribution of Hepatitis A vaccines and flu shots were also incorporated into some 2018 Summit of Hope events.

C. Tucker provided an update from the Chicago Areas HIV Integrated Services Council (CAHISC). CAHISC/ Chicago Department of Public Health (CDPH) recently submitted their revised Integrated Plan for 2017- 2021, which includes information on priority setting resource allocation. CDPH is now accepting grant applications for renewal starting March 1. Themes that applicants will be asked to incorporate into Prevention grants include heath care access, health equity, housing, and community development and engagement. RFPs and RFQs for HRSA-sponsored funding has been received, and the RFP has been released. An ad-hoc committee will be working to incorporate the following pillars for these applications: dismantling racism, trauma informed care, cultural responsiveness, and health equity.

W. Bradley provided an update from the St. Louis Regional HIV Health Services Planning Council. The St Louis Planning Council has been working with a consultant to create specific goals and objectives as they continue to develop as an integrated group. The Council has received a core services waiver from HRSA (which allows flexibility in the 75/25 HRSA allocation guidelines for core and supportive services) and will be working on FY18 reallocation activities in November. The Council is working on a series of needs assessments and is soliciting input through surveys from transgender clients, newly diagnosed clients, and clients previously lost to care. The Council will be sponsoring an LGBTQ youth Safe Space training on November 30th, and all are welcome to attend.

S. Frank provided an update from the Illinois Department of Human Service's Substance Use Prevention and Recovery (SUPR) Division. She reported that SUPR is currently operating under several grants, including the State Opioid Response grant, to provide substance use services. Thus far, 18,000 individuals have been trained to use Naloxone, and helplineillinois.org (which works in conjunction with a hotline) has been established to connect people in need of substance use treatment services to local resources and to build capacity for medication assisted therapy and other supportive resources.

1:00 pm: **Community Services Assessment: Regional Lead Agent Brief Reports to the IHIPC/Discussion** - (45 minutes)
Care and Prevention Lead Agents

Region 1- The Prevention report was provided by M. Maginn. He stated that they have been working diligently on distributing work plans. Region 1 has five prevention agencies, one of which is Chicago Recovery Alliance (CRA). After the loss of D. Bigg, M. Maginn met with CRAs new management team: they will be moving forward and do not expect a lapse in services. The Care report was provided by C. Boyd. She reported that they have been working on the follow up of several surveillance-based services referrals. Case managers are reaching out, but some simply do not want to be in care. On the other hand, Region 1 has seen a surge of contact/ calls from individuals who were lost to care but are ready to re-engage in services. These clients typically report medication assistance as their primary need, but they also engage in other services.

Region 2- The Prevention report was provided by J. Erdman. Region 2 has six prevention agencies. The region gained one new provider, the Jolt Foundation, focusing on syringe exchange/harm reduction in Peoria. The Care report was provided by P. Briggs. She reported that Positive Health Solutions (PHS) is currently serving 675 HIV+ individuals, with 550 receiving case management services. There have 60 new client intakes this year, most of which are clients who have relocated to the area. PHS's PrEP clinic has been running for about 2 years and has gained 50 clients this year. They have also initiated a Gender Affirming Care program which has had 10 intakes. They hope to continue to expand the program into more primary care setting. Currently, the overall viral suppression rate of RW clients in Region 2 is at about 87 percent, and the retention in care rate is at about 68-70 percent. Additionally, there is a newly established Reproductive Health Work Group that is working to serve youth and adolescents in Peoria.

Region 3- The Prevention report was provided by M. Maginn. Region 3 has six prevention agencies. Last year was first year that IPHA was the lead agent in Region 3, so there were some learning curves. This year will be used to further develop agency capacity. The Care report was provided by M. Ashby. The region consists of 18 counties and 18 subcontractors. She reported that 320 clients had been served in past year. This year, there has been a steady increase of new clients, consisting of both newly diagnosed and returning clients. Because of this increase, SIU has restructured program and case management staffing. The agency has recently hired a new case manager, and C. Laskowski has been promoted to clinical supervisor of medical case management. Another challenge that the region is facing is retaining an ID doctor in Quincy. Quincy is currently without a medical provider, so client are either being followed by their primary care doctors or coming to Springfield for appointments (a 2 hour drive). SIU is working on providing some services (like mental health) to clients through telemedicine. They recently hosted their third client retreat called Living Positively, which is a 1 day program that focuses on holistic topics for clients.

Region 4- The Prevention report was provided by J. Erdman. There are eight prevention agencies in this region, including the addition of St. Clair in FY18. The Care report was provided by S. Rehrig. S. Rehrig has recently taken on the Project Director role in Region 4, and W. Bradley has recently been promoted as the region's medical case management coordinator. They also have two part-time peer navigators. The region is working on a new directive that ensures that new to care clients have an opportunity to meet with a nurse educator at their first engagement in the program. S. Rehrig gave an overall review of

Region 4 data for FY17: noting that of 51 newly diagnosed clients served, 27% were young black MSM. She noted that of 136 clients that reported substance use or misuse, only two indicated a desire for treatment. This data indicates that more work needs to be done to assist clients with other underlying issues.

Region 5- The Prevention report was provided by M. Maginn. Region 5 has four prevention agencies. It is anticipated that Region 5 contracts will be built by November 1. The Care report was provided by S. St. Julian. He announced that Jackson County Health Department will be hosting its 1st annual Santa Speedo 5k run on World AIDS day. Currently, clients in their RW program have a 92 percent viral suppression rate. The region currently has five ID doctors, with another arriving in April 2019. The region also has engaged in an opportunity to partner with SIU School of Medicine to give interns HIV education and experience. S. St. Julian reports that the agency's PrEP clinic is going well and has 38 clients. Public advertising on billboards for the clinic seem to be effective. The Hepatitis C birth cohort study is also going well with about 26 percent positivity rate. Because of this, Jackson County would like to pursue grants that allow fee-for-service HCV testing. Some challenges that are being seen in the region include complexities with managed care programs and delays in the RIG grant.

Region 6- The Prevention report was provided by J. Erdman. This region is new to IPHA and has seven prevention agencies. The region currently has 2 PrEP clinics and has taken on Edgar County as a new provider in FY19. The Care report was provided by C. Crause. She reported that G. Dunn and M. Benner are working on an evaluation of the peer program in order to implement plans for expanding services. The region has also recently hired Spanish-speaking staff to engage clients. Recently, a medical student completed a community viral load model of the city of Champaign. The region looks forward to using this model with other existing data to identify gaps in services.

Region 7- The Prevention report was provided by J. Erdman. He reported that this is the largest region for IHPA with ten prevention agencies, including Agape Missions as a new provider for FY19. The region has 3 PrEP clinics and looks forward to implementing routine testing under the RIG grant. The Care report was provided by B. Olayanju, who reports that there are five care agencies in the region. Please see notes below for combined report of activities for Regions 7 &8.

Region 8- The Prevention report was provided by A. Tobin. She reports that PHIMC will monitor 15 prevention agencies in the region. The Care report was provided by B. Olayanju, who stated that there are 26 care agencies in Region 8. Region 7 and 8 are working closely with immigrant populations to help them understand their rights to the RW program. Both regions have also implemented non-medical case management for clients who are self-sufficient but may need some navigation services. This restructuring has taken allowed for expansion of services and ease of case load for medical case managers. This year, AFC will provide over 44 trainings to care agencies in Regions 7&8 with an overarching theme of HIV and Aging. Both regions are also looking to apply for recently released CDPH grants in order to continue coordinating services.

1:45 -2 pm: **Break**

2-3:15 pm: **Community Services Assessment: ISBE Liaison Update: Overview of 2017 Illinois YRBS Survey Results and Analysis of Sexual Minority Responses** - (60 minutes)

Speaker, Marleigh Andrews-Conrad on behalf of Illinois State Board of Education and Livia Navon, IDPH, HIV Section

M. Andrews-Conrad presented information on the Youth Risk Behavior Survey (YRBS) on behalf of the ISBE and L. Navon who were not available to attend the meeting. She began with the presentation received from ISBE's J. Gerdes, who has now retired. The YRBS's origins, general content categories, and methodologies were shared with participants. State wide information on the following YRBS results were reviewed as they are used to measure the third NHAS indicator (reducing sexual risk behavior among gay and bisexual men): measurement of students who had reported ever using illegal injection drugs; measurement of students who had had three or more sexual partners in the last three months; and measurement of students who reported use of a condom during their last sexual encounter. Data was present by gender (male/ female), by age group (9th-12th grade), and by race/ethnicity (Asian, Black, Hispanic, and White). It was noted that there have been significant downward trends in condom use among all youth since 2009.

Since 2009, the Illinois YRBS has asked students to identify their sexual orientation as heterosexual, gay or lesbian, bisexual, or not sure. Students identifying as gay or lesbian, bisexual, or not sure are considered sexual minority youth. To compliment statewide data, L. Navon of IDPH completed an analysis that compared data reported by heterosexual student compared to those of sexual minority. Sexual minority youth reported mores negative outcome than their heterosexual counterparts for the following: physical and electronic bully in the past 12 months; reporting symptoms of depression, and contemplation or attempt of suicide; lower rates of condom use; higher reporting of ever being physically forced into a sexual encounter; and ever using drugs such as marijuana, inhalants, cocaine, and heroin (please see presentation for specific data). It was noted that comparatively, Illinois's trends among sexual minority youth are not unique and are occurring nationwide.

In summary, M. Andrews- Conrad challenged participants to think critically about the data, stating that although the YRBS does not allow us to ask why these rates are occurring, it gives an opportunity for providers to look at how their service delivery may positively or negatively affect these reported outcomes.

– Questions & Answers, Discussion, Input - (15 minutes)

C: P. Briggs stated: Peoria County was rated as one of the top 10 counties for high STD rates, so they have been working diligently in the schools to combat this. There are now three Get Yourself Tested sites at three Peoria high schools. Each site tests about 150 students annually. Additionally, there is a school in what is considered a high risk zip code, and administrators there have worked to establish a wrap-around program where community service agencies can come into the school to serve students. PHS and Central Illinois Friends currently participate to provide services.

Q: J. Maras asked: Do we know if students were asked specifically about condom use in consensual v. non-consensual encounters? This information is important to know, especially for the Care side of the house because we need to be aware of how we ask client questions, particularly youth, in order to obtain information relevant to linking them to needed services. Sometimes, distinctions such as consensual v. non-consensual encounters need to be made so that we can approach clients with sensitivity and understand how to best serve them. I would like to challenges our Care providers to use this data and these questions as a baseline to begin to start thinking about how to target youth in our work.

A: M. Andrews-Conrad said: As far as I know, the data for condom use and ever being physically forced into a sexual encounter cannot be cross examined. If you are looking for more examples of questions that were asked on the survey to guide thought processes, please visit the CDC's YRBS website for this information.

Q: L. Jadama asked: With reported condom use decreasing in recent years, could there be a correlation to HIV rates for youth?

A: M. Andrews-Conrad said: Although we can't say it with certainly, we do know that the overall rate of new HIV cases is decreasing in Illinois. This is not true, however, for unique subset of the population (i.e. young MSM) where rates are increasing. It is definitely something to consider in our planning processes.

Q: S. Zamor asked: Is housing status/ stability asked as a question on the YRBS? Could this be further analyzed among sexual minority youth?

A: M. Andrews-Conrad stated: I do not believe that information is asked on the survey.

Q: N. Holmes stated: I wanted to point out a limitation in the data. Because this is done in the schools, it's important to remember that this survey does not follow the same students over time. Do you know if students are asked questions about their social life? Isolation can be an issue for sexual minority youth that could lead them to practice riskier behaviors. Is the sexual health curriculum gender neutral? That can also play a role in a student's ability to effectively learn and practice safer sex. Lastly, we need to consider how this survey will be affected in the future as far as how the political climate is not favorable to LGBT rights and issues. We may be in jeopardy of losing this data source if federal regulations no longer allow for the question to be asked on future YRBSs.

A: M. Andrews-Conrad stated: These are all great considerations. I appreciated what you said about isolation as a factor that can influence the choices of sexual minority youth as this is so important. I don't know that isolation is specifically asked about on the survey but it is something to consider. In terms of gender neutrality among priority school districts in ISBEs last grant cycle, I believe that each district was charged with adopting their own curriculum under general guidelines, so we cannot be certain of specific content. Lastly, when it comes to political happenings, it is good to recognize that this is a factor that we may have to face but is unfortunately out of our control.

C: J. Dispenza stated: I found the data to be heartbreaking, especially because I have seen it occurring among many young clients. One of the considerations that we should focus on is that youth and LGBT folks need to be fully supported. Sometimes, it can be a very long, detailed process to not only engage youth, but to also help them to navigate services and move towards wellness. Please realize that this specialized care and consideration of barriers that these youth face may mean longer linkage to care times.

C: C. Tucker stated: It is important to point out that issues like stigma, homelessness, and violence are often faced by transgender youth, but there is not a gender identity question on the survey. I wanted to bring this to the forefront as to not forget that transgender students also need specialized support and are important to consider in our planning processes. If there was a way to add a question about gender identity to the survey, it would be another good data source for us to draw transgender information out of.

A: M. Andrews-Conrad stated: Thank you for your comment and recognition of this population. You are correct that a question specific to gender identity is not included on the survey but would be helpful and affirming.

C: C. Laskowski stated: As a care provider, I am saddened by this data, but it is not shocking. When we look at things like viral suppression and keeping people in care, I think we sometimes get too far ahead of ourselves and don't truly address their trauma. Ultimately, if trauma-informed care is not at the forefront, clients will not be engaged. Thank you for the presentation and data to use and consider in the field.

C: J. Erdman stated: I agree that we are seeing a lot of trauma among youth people and among clients in general. Providers should serve clients, especially youth, through a trauma-informed lense. There are many trainings and webinars available on this topic for anyone who is interested. The data is heart breaking and points to how traumatic experiences can shape a person's decision and well-being. Please keep this in mind when providing services.

C: N. Holmes stated: When it comes to the questions about being physically forced into sexual encounter, I would like to see this question expanded on to allow youth to report other types of assault, such as emotional manipulation and coercion. It is important to understand how these factors come into play when serving youth.

Q: C Montgomery asked: Is the survey conducted in the schools? If so, this is a great tool because we have found it very hard to actually reach youth in the schools due to push back from administrators.

A: M. Andrews-Conrad replied: Yes, the survey is completed in the school setting through ISBEs identification of selected districts. Districts can refuse the survey, but those that were reported on in the presentation were completed in the schools. Since it is a state-sponsored survey, schools might be more open to it, but it is true that districts can vary in their openness not only to this survey, but also to other aspects of our work such as HIV education and testing.

C: E. Alvarado stated: In regards to the YRBS, Illinois has the ability to work with the CDC to purchase questions for inclusion in upcoming surveys. Hearing today's discussion, it sounds that this could be beneficial to our planning process as we move forward. We are happy to look into how the HIV section might support this if the group would like to formulate questions for this purpose.

C: J. Nuss stated: I thought that it was interesting that CDC moved the sexual health education component of the DASH grants from state agencies to directly funding local education agencies. She wondered why Chicago Public Schools was the only school district in Illinois to receive this funding. Was it the only one that applied?? This is something that agencies could partner with their local school districts to pursue in the future.

3:15-3:45 pm: **Community Services Assessment: Integrated Planning Needs Assessment Work Group 2019 Recommendations**-(30 minutes)

Needs Assessment Work Group Representative

J. Nuss presented the Integrated Needs Assessment Work Group update. She reminded participants of the background of this work group and its purpose: In preparation for 2018-2020 needs assessment cycles, a draft Community Engagement Meeting Protocol was presented to the hybrid Integrated Planning Group in December 2017. That group gave input into the protocol and recommended the process should be simplified and more solution driven. Tthe Integrated Needs Assessment Work Group was formed into order to provide further input and guidance on this task. The Work Group met in January 2018 and decided to go into hiatus until after the GTZ needs assessments were completed and results received in order to avoid duplication of activities.

The Work Group reconvened several months ago and has diligently worked to revise the protocol. The questions on the protocol have been totally updated, as well as other aspects of the protocol, such as guidelines for introductory presentations on HIV epidemiology and current HIV service landscapes, objective overviews, definition/acronym cheat sheets for participants, and resource guides have all been developed to engage individuals from all sectors in these meetings. Janet briefly reviewed the goals, objectives, and questions outline in the protocol. It was noted that these components are directly related to our NHAS 2020 goals and GTZ aims. These meetings will be hosted and collaboratively conducted in each region by Prevention and Care lead agencies.

J. Nuss concluded her presentation by noting other activities that will be conducted in the 2018-2020 needs assessment cycle. These include a series of focus group/ youth survey distribution in Juvenile Justice System settings, distribution of youth surveys among Summit of Hope participants aged 18-24, and a series of six focus groups with targets populations. All information collected from these activities will be used in updates to the Integrated Plan.

– Questions & Answers, Discussion, Input - (15 minutes)

Q: J. Dispenza asked: Some of the questions ask participants to specifically focus on priority populations (ex. young Black MSM). Can we add Latinx MSM as a priority population in Community Engagement questions?

A: J. Nuss answered: This suggestion can be taken back to the committee for consideration. The populations that were specifically mentioned were ones mentioned in the NHAS 2020 indicators and for which our data shows particular disparities.

C: E. Alvarado said: One great thing that we are doing at this time among IDPH, CDPH, and GTZ is looking at identifying clusters of HIV. It is evident that Latinx MSM clusters are included and they should be prioritized. I encourage those working on needs assessment activities to use this data to our advantage made so that priority populations can be addressed in a timely manner.

C: J. Dispenza responded: I feel that if we are not incredibly specific in our activities, minority populations will not get as much attention, even if data shows that they should be a priority. We have to continue to bring all minority populations to the forefront of activities.

C: V. Johansen stated: I agree. If there will be plans to do a young Black MSM focus group, then there should also be a focus group specifically for Latinx MSM instead of categorizing them with a general MSM of Color focus group.

A: J Nuss noted that the workgroup has agreed to work on risk targeted focus group, but those protocols are yet to be written. For the Community Engagement Meeting protocols, the work group did their best to cover overarching disparities that are seen in HIV. If a particular group or population was not specifically noted in this protocol, it can be specifically covered in other activities, particularly the focus groups for target populations.

Q: S.Zamor asked: Is the Integrated Needs Assessment Work Group a committee of the IHIPC?

A: J. Nuss responded: It is not an IHIPC standing committee. It was comprised of members of the former ILHPG and Ryan White Advisory Group as well as some additional community members and IDPH staff. It is considered as an ad hoc work group of the IHIPC and will continue to provide the IHIPC updates on this progress.

3:45 pm: **Public Comment Period-** There was no request for public comment at the meeting.

3:45 pm: **Recap Activity**

J. Nuss then moved to the meeting's recap activity. She reminded participants that at the June meeting, eleven barriers known to affect an individual's ability to access and utilize HIV Prevention and Care were presented to the group. Individuals were asked to choose one topic of interest that should be further explored and evaluated by the IHIPC in upcoming planning and needs assessment activities. The results of the June Recap activity were compiled, and the top six barriers by participants were as follows: inequitable access to affordable prevention and health care services; education (of youth and the general public); racism; stigma and homophobia; homelessness/ unstable housing; and substance use/ abuse.

J. Nuss then gave instructions on the October meeting recap meeting activity. Participants were asked to identify specific strategies or action steps that could be/ have been feasibly implemented by individuals or agencies to positively impact clients that face the six barriers identified above. Participants were asked to take about 20 minutes to document and submit ideas and input. Recap activity worksheets were collected at the end of activity and answers will be compiled. Once compiled, these ideas and thoughts will be released for use by the IHIPC, IDPH, and other agencies for incorporation into planning activities.

4:20 pm: **Adjourn -**With no further announcements, the meeting adjourned at 4:20pm.