Integrated Illinois HIV Planning Group (ILHPG)/Ryan White Part B Advisory Group Newsletter

Newsletter 20 **Winter 2017**

Calendar of 2017 Events

Dec. 1st:
World AIDS Day

Dec. 13th:
IHIPC New Member Orientation, Webinar, 9 am—noon and 1-4 pm

Dec. 14th:
ILHPG/ RWBP Advisory Group Meeting, Springfield, 8:30am– 1pm

Please visit www.ilhpg.org/webinar for more information on upcoming Integrated Planning Group meetings and events.

Updates from the Co-Chairs

Hi, everyone!

I am excited to inform you that plans for the newly formed Illinois HIV Integrated Planning Council (IHIPC) are in place and the new planning group will take effect January 1, 2018. The 2018 slate of selected and appointed voting members and at-large non-voting members is included on page 3 of this newsletter and will be formally announced at the December 14th Integrated Planning Group meeting.

Please note that because this is the last edition of this newsletter, it will be an abbreviated one. But no need to worry, beginning in 2018 this newsletter will officially be reformatted and renamed the Illinois Integrated Planning Council (IHIPC) Newsletter!

Have a great winter and holiday season!

Submitted by Janet Nuss, HIV Planning Coordinator, ILHPG/Integrated Planning Group Co-chair, Illinois Department of Public Health

INTEGRATED PLANNING GROUP UPDATE

INTEGRATED PLANNING GROUP

Thanks to all of the members of the Illinois HIV Planning Group (ILHPG), the Ryan White Part B (RWPB) Advisory Group, and all other community stakeholders and partners who have participated in Integrated Planning Group meetings and activities over the last several years. The formation of one integrated planning group that will assume the functions of the current Illinois HIV Planning Group and the Ryan White Part B Advisory Group has been a long, thoughtful, and productive process of which we should all be proud. We are almost there! I would like to extend special recognition and thanks to the Integrated Planning Steering Committee members who have been so instrumental in helping to plan for development and implementation of the new Illinois HIV Integrated Planning Council (IHIPC) that will take effect on January 1, 2018. The steering committee will assist IDPH in providing guidance and direction to the new IHIPC until there is a formal election of new leadership.

The IHIPC will be the voice of PLWH, populations at highest risk for HIV infection, and providers about HIV planning relevant issues in their regions. The group will prioritize community engagement and enhancing collaboration and integration among prevention and care organizations in order to improve the quality of HIV prevention and care services and to sustain the provision of services to individuals in need. The IHIPC, of course, will remain focused on achieving the goals of the National HIV/AIDS Strategy by strategizing to address service gaps, inequities, and barriers in HIV prevention and care, fostering seamless entry into the HIV care system, and eliminating barriers to primary prevention services, linkage to care, retention and reengagement in care, and viral suppression. If we remain focused on this goal and together continue to enhance our network of services through integration, collaboration, and implementation of evidence-based services and best practices, we can achieve our goal of Getting to Zero new HIV infections.

With our 2018 IHIPC selection of voting members (see next page), we were able to meet all of the professional and community areas of expertise and representation of our voting membership as recommended in the IHIPC Bylaws. We were also able to meet most of the recommended demographic characteristics of representation for our voting membership as determined by the gap analysis we conducted. We are very excited and ready for IHIPC implementation! Orientation for new members will be conducted on December 13th by webinar from 9 am—12 noon or from 1-4 pm.

(continued on page 3)

Submitted by Janet Nuss, HIV Planning Coordinator, ILHPG/Integrated Planning Group Co-chair, Illinois Department of Public Health

2018 Illinois HIV Integrated Planning Council (IHIPC) Selected/Appointed Membership List

Selected Voting Members:

Member Name	Agency Affiliation	Region
1. Benner, Mike	Greater Community AIDS Project/ East Central IL HIV Care Connect	6
2. Charles, James	Central IL HIV Care Connect	3
3. Crause, Candi	Champaign-Urbana Public Health District	6
4. Dispenza, Jill	Center on Halsted	9
5. Erdman, Jeffery	IL Public Health Association	2, 3, 4, 7
6. Filicette, Joe	Cook County Department of Public Health	8
7. Fletcher, Scott	The Community Action Place/Fletcher Technology Services	5
8. Fuentes, Ana	Sinai Health System	8
9. Gassett, Dwight	Southwestern IL HIV Care Connect	4
10. Green, Noel	Brothers Health Collective –Chicago, IL	9
11. Guzman, Lisa Veronica	Open Door Health Center/PFLAG-Hindsdale Chapter	7
12. Hendry, Chad	Howard Brown Health	8
13. Holmes, Nicole	Center on Halsted	9
14. Hyzer, Silas	Public Health Institute of Metropolitan Chicago	8
15. Jones, Shanett	Midwest AIDS Education & Training Center	8
16. Laskowski, Casie	SIU School of Medicine	3
17. Lewis, Karen	Aunt Martha's Health and Wellness	8
18. Maginn, Mike	IL Public Health Association	1, 2, 3, 5
19. Markovich, Tina	St. Clair County Health Dept.	4
20. Osunmakinde, Bashirat	AIDS Foundation of Chicago	7, 8, 9
21. Paesani, Trish	Winnebago County Health Dept.	1
22. Roeder, Lisa	UIC College of Medicine Peoria/ CoC Peoria Heart of IL	2
23. St. Julian, Steven	Jackson Co. Health Dept. /Rainbow Cafe	5
24. Williams, Mark	Association House of Chicago	9
25. Williams, Rashonda	Public Health Institute of Metropolitan Chicago	8
26. Williamson, Mildred	Cook County Health and Hospital Systems; UIC School of Public Health	8
27. Zamor, Sara	Lake County Health Dept/Community Health Center	7

Appointed Voting Members

Member Name	Agency Affiliation	Region
1. Bradley, Wendy	St. Clair County Health Dept. St. Louis Area HIV Services Planning Council Liaison	4
2. Choat, Lesli	IDPH STD Section	NA
3. Gaines, Michael	IDPH IDOC Corrections Project Liaison	NA
4. Nuss, Janet	IDPH IHIPC Coordinator/Co-chair	NA
5. Patterson, Reginald	IL State Board of Education -Adolescent Sexual Health Liaison	NA
6. Reed, James	IDPH Centers for Minority Health Services Liaison	NA
7. Tucker, Cynthia	AIDS Foundation of Chicago Chicago Area HIV Integrated Services Council Liaison	9
8. TBD	Illinois Department of Healthcare and Family Services	NA

At-large Non-Voting Members

Member Name	Agency Affiliation	Region
1. Hunt, Don	SIU School of Medicine	3
2. Rehrig, Susan	St. Clair County Health Dept.	4
3. Stevens-Thome, Joan	Sangamon County Health Dept.	3

HEPATITIS C TREATMENT DEMONSTRATION PROJECT

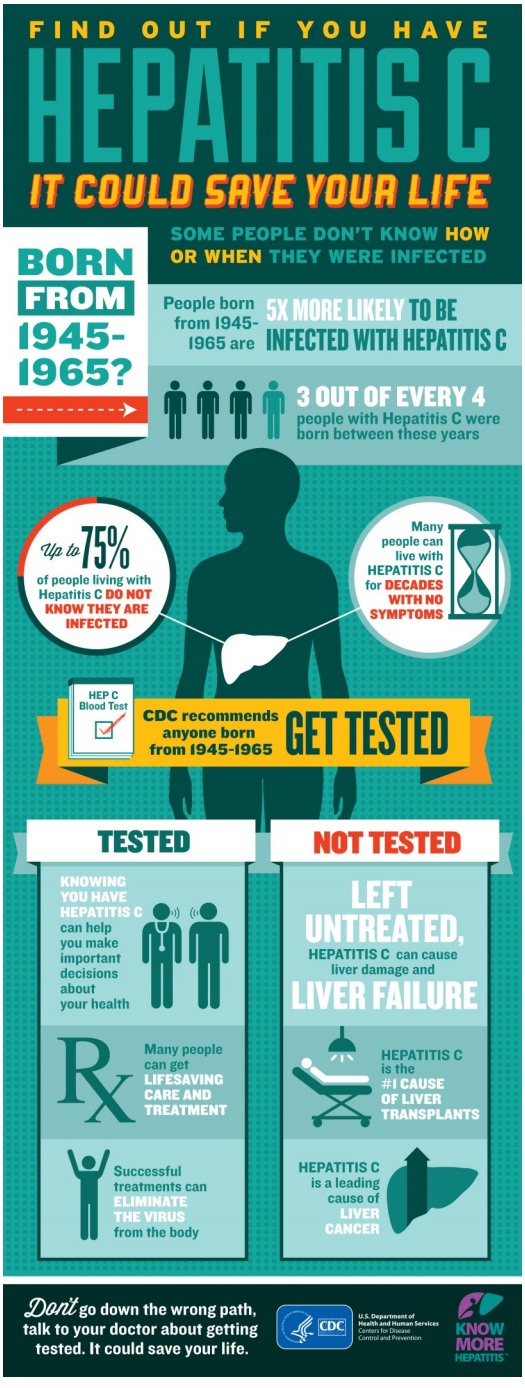
The Illinois Department of Public Health's Ryan White Part B AIDS Drug Assistance Program (IDPH ADAP-MAP) began a demonstration project November of 2016 to add curative treatment for Hepatitis C Virus (HCV) infection to the State's ADAP Formulary. Following the expanded treatment guidance of the Health Resources and Services Administration (HRSA), we have been able to successfully treat HCV in 132 persons co-infected with HIV. The success of the demonstration project and our Federal Partner's ongoing commitment of resources for curative HCV treatment have allowed us to make HCV treatment a sustainable part of Illinois' HIV Continuum of Care. Therefore, we will continue to add new HCV medications to our ADAP formulary, as they are approved and released to market.

The addition and sustainment of HCV therapy to the IDPH ADAP-MAP Formulary comes after careful monitoring of resources, efficacy, and ease of treatment. We remain grateful to those of you who provided invaluable feedback to the Department with respect to facilitating a timely and easy prior-authorization process, and reduction of administrative burden.

Moving forward, and in light of the success of the HIV/HCV Demonstration Project, we will be piloting an open and expanded formulary that would afford the State's prescribers the opportunity to engage and treat HIV/HCV clients with more flexibility. Most important, clinicians and clients will have access to the most effective therapies to improve health outcomes and enhance quality of life, for all those living with HIV and AIDS. The IDPH ADAP-MAP Program is pleased to announce that this formulary will be available to all eligible ADAP-MAP clients.

The specific drug and class exclusions are included on the next page. The Illinois ADAP-MAP expanded formulary will begin immediately for all Ryan White Part B ADAP-MAP enrolled and eligible clients. All websites that contain Illinois MAP-ADAP Formulary documents have been updated.

Submitted by Eduardo A. Alvarado, MPH, MPAP, Chief, HIV/AIDS Section and Jeffrey P. Maras, ED.D, M.S., Illinois Ryan White Part B Administrator



Illinois Medication Assistance Program – ADAP Open Formulary Exclusions

Specific Exclusions

	Examples
Antirheumatic injectables	*Enbrel*
Botulinum toxin	*Botox, Mylobloc*
Compounded medications for infusion *(Active medication containing more than one ingredient)*	
Gonadotropin	
Finasteride (Propecia) *(Approved for prostate disorders **only**)*	
Hyaluronic acid derivatives	*Hyalgan, Synvisc*
Immune globulin intravenous (IGIV)	*Sandoglobulin, Venoglobulin*
Injectable muscle relaxants	*Lioresal*
Mifepristone	
Minoxidil (Rogaine)	
Monoclonal antibodies	*Remicade, Synagis*
Nutritional supplements*	*Ensure*
Propoxyphene	
Recombinant human growth hormone (HGH)	*Geref, Humatrope*
Synthetic growth hormone	

Class Exclusions

	Examples
Durable Medical Equipment**	*Test strips; Lancet, Meters*
Cosmetic Medications	
Erectile Dysfunction Pharmaceuticals	*Viagra, Levitra, Cialis, Caverject*
Female Sexual Dysfunction Pharmaceuticals	*Addyi (flibanserin)*
Fertility Drugs	
Herbal Medications	
Vaccines/Immunizing Biologicals	*Zostavax*

Vitamins and pain relievers (i.e. ibuprofen) are covered when prescribed by a physician
****Syringes for insulin injection only are covered***
***** All medications must be order/shipped through IDPH's contracted pharmacy***

Revised 08/30/2017

INCREASING EARLY SYPHILIS CASES IN ILLINOIS—SYPHILIS LABORATORY TESTS

This article is Part 3 of a three-part series on Syphilis submitted by Lesli Choat, the IDPH STD Coordinator.

Syphilis is a sexually transmitted disease (STD) caused by the *Treponema pallidum* bacterium.

Syphilis testing should be performed on patients with signs or symptoms of infection, as well as asymptomatic patients at high risk for infection or for transmitting to others, as described in the Part 1 of this series. Diagnosis of syphilis is made using both non-treponemal and treponemal serologic tests and should not be made on the basis of a single test result. Further, clinical history and symptoms must be taken into consideration when diagnosing and staging individuals.

Serologic Diagnostic Tests:
Non-treponemal tests, also called screening tests (RPR and VDRL), do not detect antibodies specific for syphilis and are based upon the reactivity of serum from infected patients to a cardiolipin-cholesterol-lecithin antigen (regain). RPR and VDRL results should have a quantitative titer reported with them (1:2, 1:4, 1:8, etc.). A reactive RPR must also have a reactive treponemal test to be considered a case of syphilis as false positives are possible. Changes in titer are followed after treatment to detect a therapeutic response and to assess for new infection. With adequate treatment, most individuals will return to a non-reactive RPR. Some individuals may maintain a low titer RPR for life despite adequate treatment (serofast). False negatives can also occur with this test, most often during early acute infection.

Treponemal tests, also called confirmatory tests (FTA, TP-PA, EIA), detect antibodies specific to syphilis. Treponemal antibodies will appear earlier after acute infection than non-treponemal antibodies. The antibodies detected in these tests usually remain detectable for life even after successful treatment. Thus, a reactive treponemal test can indicate current or past syphilis infection.

Common Syphilis Serologic Tests

Test	Full Name	Type	Target	Notes
RPR	Rapid Plasma Reagin	Non- trepo-nemal	Cardiolipin Antibodies	Quantitative results reported as a titer.
VDRL	Veneral Disease Research Laboratory	Non- trepo-nemal	Cardiolipin Antibodies	Quantitative results reported as a titer. Only test approved for CSF (cerebrospinal fluid) speci-mens.
FTA-ABS	Fluorescent Treponemal Antibody-Absorption	Treponemal	*T. pallidum* Antibodies	
TP-PA	*Treponema pallidum*-particle agglutination	Treponemal	*T. pallidum* Antibodies	
MHA-TP	Microhemagglutination-*Treponema pallidum*	Treponemal	*T. pallidum* Antibodies	
EIA	Enzyme immunoassay	Treponemal	*T. pallidum* Antibodies	May be initial test in reverse sequencing algorithm.
CIA	Chemiluminescent immunoas-say	Treponemal	*T. pallidum* Antibodies	May be initial test in reverse sequencing algorithm.

Note: This table is not exhaustive of all the tests available for diagnosing syphilis.

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INCREASING EARLY SYPHILIS CASES IN ILLINOIS—SYPHILIS LABORATORY TESTS

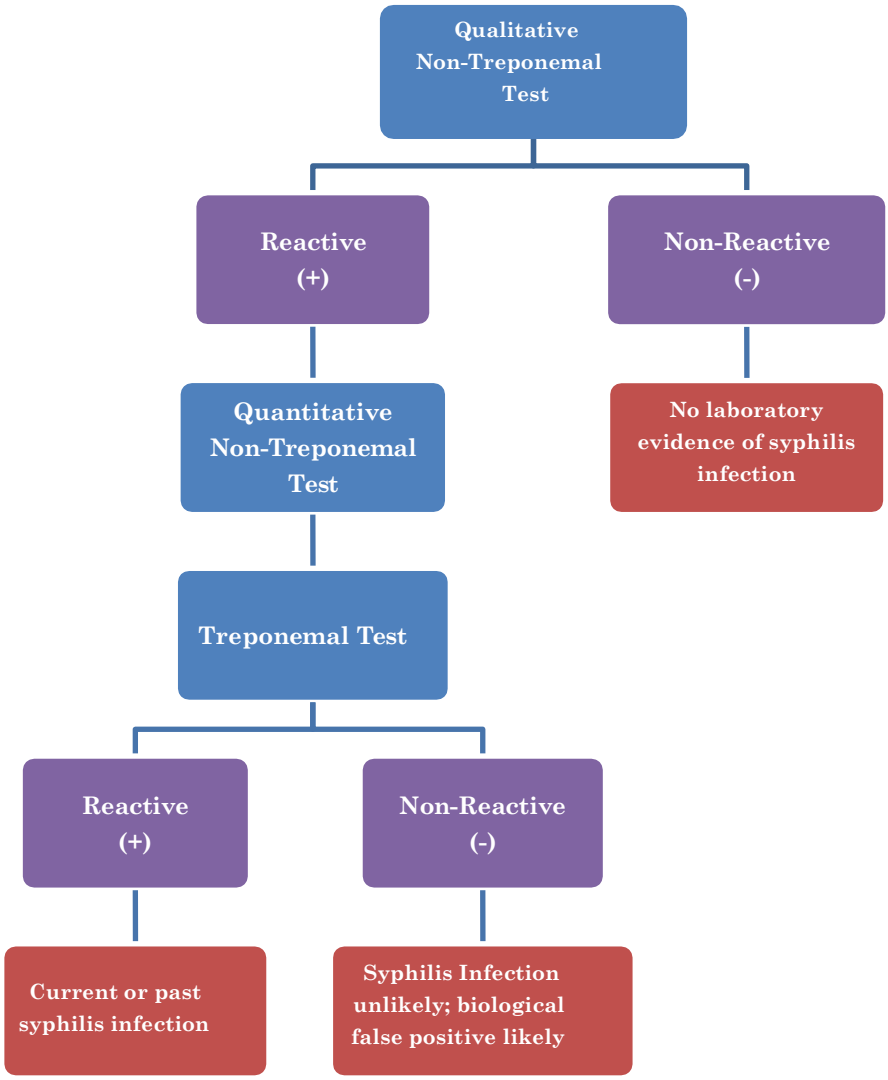
(Continued from page 6)

Testing Algorithms:

Traditional Testing Algorithm

The traditional testing algorithm for syphilis begins testing with the non-treponemal test. If the non-treponemal test is reactive, a treponemal test is then used to confirm syphilis infection. This algorithm has been in use for many years and may be most familiar for interpretation of results.

Traditional Syphilis Testing Algorithm



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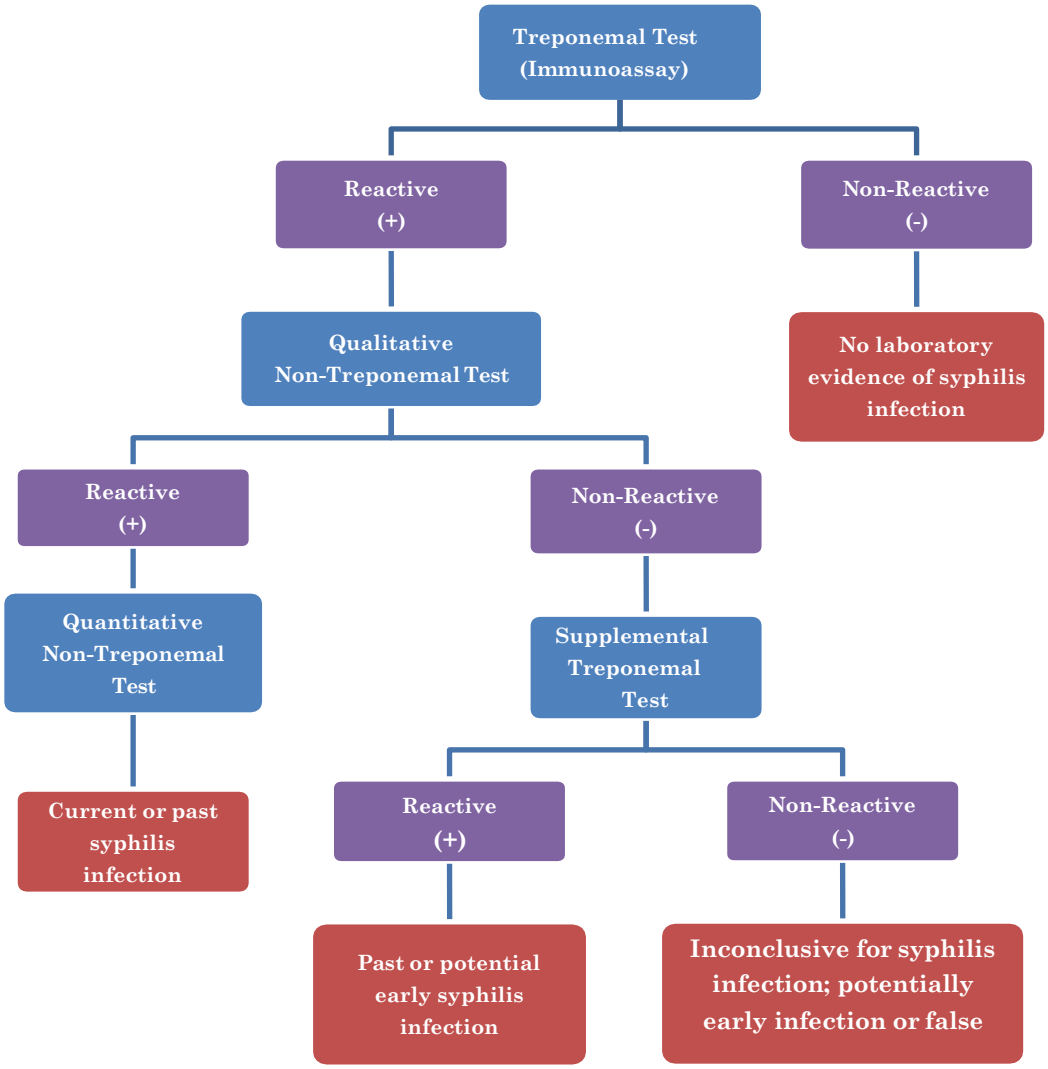
INCREASING EARLY SYPHILIS CASES IN ILLINOIS—SYPHILIS LABORATORY TESTS

(Continued from page 7)

Reverse Testing Algorithm

The reverse testing algorithm for syphilis begins testing with a treponemal test. If this test is reactive, a non-treponemal test is performed. When the non-treponemal test is non-reactive, a second treponemal test is performed to determine if the first treponemal test was a false positive. The second treponemal test performed must be different than the initial treponemal test. The reverse testing algorithm has been in place since 2009. This algorithm is attractive to laboratories that have a high testing volume because it reduces the amount of manual labor conducted for the non-treponemal tests. The reverse algorithm will detect past infections that were previously undetected by the traditional testing method (reactive treponemal test with a non-reactive non-treponemal test).

Reverse Syphilis Testing Algorithm



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INCREASING EARLY SYPHILIS CASES IN ILLINOIS—SYPHILIS LABORATORY TESTS

(Continued from page 8)

Syphilis Re-infection

Because the antibodies detected in treponemal tests usually remain detectable for life, even after successful treatment, the non-treponemal titer (RPR or VDRL) must be used to monitor for a re-infection with syphilis. An increase in titer of two dilutions represents re-infection with Treponema pallidum. For example, a titer increase from 1:1 to 1:4 would indicate a re-infection.

Neurosyphilis

Further testing is required for persons with clinical signs of neurosyphilis (headache, cognitive dysfunction, difficulty coordinating muscle movements, sensory deficits, meningitis, dementia, or ophthalmic findings), with evidence of active tertiary disease affecting other parts of the body, or with treatment failure. The diagnosis of neurosyphilis depends on a combination of cerebrospinal fluid (CSF) tests (CSF leukocyte count, CSF protein, or CSF-VDRL) in the presence of reactive serologic test results and neurologic signs and symptoms.

Interpretation of Syphilis Test Results

Traditional Testing Algorithm		
Non-Treponemal Assay	**Treponemal Assay**	**Interpretation**
Non-Reactive	Not Indicated*	No laboratory evidence of syphilis infection
Reactive	Non-Reactive	Syphilis Infection unlikely; biological false positive likely
Reactive	Reactive	Current or past syphilis infection

**If there is high clinical suspicion for early acute disease, then serologic testing should be repeated in 2- 4 weeks, or patient should be presumptively treated.*

Reverse Testing Algorithm			
Treponemal Assay	**Non-Treponemal Assay**	**Treponemal Assay**	**Interpretation**
Non-Reactive	Not Indicated	Not indicated	No laboratory evidence of syphilis infection
Reactive	Non-Reactive	Non-Reactive	Inconclusive for syphilis infection; potentially early infection or false positive. If recent exposure, recommend re- screening in 2-4 weeks.
Reactive	Non-Reactive	Reactive	Past or potential early syphilis infection
Reactive	Reactive	Not indicated	Current or past syphilis infection

Additional Resources:

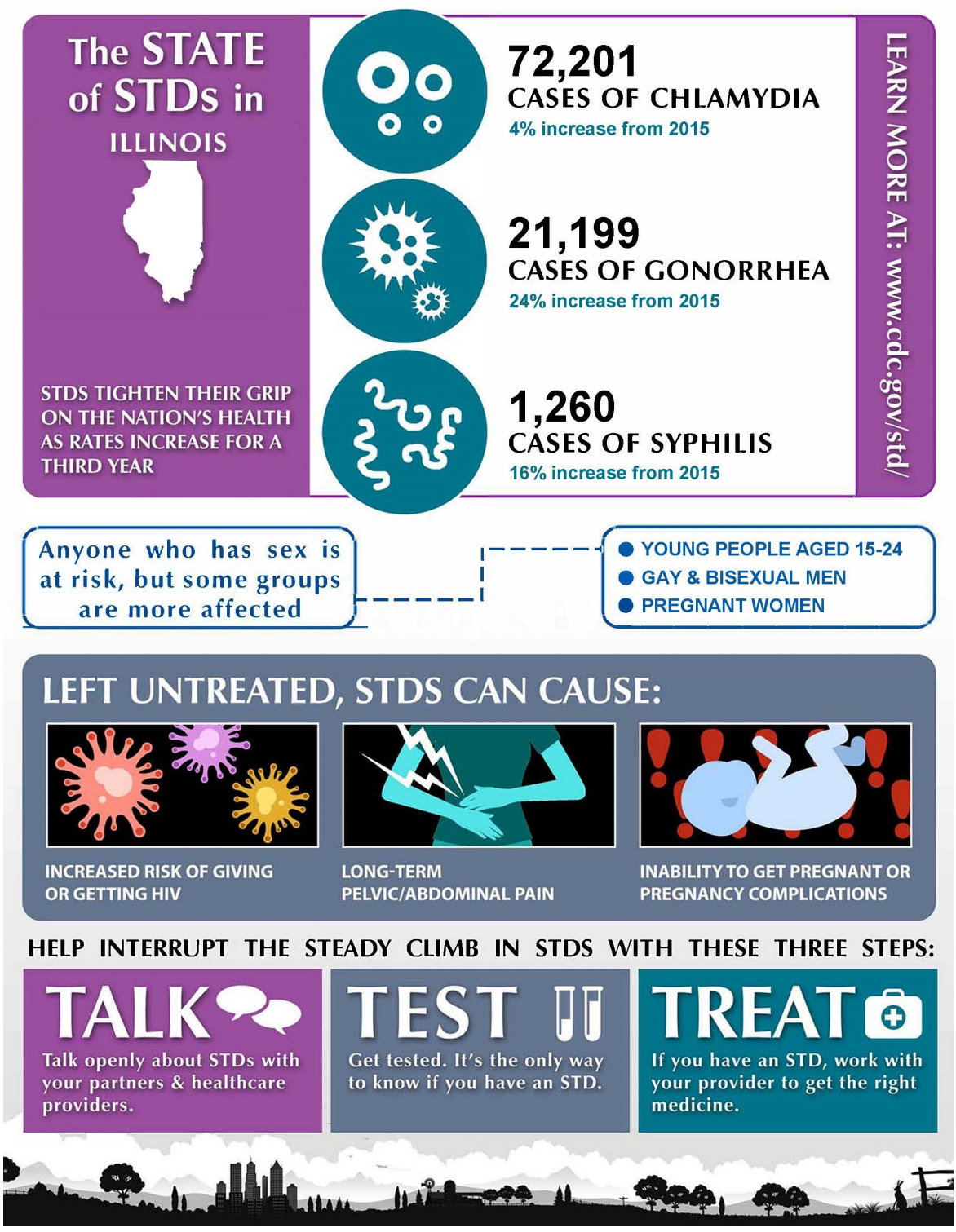
Suggested Reporting Language for Syphilis Serology Testing https://www.aphl.org/AboutAPHL/publications/Documents/ID_Suggested_Syphilis_Reporting_L ang_122015.pdf

CDC Syphilis Detailed Fact Sheet https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm

CDC 2015 Sexually Transmitted Diseases Treatment Guidelines https://www.cdc.gov/std/tg2015/syphilis.htm

STDS IN ILLINOIS

Submitted by Lesli Choat, IDPH, STD Coordinator



IDPH HIV TRAINING UNIT UPDATES

The HIV section is happy to be offering the following upcoming 2018 trainings. (Please note: if not already, registration for winter/spring trainings will open at a later date.)

Registration Link:
https://www.regonline.com/calendarNET/EventCalendar.aspx?EventID=1114125
Schedule is subject to change.

Surveillance-based Services (1 day)

- January 18, Champaign

Surveillance-based Services (1 day)

- September 26, Peoria

Foundations -formerly Skills (2 days)

- February 27-28, Belleville

ARTAS 2days

- March 13-14, Chicago

Risk-targeted Testing (4 days)

- Jan. 30-Feb. 2, Springfield
- March 27-30, Chicago suburbs

ARTAS Illinois: This course teaches the core elements and skills necessary to provide the ARTAS (Anti-Retroviral Treatment and Access to Services) intervention, which is intended to be implemented by agencies that conduct case management services for persons living with HIV/AIDS or are engaged in linking persons who are recently diagnosed with HIV to primary care providers and/or ancillary support services. Grounded in the strength-based case management model, ARTAS helps clients build on strengths they already have to successfully connect to medical care and treatment. ARTAS Illinois will focus specifically on Illinois-specific linkage to care processes.

Surveillance-based Services: This one-day course will prepare local health department staff to use HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and offer assistance with notifying their sex and/or needle-sharing partners of their potential exposure. This course is recommended for any health department employee who may be reaching out to HIV positive clients discovered through surveillance activities.

Risk-targeted HIV Testing: This new course replaces "Fundamentals of HIV Counseling and Testing", and it is required for all new HIV counselors who provide HIV testing to targeted populations. It will teach participants how to provide HIV testing in accordance with the new CDC guidance to persons most at risk for HIV infection, including men who have sex with men (MSM), high risk heterosexuals (HRH), and injection drug users (IDU). The course focuses less on counseling and more on testing and linkage to biomedical prevention and care services. The training also includes hands on practice with Partner Services.

Submitted by Jamie Burns, IDPH, HIV Training Coordinator

ILLINOIS MEDICAL MONITORING PROJECT

HIV-Positive Adults in Care in Illinois, Medical Monitoring Project, 2009-2014

The Medical Monitoring Project (MMP)

- MMP is a surveillance system funded by the Centers for Disease Control and Prevention and implemented by local health departments. It collects behavioral and medical data about HIV-positive adults receiving medical care in the United States.
- From 2009 to 2014, MMP interviewed 1,584 HIV-positive adults receiving care in Illinois. Their responses reflect their experiences during the 12 months before their interview, unless otherwise noted. All data presented are weighted.
- The information in this factsheet can guide policy decisions, resource allocation, and evaluation of treatment and prevention initiatives.

Characteristics of HIV-Positive Adults in Care in Illinois, 2009-2014

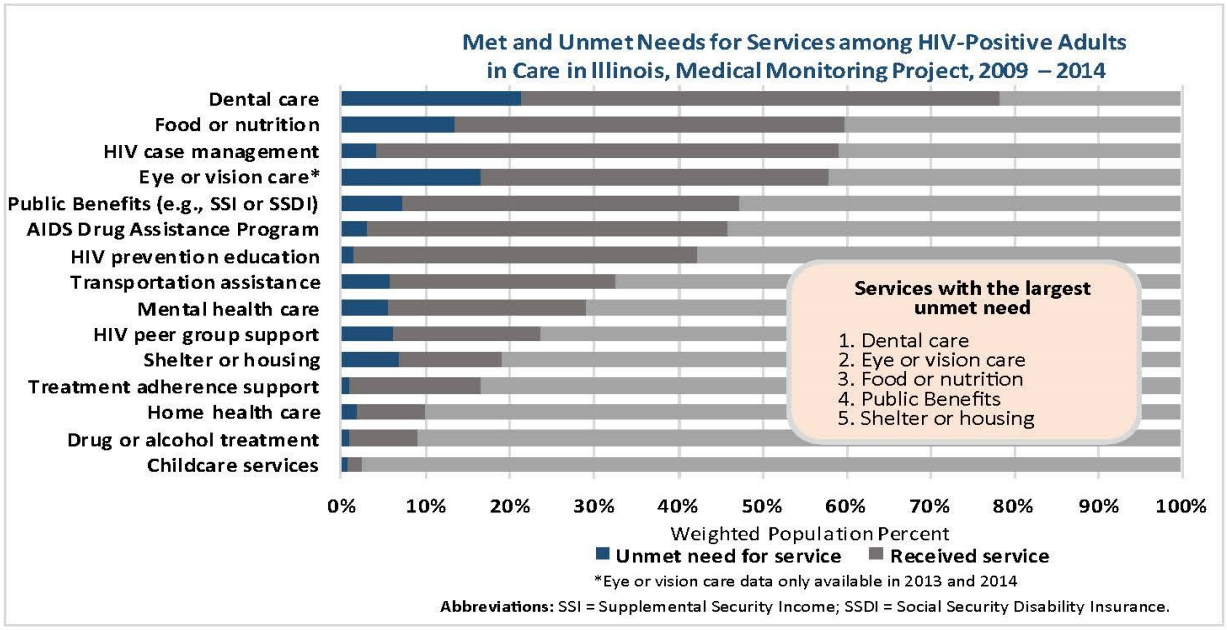
- 76% were male and 23% were female
- 52% were men who have sex with men
- 51% were black/African-American, 14% were Hispanic or Latino, and 31% were white
- 26% had been diagnosed with HIV less than 5 years at the time of their interview
- 32% had private insurance, 43% public insurance only, 20% had Ryan White coverage only, and 3% were uninsured
- 45% had a household income at or below the poverty line
- 6% experienced homelessness

HIV Treatment and Prevention Measures among HIV-Positive Adults in Care in Illinois, Medical Monitoring Project (MMP), 2009-2014*

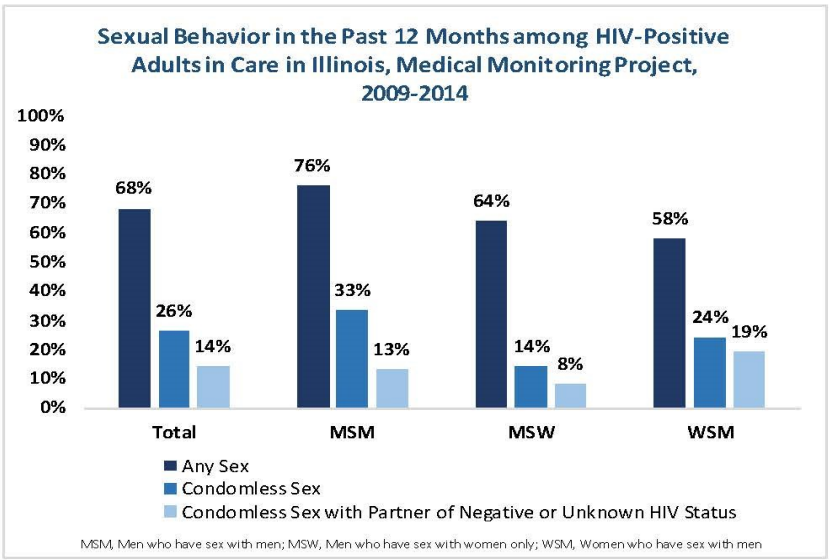
Characteristic	Prescription of ART[1,2](%)	ART Dose Adherence[3](%)	Sustained Viral Suppression[2,5] (%)	Receipt of Condoms[3,6](%)	HIV Prevention Counseling[3,7](%)
Total	**90**	**88**	**72**	**63**	**58**
Age					
18-29 years	78	79	39	75	81
30-39 years	90	90	67	67	67
40-49 years	89	88	75	60	55
≥50 years	93	90	81	60	52
Gender					
Male	91	90	74	64	57
Female	85	83	67	57	64
Race/Ethnicity					
Black/African-American	88	86	65	68	68
Hispanic/Latino	93	89	74	70	60
White	91	92	82	51	43
Insurance					
Any Private Insurance	91	91	81	51	50
Public Insurance Only	89	88	69	68	60
RW[7] Only	95	87	73	71	68
Uninsured	53	84	27	69	75
Sexual Behavior					
MSM[8]	90	89	74	65	54
MSW[9]	90	88	67	64	60
WSM[10]	85	81	66	56	62

*All data are from the past 12 months unless specified otherwise; [1]Antiretroviral therapy; [2]Documented in the medical record; [3]Self-reported; [4]Past three days; [5]All viral loads in past 12 months undetectable or <200 copies/ml; [6]Received free condoms, not counting those given by a friend, relative, or sex partner; [7]Given by a healthcare provider; [8]Men who have sex with men; [9]Men who have sex with women only; [10]Women who have sex with men

ILLINOIS MEDICAL MONITORING PROJECT



Behavioral and Clinical Characteristics



Notes: any sex = any oral, anal, or vaginal sex from 2009 to 2013, but in 2014 oral sex was excluded; condomless sex = vaginal or anal sex without a condom; condomless sex with HIV-negative or unknown-status partner=engaged in condomless sex with an HIV-negative partner or a partner whose status was unknown; all sexual behavior information is self-reported.

Substance Use[1]

- 39% were current smokers
- 20% engaged in binge drinking[2]
- 1% used injection drugs[3]

[1]Self-reported
[2]Binge drinking is defined for men as 5 or more drinks in a sitting in the past 30 days and for women as 4 or more drinks in a sitting in the past 30 days.
[3]Past 12 months

STD Testing Among Sexually Active Persons in the Past 12 Months

- 60% were tested for syphilis
- 31% were tested for gonorrhea
- 31% were tested for chlamydia

Influenza Vaccination in the Past 12 Months

- 84% received an influenza vaccine

Documentation of MMP methods can be found here: http://www.cdc.gov/hiv/pdf/HSSR_MMP_2010-PDF01.pdf

Questions? Contact us:
Illinois Department of Public Health
Division of Infectious Diseases
HIV Surveillance Program
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Chicago, IL 60603

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Cheryl.Ward@illinois.gov

IDPH Illinois Department of Public Health

MEDICAL MONITORING PROJECT

http://www.cdc.gov/hiv/statistics/systems/mmp/
http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hiv-surveillance