Illinois Department of Public Health
Joint ILHPG/RW Advisory Group Meeting Minutes

Date: December 3, 2015
Hotel: President Abraham Lincoln DoubleTree Hotel **Address:** Springfield, IL **Phone Number** 217-544-8800

Agenda Item	Time	Presenters	Purpose and Objectives
Call to order	8:00 am	Integrated Steering Committee Co-Chairs	*The meeting will be called to order.*
With a quorum of voting members presented, the meeting was formally called to order.			
Welcome and Moment of Silence; Introduce members and guests; Review Meeting Agenda/Objectives; Integrated Steering Committee Update; Review meeting flow and basic principles of respectful engagement	8-8:15 am	Integrated Steering Committee Co-Chairs	• *Moment of silence will be acknowledged for people living with HIV and providers, advocates.* • *Clear goals for the meeting and guidelines for meeting process will be defined. .* • *The agenda and meeting materials will be reviewed. .* • *Integrated Planning Steering Committee members will be introduced and goals/progress of the committee will be reviewed.*

Everyone was welcomed to the meeting then there was a moment of silence expressed for people living with HIV, people who have passed with HIV, and all the providers and planners working to fight HIV. The microphone was passed around the room and integrated planning group members and community guest people introduced themselves.
The Co-chair reviewed the materials in the meeting packet, the agenda, and the objectives for today's meeting with attendees, explaining how those activities and objectives were relevant to integrated planning and ultimately to development of the integrated plan. She noted that the Integrated Steering Committee had reviewed the evaluations from the August and October meetings. There seems to still be some lack of clarity on the part of some members on the value of the regional panel discussions, some of the presentations, and the breakout discussions and how all those are facilitating integrated planning. Overall, the evaluations were positive and continue to improve and the steering committee feels we are moving in the right direction in terms of modifications that were made to the agenda, the format and length of the presentations, and the regional breakout discussions. We certainly feel we have made tremendous strides since the first meeting of this calendar year, so the steering committee plans to continue to review the effectiveness of the meetings and make further changes as needed to ensure we are capturing the input we need for development of the Integrated Plan.
Janet and Jeff informed everyone that the Section had been instructed to plan to have all planning group meetings in 2016 by webinar or methods alternative to face-to-face. This includes meetings of the Ryan White Advisory Group, the Illinois HIV Planning Group, and the Integrated Group. The Steering Committee has discussed this and is recommending that we continue to have quarterly meetings but limit them to 2 ½ hour meetings, keeping the regional panel presentations and other presentations as well as time for input, questions, and answers after each presentation. There will still be a Public Comment Period on the agenda since we are bound to do so by the Open Meetings Act. We will not be continuing the roundtable breakout discussions, but we will be looking to develop a discussion board that we can keep up after each meeting for participant discussion and input on agenda items. People will be able to register for the webinars with a registration link we provide them and participate in the webinars from their homes or work. There was also a suggestion that we try to identify some regional sites that might host the webinars in case people in that region want to join others and participate together, thereby fostering that regional collaboration and partnership we have begun to build over the last year. Janet and Marleigh will be working with the care and prevention lead agents to identify those sites and will pass that information on as available. Janet and Jeff said that we need to make the best of the situation and look at it in a positive light – perhaps we will be able to build new partnerships and engage people into our planning process that routinely have not been able to participate for one reason or another –e.g. consumers in rural regions, and perhaps we might get people who may feel uncomfortable speaking up at face-to-face meetings to provide input electronically in a webinar format. Janet said that meeting materials and meeting surveys would all be downloadable from the ILHPG website before or after the meeting and that we would be moving to an electronic meeting survey format. She also said we would be looking to develop other opportunities for community input via electronic means – e.g., Survey Monkey, etc. Janet also said that if we have an HIV/STD Conference in 2016, we will certainly plan on having a face-to-face meeting in conjunction with the conference. In that case, the conference planners have an agreement in place with the hotel so we could potentially use that agreement to get meeting space.
Comments:
Members expressed their feelings on the value and need for face-to-face meetings in HIV planning and expressed deep sorry that we were moving away from our face-to-face meetings and asked if there was a possibility this decision would be reversed or if there could be a compromise – maybe every other meeting face-to-face. Members expressed how far we had come this year in breaking down the silos between prevention and care and in building bridges. They expressed that this will damage all the progress that has been made. They also expressed they feared this would limit

community input into HIV planning and put up barriers to HIV prevention and care.
Janet and Jeff said that at this time this is the direction we have been given. It's uncertain if this will change later in 2016.We still have funds for HIV planning but without the ability to enter into agreements with hotels for lodging and meeting space large enough for our memberships and without the ability to reimburse members for travel to meetings, we can't have the face-to-face meetings.
A member expressed concern related to the quality and the effectiveness of webinar meetings. She stated that we all know people easily become distracted on webinars. Janet commented that she understood and had actually assessed the attentiveness of members' webinar participation on past webinars. The range of attentiveness is extreme with a median range of 40-60. She had expressed that concern as well to IDPH leadership. The member then expressed concern about our ability to get input from frontline workers.
A member expressed concern that community advocacy efforts especially in areas such as intimate partner violence, sexual and reproductive health, and decriminalization of HIV would be diminished. He said we may need to consider forming a task force or affinity groups to gather more community input.
Janet said at this time we will plan on having quarterly meetings. A proposed meeting schedule was provided in the packet. The first two meetings of the year will be in March and May, so that we can use information gathered from those meetings as input into the Integrated Plan that the Section needs to have finalized for internal IDPH review by June. We will then plan on having an August and December meeting, and perhaps the face-to-face October meeting.
Janet and Jeff mentioned also that since we cannot plan on a large face-to-face meeting in Regions 8 and 4 to solicit more input and involve our Parts A, C, D, and F grantees and our CDC-directly-funded prevention partners further in our integrated plan development, they had talked with CDPH and are planning to attend as many town halls in the Chicago area in early 2016 as possible to contribute and gather input from those entities. CDPH has also agreed to collaborate with us on their plan development and to provide us with results from their past needs assessment activities.
***Action Item:** Janet asked Tina Markovich if she could make IDPH aware of needs assessments results we could collect and integrated plan activities for the St. Louis TGA in which we might be able to participate. She agreed.*

Overview of 2020 Updated NHAS, Connection to Integrated Plan, Plan Development, & 6 Primary Prevention Aims	8:15-8:45 am	Integrated Steering Committee Co-Chairs	*Participants will gain knowledge and understanding of the updated NHAS goals, 6 primary prevention aims, and their connection to the Integrated Plan development.*
Interactive questions/discussion/input	8:45-9 am		

Jeffrey Maras provided an overview of the updated 2020 National HIV AIDS Strategy goals, priorities, and outcomes benchmarks and how that guidance impacts the work we are doing in terms of our integrated planning process and development of the Integrated Plan. He also spoke about the six primary prevention aims on which the HIV Section has agreed to focus and prioritize.
Comments:
We need to rally PLWH to become more engaged in planning, policy development, etc. As we are scaling planning bodies back, we need the voices of the community to play an intricate role.
We as providers have a responsibility of educating and advocating, but also need to arm our consumers with this responsibility for themselves.
We should collaborate with Planned Parenthood and other providers in terms of providing trauma informed care, FIMR - Not only providing treatment and education to those pregnant and infected but also providing this preventative information before they are infected, filling these gaps and opportunities.

Regional provider panel discussion:	9-10:00 am	• Marcy Ashby, SIU School of Med., HIV Care Project Director; • Joan Stevens-Thome, Sangamon CHD, HIV Prevention Lead Agent; • Cheryl Ward, IDPH HIV Surveillance Administrator; • Martin Brady, Case manager; • Jonna Cooley, Phoenix Center; • Don Hunt, Sangamon CHD, DIS Worker; • Terry Beard, Peer navigator	*This presentation and discussion will enhance knowledge, understanding, and engagement of members/stakeholders in HIV care and prevention service delivery, planning and related issues, by fostering collaborative discussions with regional prevention and care representatives; looking at the regional scene and Cascade, discussing successes, accomplishments, challenges, and opportunities in advancing the Gardner Cascade and achieving the goals of the NHAS: reducing incidence, increasing linkage to and retention in care, reducing health disparities, improving health outcomes, and viral suppression.*
Questions/discussion/input	10-10:15 am	Full group	

There was a Region 3 panel presentation including a review of the region's HIV epidemiological trends and the region specific Continuum of Care LTC, RRC, and viral suppression rates. The HIV prevention and care lead agents presented on the clients they are serving, the services they provide, and their successes, challenges, and how they are dealing with those challenges, including care-prevention collaborations. Specifically, one of the Ryan White case managers, an LGBT prevention provider, and the regional peer navigator presented and spoke on their activities and progress made.
Comments:
There was discussion about doctors at the biggest medical clinic in the area not always being willing to accept Medicaid clients. A nurse of one of the infectious diseases providers from that clinic spoke up and said she thought the physicians in her area did accept Medicaid clients. There was also discussion about a lack of dental providers willing to accept Medicaid. Then there was discussion about the lack of buy-in from physicians in general on PrEP. There remains a great need for provider education in the area. It was suggested that MATEC collaborate with the Primary Health Care Association to educate primary care providers.

Break	10:15-10:30 am	Full group	
Summary of Needs Assessment Results & Recommendations: Integrated Meeting Breakout Discussions, Engagement Mtgs, Focus Groups, MSM of Color Workgroup, Client Satisfaction and Provider Surveys	10:30-11:15 am	Integrated Steering Committee Co-Chairs	*Members will be provided with a summary of input and suggestions received from this group and in previous needs assessment analyses that may be useful in development of the Integrated Plan.*
Questions/discussion/input	11:15-11:30 am	Full group	
Janet provided a detailed summary of the many needs assessment activities the ILHPG, the RW Advisory Group, and the Integrated Group have either initiated, conducted, reviewed, or evaluated since 2012 including: *Eight Regional HIV Strategy Stakeholder Engagement Meetings* *Eight Regional HIV Focus Groups of Risk Groups* *RW Client Satisfaction Surveys* *HIC Care and Prevention Provider Surveys* *MSM of Color Townhall and Work Group* *YRBS, Youth Analysis of Literature Review, Seminar and Surveys* *Integrated Planning Meeting Breakout Discussions –broken into themes and areas* *Janet said that these summaries should help guide the next breakout discussions that will now focus on solutions and potential strategies. The below instructions were reviewed prior to the breakout discussions. Groups were told that they had 15 minutes for brainstorming and prioritization of recommendations for each identified need.*			
Small Breakout Group Interactive questions/discussion/input	11:30-12:15 pm	Full group	**Instructions:** Below are three HIV care and prevention gaps and barriers that have been identified through the breakout discussions of this group in 2015. Three more will be discussed after our lunch break. -You have been given examples of some comments related to these gaps and barriers that have been compiled from previous breakout discussions. You are then asked to brainstorm at your table to discuss and identify possible solutions to address the problems. These can be state-level, region or provider level, or involve collaborations with other stakeholders. -The facilitator at each table will record suggestions from the brainstorming. Then each group will be asked to come to a consensus on its top 3 recommendations. -Note: The groups should strive to develop recommendations that are realistic, within our collective ability to influence/control, and are achievable. These recommendations will be compiled, summarized, and taken into consideration when developing strategies and activities to meet the goals and objectives identified in the 2017-2021 Integrated HIV Care and Prevention Plan. 1. Need: **Transportation necessary to access prevention and care services** Client-level Gap/Barrier: **Multiple issues with transportation to care and prevention services** –funding, availability of providers, issues in rural areas, accessibility, etc. Strategies/Solutions: a. State-level: b. Regional and/or provider level: c. Those that may involve collaborations with other stakeholder agencies: Top 3 Recommendations: 2. Need: **Increased Access to Housing and Housing Assistance to Retain PLWH in Care.** Client-level Gap/Barrier: **Issues with Housing and Housing Assistance -** Lack of affordable, available and accessible housing; limitations of housing assistance; lack of or limited housing for ex-offenders Strategies/Solutions: a. State-level: b. Regional and/or provider level: c. Those that may involve collaborations with other stakeholder agencies: Top 3 Recommendations:

			3. Need: **Increased Knowledge about Public/Private Insurance** Client and Provider-level Gap/Barrier: **Issues with Public and Private Insurance Systems for Prevention and Care Services** - Lack of education and knowledge about insurance systems; availability of services and providers, selecting providers; navigating the systems, knowing which services are covered by insurers; billing for services, etc. Strategies/Solutions: a. State-level: b. Regional and/or provider level: c. Those that may involve collaborations with other stakeholder agencies: Top 3 Recommendations:
Working Lunch	12:15-1 pm	Full group	
Small Breakout Group Interactive questions/discussion/input	1-1:45 pm	Full group	**Continuation of Breakout discussions:** 4. Need: **Culturally competent/sensitive HIV/STD providers and services** Service Provider Gap/Barrier: **Limited availability of culturally competent and sensitive providers in all regions**- Insurance carriers restricting available providers may result in providers not trained and sensitive to needs of PLWH and populations at high risk of HIV (i.e., MSM, specific racial/ethnic groups, transgender, IDUs, etc.), Limited trainings, Providers not mandated to attend trainings, etc. Strategies/Solutions: a. State-level: b. Regional and/or provider level: c. Those that may involve collaborations with other stakeholder agencies: Top 3 Recommendations: 5. Need: **Enhanced collaboration and integration across HIV/STD prevention and care programs** Program Barrier: **Lack of, limited or inconsistent communication, collaboration, and coordination between Prevention and Care programs and providers and across all programs** –Care not knowing Prevention scopes that impact care providers and clients; Prevention and care may not always communicate or collaborate on program initiatives or decisions that impact each other; Prevention providers who are doing more prevention for positives interventions are concerned about duplicating or overlapping care services, etc. Strategies/Solutions: a. State-level: b. Regional and/or provider level: c. Those that may involve collaborations with other stakeholder agencies: Top 3 Recommendations: 6. Need: **Statewide implementation of PrEP** Program Barrier: **Limited implementation of PrEP:** Limited PrEP education for at risk consumers and PLWH (for their partners); Lack of institutionalized statewide process for state and regional programs to make referrals and help clients enroll in PrEP, etc. Strategies/Solutions: a. State-level: b. Regional and/or provider level: c. Those that may involve collaborations with other stakeholder agencies: Top 3 Recommendations:
Provide Overview of Integrated Plan draft, activities planned and input still needed	1:45-2:15 pm	Mary McGonigel, Consultant; Committee Co-chairs	*Participants will be informed, discuss, provide feedback on initial draft of the Integrated Plan and any deficiencies/weaknesses in processes still needed for development of the plan.*

Questions/discussion/input	2:15 - 2:30 pm	Full group	
Mary provided a comprehensive overview of what we have done so far in terms of compiling the draft Integrated Plan. We have completed the majority of our needs assessment activities. We still need to collect needs assessment results from the Chicago EMA and the St. Louis TGA. We will be working with them to get their data. We will now be focusing on development of the plan itself. Each of the programs in the HIV Section will be defining program-specific objectives, strategies, and activities to meet the goals of the Integrated Plan, which align with the updated 2020 NHAS. Janet will be incorporating specific activities for the planning groups. **Comments:** Michael Gaines stated that we should not only look at including IDOC in our activities but also county jails because of the numbers of persons and the STI rates. CAHISC needs IDPH prevention representation, Jeff is currently the only IDPH representation. CAHISC forgets there is actually a separate Prevention unit. It was recommended that we reconsider the needs that have been neglected in the past- transgender being taken out of the MSM risk, women and reproductive health, etc. We need to bring information from CAHISC and the St. Louis Planning Council to our plan. CDPH should be involved in these meetings as well.			
Update on IL Gardner Cascade and Accomplishments of NHAS Goals	2:30-3 pm	Cheryl Ward, IDPH HIV Section, Surveillance Administrator	*Participants will be informed, discuss, provide input on updated Illinois HIV Care Continuum, state progress in meeting the NHAS goals/indicators, and plans to meet 2020 goals/indicators.*
Questions/discussion/input	3-3:15 pm	Full group	
Cheryl provided an in-depth overview of the current Illinois Continuum of Car, including where Illinois is at in meeting the current NHAS goals and benchmarks. We estimate that 14% of the PLWH are not yet diagnosed and that of those diagnosed and in care, 44% are virally suppressed. We have work to be done.			
Public comment/ /community input/discussion	3:15-3:30 pm	Full group	*An opportunity for public comment/ community input relevant to HIV care/ prevention planning.* *Results-Oriented Comments/ /Input:* *Based on today's presentations/discussion of issues, what other recommendations do you have for advancing integrated planning and development of the Joint HIV Plan:* • *Where are we now?* • *Where do we want to be?* • *How and what do we need to do to get there?*
Public Comment request: *Brian Drummond, a reentry case manager for the Austin Health Center in Cook County asked to be recognized for public comment. He said that he wanted to ensure the reentry population stays on the radar. We need to empower that population to take and use the information we give them to improve their health outcomes and reduce health disparities within that community. Brian mentioned a peer-led, peer-driven HIV positive support group that he is aware of – Returning Citizens. It is composed of men and women ages 25-65. Through its efforts, the participants have been able to increase their viral suppression rate and retention in care rates. The key is that the members take ownership of the group. It becomes a psychologically safe environment and the individuals open up and are able to focus on practicing wellness and pro-social behavior.* *Janet asked the group to identify some take-away messages from this meeting so that we could see how the content and purpose of this meeting are relevant to what we are doing or could be doing at the state and local in terms of integrated planning and the NHAS.* ***Comments:*** *We have to ensure that agencies are utilizing this information for planning and for bridging the gaps between prevention and care. Prevention and Care may have a lot of the same ideas but have different policies that change the way it is carried out. CDC and HRSA guidelines sometimes don't parallel each other and instead create a burden to collaboration. Continued collaboration with decision making and through policy implementation is needed. Sometimes wrinkles restrict our working together or succeeding so we have to continue to work together to address those challenges. This is an opportunity for us to identify key findings from the data and the needs assessment results. How can we use this information? Now is the time for planning group member, client reps and peer navigators to communicate this information to their communities to discuss hat the data shows and why is this happening and what can we do to address it. Why are PLWH not taking meds, why are they not in care, etc. There is a tremendous opportunity for continued advocacy by the planning bodies.* *This process has worked. This integrated planning process demonstrates how well two groups can work together to come to reasonable consensus and for a common goal. We have worked well together. The member expressed being very emotional about the decision to go to web-based meetings. "My success in HIV planning and programming is due to the connections I have made at these meetings. I'm grieving for the loss of our face-to-face meetings".*			
Wrap Up and Adjournment	3:30 pm	Full group	
The meeting was formally adjourned.			