Illinois HIV Integrated Planning Council (IHIPC) Webinar Meeting Minutes
February 15, 2018, 9:30 am – 12:00 pm

9:30 am: Welcome; introduce co-chairs and facilitators, acknowledge moment of silence

The Co-chair welcomed everyone to the first meeting of 2018 and the first meeting of the newly formed Illinois HIV Integrated Planning Council (IHIPC). The facilitator and presenters were introduced and a moment of silence was held in recognition of people past and present living with HIV, people at high risk for HIV infection, and all people working to reduce new infections and improve the quality of life for PLWH.

9:35 am: Meeting process; Attendance; Announcements; Updates (10 minutes)

- Meeting process, meeting survey, online discussion board instructions
- Roll call attendance of voting members, announcement of non-voting members and others, including those participating remotely
- Review of agenda, meeting objectives, IHIPC purpose
- Announcements

The Co-chair reviewed instructions for the webinar, the meeting survey, and online discussion board, and took roll call of voting members. The agenda, objectives for today's meeting, and their relationship to the purpose of the IHIPC were reviewed with all.

The Co-chair announced that the first newsletter of the new IHIPC group would be released in early spring.

9:45 am: Introduction of 2018 IHIPC Membership and Demographic/Expertise Breakdown - (15 minutes)
Janet Nuss, IHIPC Coordinator/IDPH Co-chair

The Co-chair provided an overview analysis of the new voting membership of the IHIPC by demographic characteristics, community and risk group affiliation, skills and areas of expertise, and region. She noted that we were able to meet all of the goals we had set for our membership in terms of experience, community affiliation, and PLWH and risk group representation. We were able to meet most of our demographic goals, including youth representation; however, would like to have more representation from blacks, Hispanics, and from Regions 1 and 6. That will be a priority for our next recruitment and selection cycle.

The Co-chair noted that one of our selected voting members had to leave the group and has been replaced by Joan Stevens-Thome, one of the three at-large members. We also were able to add Stephanie Frank, an appointed voting member representing the IL Dept. of Human Services Division of Alcohol and Substance Abuse (DASA), to our planning group.

The floor was opened for questions and comments, but none were received.

10:00 am: Brief Update on 2018 IHIPC Needs Assessment Activities – (10 minutes)
Janet Nuss, IHIPC Coordinator/IDPH Co-chair

The Co-chair provided an overview of upcoming timelines for member training and documentation requirements, upcoming meetings on our calendar and their planned content, and an overview of upcoming timelines for establishment of committees and selection of committee co-chairs and IHIPC leadership.

The IHIPC website is in the process of final development. Once completed, Scott Fletcher will develop a tutorial that will instruct members on how to navigate the website and on the content stored there. Ant member who needs assistance with the webinar application should contact Scott who will provide one-on-one instruction.

The Co-chair provided an update on plans for 2018-2020 needs assessment activities. The final development of protocols and discussion guides for the needs assessment portion of the planned regional engagement meetings and the focus groups with special risk population groups is on hold until we receive a summary of the results from the Getting to Zero (GTZ) town halls, focus groups, and surveys, which should be early to mid-summer. The Needs Assessment Workgroup will then reconvene to review the results and determine what our areas of needs assessment focus should be. The plan is to conduct the regional meetings in early 2018.

We updated a previously used youth survey tool and protocol for HIV focus groups to include more questions re: drug use, knowledge, and related risk behaviors. The protocol includes providing some health education but also facilitating discussion about current awareness and risk behaviors among youth. We are wanting to conduct these in juvenile justice detention centers and have had some preliminary conversation indirectly with a few local health departments that already provide services at their juvenile justice centers. They believe the centers would welcome us conducting the surveys and focus groups. As soon as the Epi/Needs Assessment Committee is established, we will have them review, provide feedback, and approve the documents before we initiate formal discussion with the juvenile justice centers.

The floor was opened for questions and comments.

C: L. Choat commented that the HIV Epi Training for members was very well done. She complimented C. Ward.

The Co-chair apologized. She said that she had neglected to have Eduardo Alvarado, the HIV Section Chief, make some opening comments to the group, as he had requested. She gave him the floor.

E. Alvarado stated that he was very excited about the start of the new integrated planning group. He believes that 2018 will be a very productive year. He referenced the importance of the GTZ framework and achieving "functional zero" new HIV infections by 2027. He knows that this group will be a conduit to the HIV Section and to the community in helping to make that happen.

10:10 am: Overview: IHIPC Committees, Functions, Draft Objectives, and Member Expectations – (20 min)

Janet Nuss, IHIPC Coordinator/IDPH Co-chair

– Questions & Answers, Discussion, Input – (10 minutes)

The Co-chair provided an overview of the IHIPC Committees, their focus areas and functions, and their objectives for 2018. She also provided an overview of the expectations for members' participation on their assigned committees. She realizes some of this was covered in new member orientation, but new members were provided with a lot of new information, so a refresher is beneficial. It is also important that our community stakeholders have an understanding of the work that happens within the IHIPC committees. The committees work collectively to enable the IHIPC to meet its objectives which are all in alignment with the National HIV/AIDS Strategy goals, the GTZ Framework, raising the bars on the HIV care Continuum, and meeting federal program and legislative guidance.

The floor was opened for questions and comments, but none were received.

10:40 am: Overview: Illinois HIV and STD Epidemic Overviews-- (60 minutes)

Cheryl Ward, IDPH HIV Surveillance Administrator; Lesli Choat, IDPH STD Coordinator

– Questions & Answers, Discussion, Input – (10 minutes)

STD Update:
L. Choat, the IDPH STD Section Coordinator, presented on the STD epidemic nationally and in Illinois. She spoke about the four national STD priorities: adolescents and young adult, MSM, monitoring the emergence of antibiotic-resistant Gonorrhea (Ng), and eliminating congenital syphilis (which is on the rise). She noted that there continue to be significant disparities among ethnic minorities in both the adolescent and young adult and the MSM populations. From 2015 to 2016, there was a large increase in the rates of chlamydia (4.7% ↑), gonorrhea (18.5%↑), syphilis (17.6%↑), and congenital syphilis (27.6%↑) in the U.S. The rates for reported chlamydia, gonorrhea, and syphilis cases in Illinois are actually above the national rates. In Illinois in 2016, among the primary and secondary syphilis cases in MSM, 53% were co-infected with HIV where HIV status was known. This data highly demonstrates the need for PrEP in the MSM population.

L. Choat spoke about some of the barriers to combating the STD epidemic (budget cuts, limited resources, healthcare access, patient co-pays, reduced hours and staff in STD clinics, etc.). She also addressed what providers could do in terms of talk (routinizing sexual history taking), test (screening), and treat (including offering partner services). She spoke about initiatives the health departments are currently undertaking and could be doing more of if funding and resources were available- educating providers, partnering with HIV care and prevention programs, working with school health centers and maternal child health programs, increasing screening, and improving surveillance. She also spoke about the importance of Expedited Partner Therapy (EPT) for chlamydia and gonorrhea, something that despite having being legalized, it is underutilized in Illinois. She spoke about the importance of extra-genital testing for gonorrhea and chlamydia in MSM as a method to curb the high rates of STD infection in the U.S. We miss an astounding number of infections with genital-only testing.

The floor was opened for questions and comments.

Q: Is the gender imbalance in chlamydia (greater in females) because females are targeted for testing more than males?
A: Yes, partly. Females are targeted for testing because they suffer more symptoms and sequelae, but also because females are at a higher risk, especially younger females, due to their genital physiology.
Q: There was a question about the large number of syphilis cases among MSM.
A: In the early 90s, syphilis was about 50/50 female and male. We saw a big increase among men, especially among MSM in the late 90s, while case among females remained stable. Not really sure what accounted for the change.
Q: Have we implemented any new interventions targeted to transgender and gay men to combat syphilis?
A: The STD Section currently has a project with Howard Brown health to provide syphilis partner services. The STD clinics at the local health departments (LHDs) also provide these services. More education with primary care providers is needed to combat this epidemic.
Q: Can the availability of rectal and oral testing and funding for gonorrhea and chlamydia be expanded?
A: The STD Section has done that on a small scale. LHDs with "S" or "K" in their provider codes are able to provide that now. We are about to roll out Phase 2 in which STD clinics will have the ability to provide extra-genital testing to clients who identity an extra-genital exposure. Expanding this service stays on our radar.
C: The Co-chair and others thanked L. Choat for her presentation and the great work she does.

HIV Update:
C. Ward, the IDPH HIV Surveillance Administrator provided an update on the HIV epidemic in Illinois, presenting data for the state except for the city of Chicago and city of Chicago data only, highlighting similarities and differences. Illinois still ranks 6th among all states in terms of ranking, but our total number of new HIV diagnoses decreased from 1,728 in 2014 to 1,472 in 2015. On average, over the last 10 years, Illinois has had an average of 1,700 new diagnoses per year with an average annual percentage change (APC) decrease of 2.5%. HIV diagnoses have decreased among males and females in Chicago as well as Illinois excluding Chicago; however, the number of new diagnoses has remained higher in Chicago than the rest of Illinois. From 2007-2016, the average APC of new diagnoses in Illinois excluding Chicago and only Chicago remained stable for Hispanics and decreased for both whites and blacks; however, the decreases for whites were greater.

Cheryl provided some examples of HIV epidemiological disparities:

- In 2016, the rate of new HIV infection in African Americans in IL excluding Chicago was over 2 times that of Hispanics and 11 times that of whites. In Chicago, the rate in African Americans was 2 times that of Hispanics and 4 times that of whites.
- The estimated rate of new HIV infections for African American males in Illinois excluding Chicago was more than 10 times that of white men and double that of Hispanic men, while the estimated rate of new HIV infections for African American females was more than 8 times that of Hispanic women and 14 times that of white women. In Chicago, the estimated rate of new HIV diagnoses for African American males was more than double that of white and Hispanic men, while the estimated rate of new diagnoses for African American females was more than 5 times that of Hispanic females and nearly 20 times that of white women.
- From 2007-2016, in Illinois excluding Chicago, there was an average APR 2.89 % increase in new HIV diagnoses among 20-24 year olds, while the APC of new cases among those 60+ years of age remained stable and the APC decreased among those 30-39 and 40-49 years of age.
- In Illinois inclusive of Chicago, the largest APC decrease in new HIV diagnoses was seen among People who inject drugs (PWID).

Summary of Findings:

- Over the last 10 years, Illinois has seen a significant decrease (from 33% in 2007 to 26% in 2016) in the number of new HIV cases that were late diagnoses. Of the HIV late diagnoses between 2012 and 2016, 31% were Hispanics, 43% were over the age of 50, 37% were 40-49 years of age, 47% were heterosexuals.
- In recent years, Illinois has seen an increase in our estimated rate of Linkage to Care within 1 month of diagnosis (from 65% in 2012 to nearly 81% in 2016.).
- Between 2014 and 2016, Illinois has seen a slight decline in our rates of engagement in care (1 CD4 and/or viral load in a 1 year period), retention in care (2 CD4 and/or viral load in a 1 month period at least 3 months apart), and viral suppression (VL≤200 copies/mL). Blacks were less likely to be retained in care and had lower rates of viral suppression than whites, Hispanics, and Asians.

The floor was opened for questions and comments.

Q: Are we able to get HIV epidemiological information specifically on the transgender population and is there a transgender-specific care continuum available?
A: The numbers for the transgender population are small which makes breaking that data out even further less usable. Dr. Ma will be preparing updated regional Care Continuum charts. Those should be used by the regions to drive planning and resource allocation to effect changes on the Care Continuum where needed.
C: There was discussion about the reasons behind the decline in the rates of engagement and retention in care and viral suppression. It likely is a combination of people experiencing various barriers to care, patients being lost to follow up, and providers not following up with patients.
C: C. Hicks noted that hundreds of surveillance-based services cases have recently been assigned to providers for follow up and for Partner Services.
Q: Are physicians provided with HIV treatment guidelines?
A: C. Ward stated that the Surveillance Program does not field calls from providers so does not do that. J. Maras stated that the treatment guidelines are made available online and MATEC provides outreach and education to providers statewide. S. Jones from MATEC stated that the providers on its list serve usually work in the HIV field. It is difficult for MATEC to outreach to other providers. There was discussion and a recommendation that the HIV Program and the planning group should further explore how to outreach and educate primary care providers more.
C: The Co-chair and several others thanked C. Ward for her presentation.

11:55 am: Public Comment Period/Parking Lot/Announcements - (10 minutes)

The Co-chair stated that no formal requests for public comment had been received and there had been no items placed on the Parking Lot. The floor was opened for other announcements. None were received.

12:00 pm: Adjourn

The Co-chair formally adjourned the meeting.