Illinois HIV Integrated Planning Council (IHIPC) Webinar Minutes
Thursday, August 15, 2019, 9:30 am – 12:30 pm

9:30 am: Welcome; Introductions; Moment of Silence

The Co-chairs, J. Nuss and M. Benner, welcomed participants to the meeting. Webinar instructions were reviewed, and the IHIPC leadership and the webinar facilitator were introduced. The moment of silence was recognized in honor of all people living with HIV past and present as well as for those working to end HIV in Illinois.

9:35 am: Meeting Process/Instructions

» Take attendance of voting members; Roll call of those not logged on; Brief introduction of new members

M. Andrews-Conrad conducted roll call by recognizing voting and at-large members logged into the meeting. Members who were not logged in were announced and given the opportunity to make their presence known. Although other participants were not announced, it was noted that their attendance was being tracked and recorded.

» Review of agenda, Meeting objectives, IHIPC purpose, Announcements, Updates

The meeting agenda, objectives, purpose of the IHIPC, and the Concurrence Checklist were reviewed. The following announcement and updates were also made:

- Meeting documents are available at the registration link: https://www.regonline.com/August152019ihipcmeeting .
- Meeting surveys can be submitted through August 22. All participants will be emailed the link after the meeting.
- Minutes from the June meetings and all committee meetings have been approved and published on the IHIPC website: http://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg .
- So far in 2019, 51 new community/agency representatives participated in IHIPC webinars/ meetings/ trainings. An additional 60 have been engaged in focus group/ needs assessment activities.
- Member updates: J. Calderon is no longer an at-large member.
- The Summer issue of the IHIPC newsletter is in the process of being reviewed and receiving approval from IDPH Communications for posting.
- IHIPC voting and at-large members were made aware of two upcoming, required trainings: High Impact Prevention: 2020 Strategies and Interventions and HIV Care Interventions: Models and Best Practices Training. Once released, trainings must be completed by October 20th .
- The Regional Community Engagement Meeting schedule was shared.
- Planning for the series of Undoing Racism Trainings for Illinois HIV providers has been finalized and will be conducted in August and September 2019.

9:45 am: 2020 HIV Prevention Grants, Funding, Services: Linkage to Integrated Plan/2020 HIV Prevention Services Regional Gap Analysis/Q&A, Discussion/Input

(**NHAS Goals 1, 2, 3, and 4, Steps of the HIV Care Continuum: All)*

Curt Hicks, HIV Prevention Program Administrator

C. Hicks presented information about the HIV Surveillance and Prevention Program's application and budget for PS18-1802 (CDC funded grant). PS18-1802 Priorities, Strategies, and Outcomes were reviewed. Their alignment with the National HIV/AIDS Strategy was demonstrated (please see presentation slides for more information).

The following changes will be implemented for PS18-1802-funded services in 2020:

- Comprehensive Prevention for Positives: capacity building trainings will be available for Testing Together; new forms will be developed in Provide™ for HIV Navigation Services; and new CDC Partner Services variables will be implemented in Provide™.
- Program Coordination and Service Integration: new forms will be developed in Provide™ for extra genital gonorrhea/ chlamydia testing as well as meningitis vaccinations.
- Evidence-Based Interventions for Highest Risk HIV-Negatives: new, required CDC variables for HIV testing will be implemented in Provide™; and new forms for HIV Navigation Services will be developed in Provide™ .

- Policy Initiatives: an HIV Outbreak Cluster Detection and Response Tabletop exercise will be conducted; insurance billing capacities for Integrated Testing, EBI's, and PrEP & nPEP will be built; non-Ryan White HIV care providers will be sent "report cards" documenting their practice outcomes in linkage to care, retention in care, and viral suppression rates; and automatic, electronic cross-jurisdictional Partner Services referrals will be implemented.
- Changes in the Regional HIV Prevention (RIG) Grant: Regional lead agencies will rebid for the grant through a competitive RFA process in 2020 for 2021; access to an nPEP counseling training and prescriber networks will be built; and harm reduction counseling (new risk assessment, counseling, and materials provision) will be reimbursed at $150 per service, while harm reduction contacts (material provision only) will be reimbursed at $30 per service.

C. Hicks then reviewed the 2020 HIV Prevention Regional Gap Analysis. First, the 2020 budget and funding formula for the RIG grant was reviewed. Because the RIG grant remains in a renewable grant cycle, there has been no change in the amounts awarded to each region from 2018-2020 (please see presentation slides for details).

The presentation continued by explaining how RIG grant activities fill gaps in service that are not fulfilled by other state grants (African American AIDS Response Act, Quality of Life, Direct Grant, etc.). It was explained that in the analysis, each region's HIV incidence proportion by prioritized population (16 categories by transmission category/ race) is compared to services rendered to each prioritized population by other state grants, then any identified gaps per prioritized population are determined to be scopes in the RIG grants. Results of the statewide gap analysis were presented and explained. It was noted that although some prioritized populations have 0% scopes in the RIG grants, RIG providers can still test/ provide services for persons outside of targeted scopes through supplemental services.

Participants were encouraged to voice questions/ discussion:

C: J. Nuss thanked C. Hicks for his presentations, saying that the information was comprehensive and presented in a very understandable way.

C: Thank you for keeping the focus on communities most impacted by HIV. Historically, this has not always happened. It is very reassuring that populations most impacted will be able to access these services. We have a lot of work left to do in deconstructing racist systems and homophobia, so we still have much to strive towards.

A: C. Hicks responded: Thank you and thank you to all HIV providers who work hard to hire community peers and going above and beyond to engage communities. There are a lot of exciting strategies and initiatives taking place in the regions as reported by prevention providers through quarterly reports. Grantees are also doing a great job incorporating CDC campaign messaging, social media, and other advertisements (i.e. billboards) into their work. We will keep doing our best to provide support to and serve populations that have been missed or have not received a fair share of services in the past.

Hearing no more questions, we moved to the next presentation.

10:35 am: Results of Ryan White Part B Client Satisfaction Survey/ Q&A, Discussion/Input (**NHAS Goals 1, 2, 3, and 4, Steps of the HIV Care Continuum: All)*

Jamie Fitzpatrick, IDPH HIV Section ADAP Formulary Specialist

J. Fitzpatrick presented information about the 2019 Ryan White Part B client (RWPB) survey results. This year, there were 612 respondents. The following demographic information of survey participants was shared: gender, age, race ethnicity, current living situation, time since diagnosis, HIV transmission category, and region of residence.

Each respondent was asked to identify which RWPB services they had received and were then asked questions about satisfaction with services. Survey results for the following services were reviewed: case management, outpatient/ ambulatory care, oral health/ dental services, mental health, ADAP/ medication assistance, CHIC/ insurance premium assistance, food/ meal assistance, housing, legal assistance, transportation assistance, and utility assistance. Clients were also asked about PrEP knowledge/ partner use and were given the opportunity to identity services that they wanted more information about. Please see the presentation slides for specific information and satisfaction scores.

Overall, the survey results were favorable. The RWPB program will use survey information to improve programming as needed. They will also be sharing regional results with the Care lead agents for quality assurance purposes.

Participants were encouraged to voice questions/ discussion:

Q: For the question "Has your case manager been able to meet with you outside of the office", does this question account for clients who do not have a need or desire to meet outside of the office?

A: J. Fitzpatrick said: I think that is a good point. Clients could answer wither "yes" or "no" to this question. We can look into rewording this question next year to account for this.

Q: I have a question regarding the condom/needle services. For those that answered that it was difficult for them to access those free services, was there an opportunity to explain why there was difficulty, and what they were?

A: J. Fitzpatrick responded: Clients were able to enter comments into the survey, but there were not comments about this that I recall.

Q: In next years survey, can we add a question about U=U? We are doing a lot to try to educate clients on this in our region. Like the PrEP questions, it would be interesting to assess client knowledge about this.

A: J. Fitzpatrick responded: Yes, we can add a question about U=U to the survey.

J. Fitzpatrick then shared that IDPH is aware of and has continually worked with CVS Specialty Pharmacy to improve pharmacy services. One new initiative that will be taking place very soon is a CVS-implemented ADAP Center of Excellence and corresponding ADAP only telephone line for medication orders. There will be a new telephone number for this line, which will be released to clients and case managers very soon. Clients can still use the old number and will be redirected.

Hearing no more questions, the group was informed that we would have a short 10-minute break and resume promptly at 11 am.

11:00 am: Short 10-minute break

11:10 am: IDPH HIV Corrections Program Update/ Q&A, Discussion/Input (*NHAS Goals 1, 2, 3, and 4, Steps of the HIV Care Continuum: All)*

Michael Gaines, IDPH HIV Corrections Project Coordinator

M. Gaines presented information about the partnership between IDPH and Corrections on a multitude of initiatives. Presentation topics included:

- Surveying of county jails to assess current HIV testing and education for inmates;
- Opt-out testing, rapid testing, and partner notification service policies in Illinois Department of Corrections (IDOC) facilities;
- HIV Peer Education Programs in IDOC facilities;
- Linkage to care, discharge planning, telehealth, and case management services for recently released individuals from IDOC facilities; and
- Summits of Hope: events that are 'one stop' environments for local parolees and probationers (returning citizens) to obtain the necessary skills to move past barriers which may be preventing him/ her from leading a successful life.

Please see the presentation slides for further details on these topics.

Participants were encouraged to voice questions/ discussion:

Q: Regarding the county jail surveys, it was reported that 23 are providing some sort of HIV services, but that was out of the 25 jails that completed the survey, correct? Does this mean that there could be more that we do not know of?

A: M. Gaines responded: Yes, that is correct; not every jail responded to the survey. There are two major barriers to survey participation: some county jails have no internet access so they must be mailed a survey, and it can be difficult for the jail to identify who should complete the survey, especially for small counties with no medical provider. We have worked with IDOC and Sheriff's Departments to try to get the survey out to the right contacts, but it has been difficult. Hopefully more responses will be submitted in the next survey effort.

C: It is interesting that some jails do not have any internet access. That must make it extremely difficult for non-medical staff to access health information/ education.

Q: In order for someone to get credit to for a parole visit at the Summit of Hope, does their parole officer need to be there?

A: M. Gaines responded: No, their specific parole officer does not have to be there. To get credit for a parole visit, the returning citizen must check in with the parole agency upon arrival and then submit a Summit of Hope "worksheet" at the end of their visit to get credit. It is good for returning citizens because they not only meet their parole visit requirement, but they also get credit for meeting assigned mandates (finding housing, finding a job, looking into educational opportunities, etc.)

There were no other questions asked or submitted during the webinar.

Addendum: These questions for M. Gaines were submitted after the webinar:

Q: Of the 20+ % returning citizens living with HIV who don't re-connect to care, what do you suspect are the barriers that result in losing them to care?

A: M. Gaines responded: There are many reasons that a person might not connect to care. First, the program is not always notified of where returning citizen are placed or sent. They might obtain care on their own in this situation, but we cannot know this for sure. Second, some people being released from an IDOC prison might be violated at the gate or be sent to another state prison system. If the program is not aware of this, they cannot be tracked. Lastly, there are some who refuse to be linked to care by IDOC. Before leaving, they are given information about Care Connect and the ADAP hotline.

Q: How long is a person tracked by the program when they don't reconnect to community HIV care?

A: M. Gaines responded: This is dependent on a few variables. If the client can be contacted, they might be tracked 30 day to 6 months, or sometimes even longer depending on the situation. Sometimes, staff resources can change how long clients are tracked and pursued for linkages to care. Each month, the program meets to strategize on ways that effective tracking can be sustained. Parole has allowed the UIC Telemedicine representative to use their database to do some tracking that does not break confidentiality.

Q: Would there be any point in developing a list of these clients who haven't reconnected, let's say 3-6 months after we expected to see them in care and referring them out to SBS providers to try to find?

A: M. Gaines responded: We are actually doing this with UIC Telemedicine and IDOC HIV Peer Program. They are helping us track individuals who have signed a Ryan White consent form and are following up with them to see why they could not make their referral appointment and if they a case manager can help them get a new appointment. This is how we have achieved the 80% tracking level.

Q: Any case that goes without a lab for 12 months will eventually be referred for SBS outreach, but if it would be helpful to refer these cases faster after release if they don't connect to care, it's something that could be considered.

A: M. Gaines responded: This is good information to know. Thank you.

11:45 pm: Review Compiled Strategies from Health Disparities Activity at June meeting

Mike Maginn and Nicole Holmes, IHIPC Epi/Needs Assessment Committee Co-chairs

J. Nuss presented the compiled priority strategies submitted by members and stakeholders who participated in the Health Disparities Activity at the June IHIPC meetings. The steps of the Health Disparities Root Cause Analysis Project completed to date were reviewed, and identified strategies were shared for the following disparities: lower rates of linkage to care among youth/ young adults; lower rates of viral suppression among people of color; and lower rates of PrEP utilization among people of color. Within each disparity, strategies were categorized by the following levels: client/ family, community/ structural; policy/ program; and providers. It was noted that the fifth and final step of the Root Cause Analyses Project is to implement agreed upon recommendations to address health disparities. J. Nuss will be following up with the committees and the HIV Section Administrators to see which of these recommendations they can commit to in the next year.

Participants were encouraged to voice questions/ discussion:

Q: Thanks Janet. The portion addressing youth is quite timely with the recent bill signed by Governor Pritzker last week opening access to PrEP by youth 12 years or older in Illinois.

A: Yes, this is an important announcement. Please note that this law does not go into effect until January 1, 2020.

12:05 pm: Public Comment Period/RECAP (Review, Evaluation, Challenges, Actions, Preview) –

There were no requests submitted for public comment. Participants were asked if they had any additional comments or announcements. None were received.

12:10 pm: Adjourn – Everyone was thanked for their participation, then the meeting was adjourned at 12:10pm.

**Planning Group presentations/discussions are centered on IHIPC functions/processes, the goals/indicators of the National HIV/AIDS Strategy (NHAS), and/or the steps of the HIV Care Continuum.*

**NHAS Goals*

Goal 1 (Reduce New HIV Infections),
Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH),
Goal 3(Reduce HIV-Related Health Disparities);
Goal 4(Achieve a More Coordinated National response to the HIV Epidemic)

** Steps of the HIV Care Continuum:*

Linkage to Care
Engagement in Care
Retention in Care
Antiretroviral Therapy
Viral Suppression

2019 Illinois HIV Integrated Planning Council (IHIPC) Voting Log: August 15, 2019 IHIPC

Member Name	Member Type	Date: June 26, 2019, 12:00 pm
		Motion 1: A motion was made by M. Benner at 10:53 am and seconded by J. Nuss at 11:11 am, both on 6/20/19, to adopt the agenda for the August 15, 2019 IHIPC meeting as approved by the Steering Committee. The motion was sent to the full IHIPC at 11:56 am on 6/20/19. Members were given until 12:00 pm on 6/26/19 to submit their votes.
IHIPC Voting Members		
Benner, M.	Voting	Y
Bradley, W.	Voting	X
Charles, J.	Voting	Y
Choat, L.	Voting	Y
Crause, C.	Voting	Y
DeLaFuente, J.	Voting	X
Dispenza, J.	Voting	X
Erdman, J.	Voting	Y
Filicette, J.	Voting	Y
Fletcher, S.	Voting	X
Frank, S.	Voting	Y
Gaines, M.	Voting	Y
Guzman, L.	Voting	X
Hendry, C.	Voting	X
Holmes, N.	Voting	Y
Hoots, C.	Voting	Y
Hunt, D.	Voting	Y
Johnson, R.	Voting	X
Jones, S.	Voting	Y
Laskowski, C.	Voting	Y
Lewis, K.	Voting	Y
Maginn, M.	Voting	Y
Meirick, A.	Voting	X
Meyer, L.	Voting	Y
Nuss, J.	Voting	Y
Olayanju, B.	Voting	Y
Paesani, T.	Voting	Y
Rehrig, S.	Voting	Y
Roeder, L.	Voting	X
Stevens-Thome, J.	Voting	Y
St. Julian, S.	Voting	X
Tucker, C.	Voting	Y

Y: In favor;
N: Opposed;
A: Abstain;
X: Absent or No vote cast/received
TS: temporarily suspended

Williams, M.	Voting	Y
Williamson, M.	Voting	Y
Zamor, S.	Voting	Y
Type of Vote: Hand Count, voice, electronic		**electronic**
Results: Carried/Defeated		**carried**
Results: Vote Count		**25 in favor , 0 opposed, 0 abstentions, 10 members absent or "no vote cast/received"**