Illinois HIV Planning Group (ILHPG) Meeting Minutes

May 12, 2017, 2017, 9:30 am – 12:00 pm

- **9:30 am:** Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence
  The ILHPG Co-chairs, Parliamentarian and Website/Webinar Administrator, and presenters for today's webinar were introduced. The Health Department Co-chair noted that the Community Co-chair was ill and would be participating by phone only. A moment of silence was recognized for all people past and present living with HIV. The leadership of the ILHPG was recognized.
- **9:35 am:** Review formally adopted agenda
  The Co-chair reviewed the agenda for today's meeting, noting the three topics for which there will be presentations, discussion, and votes.
- Webinar process; Attendance; Announcements; Updates
  - Webinar meeting, online meeting survey, and online discussion board instructions
    The Website Administrator provided instructions about webinar conduct, troubleshooting problems, completing the meeting evaluation, and accessing the discussion board that will be posted after the meeting.
  - Announce logged in members and take roll call of other voting members to verify quorum
    Attendance was taken by announcing voting members who had logged onto the webinar, then conducting roll call of other voting members. With 16 of our 22 voting members present, it was verified that we have the quorum of voting members needed in order to conduct business.
  - Review meeting objectives
    The Co-chair reminded members and other stakeholders in attendance of the primary goal of the ILHPG and the importance of community participation to integrated planning and to achieving the four goals of the National HIV/AIDS Strategy. She then reviewed the objectives for today's meeting.
  - Review concurrence checklist
    The Co-chair reminded members about the essential elements of concurrence and that the checklist itself is posted on the ILHPG webinars webpage. She reminded the group of the email correspondence she had sent out to the group notifying them that CDC has informed us that the concurrence letter is no longer associated with health departments' HIV prevention grant applications, but is associated with the Integrated Plan itself. As such, a letter of concurrence with the Plan is not required annually unless there have been major updates to the Plan. That being said, we are continuing with our original plan for face-to-face August 24th Integrated Planning Group and August 25th ILHPG meetings to be held in Springfield. More details will be forthcoming.
  - Announcements
    - Member updates
      New members were reminded to complete the online HIP training available on the ILHPG webinar webpage.
    - 2017 Cumulative voting and non-voting member meeting attendance log
      The updated attendance log will be sent out after today's meeting. Members were instructed to review the log and to make up any meetings for which they can still receive credit by viewing recordings of past meetings (Members are able to receive credit for viewing past meetings as long as no votes occurred at the meetings.).
    - Posted Reports/Updates:
      - Committee, Liaison and Regional Lead Agent, RIG Rep, and IDPH HIV Section reports
        These reports have been posted and are available for viewing and download via the May 12th meeting link on the ILHPG webinar website.
    - Draft IHIPC Bylaws and Procedures
      As was noted on yesterday's Integrated Planning Group meeting, the draft IHIPC Bylaws and Procedures will be posted in mid-May for public comment and review. Our goal is to have all public comments reviewed and considered by the Integrated Planning Steering Committee by its early July meeting so that the final draft can be reviewed by voting members prior to the August meeting, at which time it will be voted upon.
    - 2017 Community Stakeholder Participation

The Co-chair noted that as of 4/14/17, 30 new community/agency representatives (other than voting and regularly-attending non-voting members) have participated in ILHPG/Integrated Planning webinars in 2017. The Co-chair noted that that once yesterday's and today's attendance have been recorded, that number will be close to 50.

- **9:50 am:** Present, Discuss, Vet, **and Vote** on Updates to Recommended Priority Populations for Targeted Prevention Services for 2018

  : *NHAS Goal 1(Reduce New HIV Infection); Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All Steps*

  Marleigh Voigtmann, IDPH HIV Community Planning Graduate Student Intern
  Candi Crause and Mike Maginn, ILHPG Epi/Needs Assessment Committee Co-chairs

  Marleigh Voigtmann, the IDPH HIV Community Planning Intern, presented the recommended 2018 prioritized populations for targeted prevention services on behalf of the ILHPG Epi/NA Committee. Marleigh explained the importance of prioritizing our prevention services. In alignment with CDC's High Impact Prevention concept, prevention services should target at-risk populations bearing he greatest burden of HIV disease and most disproportionately impacted. We strive to have our statewide HIV prevention services reach each priority population and sub-population in proportion to their percentages specified in our prioritization tables. The Epi/NA Committee derived the prioritization tables using IDPH HIV Surveillance data between 2011 and 2015 and using an agreed-upon weighted average of 90% incidence, 5% prevalence, and 5% late diagnoses. Marleigh mentioned that in consideration of our integrated planning, the Epi/NA Committee had discussed and assessed other weighted averages but the committee decided to keep the formula that was highly incidence-weighted in order to focus in on where new infections are occurring.

  The 2018 recommended prioritization table continues to rank MSM, HRH, PWID, and MSM/WID as the prioritized populations, in that ranked order. In comparison to 2017 rankings, the populations experienced the following changes in their 2018 weighted averages: (MSM: increased from 66.3% to 68.0%; HRH decreased from 24.3% to 23.8%; PWID: decreased from 6.0% to 4.8%; and MSM/WID: increased from 3.3% to 3.4%). Among sub-populations, MSM of color all experienced and increase in their weighted prioritization, with Hispanic MSM having the greatest increase (from 12.8% to 14.0%). There were no significant changes in the weighted prioritization of the subpopulations for the HRH category. Overall, all the sub-populations in the PWID category stayed constant or experienced a decrease in their weighted prioritization, but NH Black PWID experienced the greatest decrease (from 2.8% to 2.1%). Within the MSM/WID category, most sub-populations experienced a decrease or remained constant. Only White MSM/WID experienced a slight increase (from 1.6% to 1.8%).

  Marleigh detailed a listing of other recommendations that were derived based on social-determinant data and data demonstrating the disproportionate impact of HIV among certain exposure categories, most especially among sub-populations within each exposure category. These recommendations and points of consideration should be taken into account when identifying service goals and allocating funding for statewide and regional HIV prevention services for disproportionately affected and hard to reach populations such as MSM of color, especially young MSM of color; PLWH, PWID, and transgender persons.

  – Questions & Answers, Discussion, Input, and Vote

  The group was asked to raise their hand on the webinar interface or enter comments or questions for discussion using the Chat feature. There was no discussion so the Co-chair asked if there was a motion to accept the 2018 Prioritized Populations as recommended and presented by the ILHPG Epi/NA Committee?

  Vote: At 10:10 am, a motion was made by Scott Fletcher and seconded by Jeffery Erdman to accept the recommendations as presented. The motion was called for a roll call vote. At 10:15 am, it was announced that the motion passed with 15 members voting in agreement (yes) and 7 members either not present or not casting a vote.

- **10:15 am:** Present, Discuss, Vet, **and Vote** on Recommended Changes to the Prioritized Risk Group definitions for 2018

  : *NHAS Goal 1(Reduce New HIV Infection); Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All Steps*

  Candi Crause and Mike Maginn, ILHPG Epi/Needs Assessment Committee Co-chairs

  Mike Maginn, one of the Co-chairs of the Epi/NA Committee began the presentation by detailing the necessity of defining the highest risk groups so that we can prevent the largest number of new infections with our limited funding and resources. Since 2013, the Epi/NA Committee and IDPH have reviewed the results of in-depth analyses of thousands of HIV testing risk assessment data to determine which factors are most associated with a new sero-positivity of 1.0% or greater. These factors are then included in the risk group definitions. Using these risk group definitions, in 2014-2015, 90% of the testing conducted by RIG and Direct GRF-funded grantees was provided to our prioritized populations and of their newly diagnosed positives, 95% disclosed prioritized risk factors. HIV incidence data shows that only 76.7% of all cases diagnosed reported one of the prioritized risks. That demonstrates the strength of targeted testing.

  The risk group definitions and new factors for consideration are also examined each year. Since testing numbers in 2016 were way down due to the budget impasse, the committee decided not to look at updated testing data this year. This year only one request for changes to the risk group definitions was received: "Re-examine the need to keep "cis-gender female who had ever had anal sex with a male" as a prioritized risk in the HRH definition". The rationale behind this was discussed. The data supported such a prioritization only for transgender females. Also, since a large amount of routine testing provided by IDPH is provided to females, shouldn't our targeted testing more appropriately focus on risk-targeted testing that will enable us to meet our 1.0% new seropositivity benchmark? The committee vetted this request and decided to recommend removal of that risk factor for cis-gender females because: research suggests that 30% of cis-gender women report anal sex, so we are targeting a huge group with low seropositivity by including that risk factor in the definition. Mike then reviewed the recommended updated 2018 risk group definitions in their totality.

Candi Crause, the other Co-chair of the Epi/NA Committee, then explained in detail the vetting process (analysis of incidence and HIV testing data, research findings, cost-benefit analysis, etc.) used by the committee to determine and make recommendations about the risk factors to include in the definitions of the prioritized populations. There are other streams available (routine testing, special funds, third-party reimbursement, etc.) to pay for HIV testing, so with our limited targeted testing funds, we need to focus on testing those defined as at highest risk for HIV infection.

– Questions & Answers, Discussion, Input, and Vote

The group was asked to raise their hand on the webinar interface or enter comments or questions for discussion using the Chat feature.

Question: Scott Fletcher voiced concern about the PWID and MSM/WID definition. There are people who crush their prescribed drugs, mix them with water, and inject them, although they were not prescribed that way. Shouldn't the definition "person who discloses ever injecting non-prescribed drugs" be changed to include "or drugs not as prescribed"? Debbie Knoll and Mike Maginn all voiced that they agreed with that clarification.

The group was asked if there was any more discussion or comments. With none voiced, the Co-chair asked if there was a motion to accept the 2018 Risk Group definitions for the Prioritized Populations as recommended and presented by the ILHPG Epi/NA Committee, with the stipulation of adding "or drugs not as prescribed" to the PWID and MSM/WID definitions?

Vote: At 10:50 am, a motion was made by Jeffery Erdman and seconded by Jill Dispenza to accept the recommendations as presented. The motion was called for a roll call vote. At 10:55 am, it was announced that the motion passed with 16 members voting in agreement (yes) and 6 members either not present or not casting a vote.

- **10:55 am:** Present, Discuss, Vet, **and Vote** on Current and Proposed Changes to HIV Prevention Interventions and Services Guidance for 2018

  : *NHAS Goal 1(Reduce New HIV Infection); Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All Steps*

  Jeffery Erdman and Jill Dispenza, ILHPG Interventions and Services Committee Co-chairs

  Jeffery Erdman and Jill Dispenza, the Co-chairs of the ILHPG Interventions and Services Committee presented the committee's recommended changes in the guidance for 2018. This comprehensive document guides lead agents and service providers in the provision of approved, cost-effective, and behaviorally-effective HIV prevention strategies and interventions that are in alignment with CDC's high impact prevention (HIP) concept. Dr. Charles Collins at CDC was consulted on the recommendations discussed in this presentation. The key changes to the guidance are as follows: 1). Adding Sin Buscar Exvusas (an evidence-based behavioral intervention for Latino MSM); 2). Adding "Stay Connected" (a Linkage-Retention-Re-engagement in Care) intervention; 3). Adding "Meningitis Vaccination for MSM and MSM/WID" to the list of approved public health strategies; 4). Requiring the use of new curricula in several approved behavioral interventions which have been updated to include biomedical/HIP elements; and 5). Requiring the use of the new curriculum for Personalized Cognitive Counseling (PCC), which has been updated to focus on PrEP and episodic drug use among MSM. In addition, the committee is recommending that all service providers new to implementing the interventions with updated curricula should be required to attend the updated training before delivering the intervention and that providers previously trained on the older version of the interventions should be strongly encouraged to attend the revised training, but will still be required to utilize the updated curricula.

  – Questions & Answers, Discussion, Input, and Vote

  The group was asked to raise their hand on the webinar interface or enter comments or questions for discussion using the Chat feature.

  Question: Why are the recommendations for meningitis vaccination limited to MSM? Jill and Jeffery explained that in the Chicago-centered outbreak, MSM were at determined to be at a much greater risk for contracting meningitis, so we would like to focus on and prioritize MSM. There was only one female who became infected in the outbreak.

  The group was asked if there was any more discussion or comments. With none voiced, the Co-chair asked if there was a motion to accept the Changes to the 2018 Prevention Interventions and Services Guidance as recommended and presented by the Interventions and Services Committee?

  Vote: At 11: 20 am, a motion was made by Cynthia Tucker and seconded by Silas Hyzer to accept the recommendations as presented. The motion was called for a roll call vote. At 11:25 am, it was announced that the motion passed with 16 members voting in agreement (yes) and 6 members either not present or not casting a vote.

- Public Comment Period/Parking Lot

  No requests for public comment were received and there were no items left on the Parking Lot.

- **11:30 am:** Adjourn

  Everyone was thanked for their attendance and the meeting was formally adjourned.

: *Planning Group presentations/ discussions are designed to be centered on Planning Group functions/processes and the goals/ indicators of the National HIV/AIDS Strategy (NHAS) and/or the steps of the HIV Care Continuum. This symbol, followed by its description, indicates the focus of the presentation in relation to NHAS or the HIV Care Continuum.*