Illinois HIV Planning Group (ILHPG)/Ryan White Advisory Group Integrated Workshop Minutes
December 14, 2017, 8:30 am -1:30 pm
Memorial Center for Learning and Innovation, 1A Auditorium, 228 West Miller St., Springfield, IL 62702

8:30 am: Welcome; introduce co-chairs and facilitators, acknowledge moment of silence (5 minutes)

Co-chair Janet Nuss welcomed all Integrated Planning Group members and guests to the meeting. Participants were reminded that this meeting was the last meeting of 2017 as well as last integrated meeting of the combined ILHPG/Ryan White Part B Advisory Group before the initiation of the Illinois HIV Integrated Planning Group (IHIPC), effective January 1st. Each participant was asked to introduce themselves by name and agency, including those participating remotely via webinar. Meeting presenters were also introduced. The group then joined in a moment of silent recognizing all those living with HIV past and present and for all those continually working to end the disease in Illinois.

8:35 am: Meeting process; Attendance; Announcements; Updates (15 minutes)

- Meeting process, meeting survey, online discussion board instructions

  Instructions for participants who were participating in-person and remotely were reviewed, and it was noted that the meeting was being recorded and will be available for viewing on the ILHPG website. Participants were notified an active discussion board for post-meeting questions and discussion as well as the online evaluation survey would be available online until December 21st.
- Roll call attendance of voting members, announcement of non-voting members and others, including those participating remotely

  Completed earlier
- Review of agenda and meeting objectives

  Janet reviewed the meeting agenda and meeting objectives. Participants were reminded that all agenda items/objectives for the meeting designated for presentation and discussion align with National HIV/AIDS Strategy goals, the HIV Care Continuum, or the HPG process. All documents and other information regarding the meeting have been posted on the website prior to the meeting. Public comment cards are available in-person and could be submitted prior to the Public Comment time on the agenda. No one has submitted an online Public Comment request.
- Announcements

  Janet mentioned the winter edition of the Integrated Group Quarterly newsletter would soon to be released. The updated 2017 community engagement list, which totaled 63 new engagements in 2017 meetings thus far, was also reported to participants.

8:50 am: Announce 2018 IHIPC Membership, Meeting Schedule, 2018-2021 Timeline, Plan to Form Committees and Select Leadership - (30 minutes)

Janet Nuss, IDPH ILHPG Coordinator, Integrated Planning Group Co-chair

Janet presented a review of the 2018 IHIPC membership recruitment and selection progress. The goal for composition for the group was to identify and elect 27 voting member and 3 at-large members. Recruitment for membership began in September 2017, which resulted in a total of 34 applications received. Information on each applicant was compiled and scored according to criteria identified by the Steering Committee (including epidemiological link, demographic representation such as race/ethnicity and age, expertise, and status/ relationship with HIV positive individuals). Applicants were scored initially by Janet, then secondarily by Lyyti Dudcyck, a long-term member of the ILHPG and Steering Committee who did not plan to apply for

membership. In addition to scoring according to criteria listed above, professional and community representation were also considered in the selection process (see slide 16 in the presentation for these targets).

Janet reported that all of the targeted goals for professional and community representation of our new membership were met as well as targeted goals for regional representation, people living with HIV, risk representation, recruitment of youth, and an even distribution of Care and Prevention representative. It was noted that one goal that was not fully met was representation by race/ ethnicity. We had wanted to select more non-Hispanic Black and Hispanic members, but there were not enough applicants with those demographics. Filling these gaps will be prioritized in the next recruitment cycle.

Names of the selected IHIPC members were then introduced. Janet expressed she believes the membership is a diverse group and she is eager to welcome them in 2018. Appointed voting members were also introduced. Janet also mentioned that the group is still looking for an appointed member from the Department of Healthcare and Family Services. There may be a representative from the agency willing to provide consultation and input as needed as a non-voting liaison but is not able to commit to the expectations of fully voting membership at this time. Janet has reached out to the IL Department of Human Services Division of Alcohol and Substance Abuse (DASA) to inquire about recruitment someone from that division who could represent on the group the state's targeted response to the Illinois opioid epidemic. Most voting and at-large IHIPC members completed new member orientation yesterday.

After the introduction of members, the 2018 IHIPC calendar was reviewed. The calendar was included in the materials for this meeting and is also on the IHIPC website. Members were encouraged to print the calendar and keep it handy for their reference. Activities for 2018 include webinar trainings, in-person meetings (two 2-day meetings), and webinar meetings (four 2 ½ hour meetings). Guests are welcome to attend all activities. There also will be some planned focus groups targeted toward PLWH and/or members of our risk populations. The Steering Committee is working to ensure that 2018 meetings have more time for input and discussions as well as break outs for committee meetings at the in-person meetings. Throughout 2018, the IHIPC will continue to be updated on the Getting to Zero Initiative. As always, meeting documents, presentations, and recording will be made available on the IHIPC website. Presentations will continue to focus on the NHAS goals, the Continuum of Care, and High Impact Prevention Strategies in line with Integrated Planning and HPG Guidance from federal partners.

Janet continued with a brief 5-year timeline for planning group activities, beginning with goals achieved in 2017 regarding preparation and initiation of the IHIPC. IHIPC committees and objectives will be developed and new leadership elected in the first half of 2018. Janet also mentioned that the 5 year plan will continue to be updated annually. We are planning a 2-3 year cycle of needs assessment activities that will begin in 2018. Standing committees of IHIPC include Primary HIV Prevention; Linkage, Retention, Reengagement, Antiretroviral Therapy, and Viral Suppression; Epidemiology/Needs Assessment; and Membership. We want each committee to be composed of both Prevention and Care representatives as the group strives for integration on all planning group levels, including its committees.

Participants were informed of tentative plans for needs assessments to be conducted from 2018-2020. IDPH/IHIPC will be coordinating with regional lead agents to plan for and conduct a series of eight focus groups determined according to regional input and needs. Youth focus groups with pilots in the juvenile justice systems are also being planned. The Evaluation Committee has already developed a youth survey as well as protocol and discussion questions for the youth focus groups. Regional care and prevention lead agents will be planning a community engagement meeting in each region over the next 2 years to educate and coordinate efforts with regional providers and community stakeholders. A portion of these meetings will include a needs assessment section. A draft protocol and questions for this needs assessment section have been developed with input from the ILHPG Evaluation Committee and will be reviewed with participants, soliciting everyone's input, later in the meeting. Information collected and compiled from the Getting to Zero (GTZ) town halls will also be included in the portfolio of needs assessment results that will be presented to the IHIPC and used for development of the next Integrated Plan. Jeff Maras and Curt Hicks mentioned that jointly planning for and participating in the conduct of regional engagement meetings has been written into both the regional Care and Prevention lead agency grants as part of community engagement and integrated planning.

- Questions & Answers, Discussion, Input – (10 minutes)
  There were no questions from participants at this time.

: NHAS 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: All

9:30 am: HIV ER and Hospitalization Visits in Illinois – (20 minutes)

Livia presented a summary of 2008-2014 hospitalization billing data for insurance purposes (includes uninsured data). Four HIV-related billing codes were identified and used for analysis, billing codes for other diseases and illness were also collected. eHARS data was used to determine rates. Livia explained that primary HIV hospitalizations include those individuals where the primary diagnosis/reason for hospitalization was listed as the HIV billing code; whereas, secondary HIV hospitalization is for another reason (ex. heart attack), though HIV is still listed as a later diagnosis.

Livia then posed the following questions to the group: Do you think hospitalization rates are higher among people living with HIV? Yes. How much higher? What disparities occur - age, race, sex? What are the main reasons for their hospitalizations- Is HIV the primary or secondary diagnosis?

Livia presented a bar graph of HIV hospitalizations- The number has declined for both P& S. The hospitalization rates for primary and secondary hospitalizations have declined - primary by 50%. Despite declines over the last 6 years among both HIV visit and Non-HIV visit hospitalization rates, the rates for HIV visit hospitalizations in are still higher than those for non-HIV visits (2.8 times higher in 2008 compared to 2.2 times higher in 2014). HIV remains the highest primary diagnoses. 2nd-4th highest diagnoses are related to mental health, which is predominant in the total population as well but with higher rates among PLWH. The most common associated condition among patients with a Primary HIV hospitalization is pneumonia. Livia then reviewed demographics. The rate of hospitalizations is higher among females living with HIV compared to men living with HIV. Livia noted that although women represent a lower proportion of people living with HIV they continue to be hospitalized at a higher rate. Among race groups, Non-Hispanic Blacks have had the highest rates of hospitalization. Livia noted that although this rate has declined from 2008 to 2014, the disparity has persisted. There has been an overall decrease in the HIV hospitalization rates among all age groups, but the highest rates are among older people, with >= 65 being the highest. This differs for primary HIV hospitalizations. There has been an increase in the average length of stay for primary HIV hospitalizations (7/1 days in 2008 compared to 8.4 days in 2014); whereas, the length of stay for secondary HIV hospitalizations has remained fairly constant (5.2 days in 2008 compared to 5.3 days in 2014).

In terms of Emergency Department (ED) visits data…unlike hospitalization, the number of secondary HIV ED visits rates have increased (11,846 in 2009 compared to 15,896 in 2014). The proportion of HIV ED visits only (those that did not result in a hospitalization) have continued to grow- 53% of HIV ED visits in 2008 compared to 62% in 2014. People with HIV as primary diagnosis who visited the ED were more likely to be hospitalized compared to people with HIV as a secondary diagnosis. Livia explained that if admitted, data was included in hospitalization slides, so the next slides sets were out-patient visits only. The rates are higher for females than males and among non-Hispanic Blacks compared to other race/ethnicities. In terms of age, young people <25 had a large increase in rates of visits from 2009-2014, with the lowest rate of HIV ED visits seen in the >=65 age group. Reasons for HIV ED visits - HIV 3rd highest, other reported conditions include chest pain (1st), abdominal pain (2nd), etc.

In summary, although primary and secondary HIV hospitalizations have declined from 2008-2014, HIV remains the primary reason for hospitalizations among PLWH (approximately 20%). Disparities remain among females and NH Blacks. ED visits have increased, but primary HIV ED visits have declined.

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

Q: Dr. Ma asked if differences in the data for those with an HIV vs. an AIDs diagnoses can be determined.

A. Livia - This was not determined as part of this analysis.

Q: Does the data take incarcerated individuals hospitalized within corrections facilities into consideration?

A: Livia - The data does not account for treatment within a correctional facility, but it does account for incarcerated individuals who were taken to a hospital for treatment. Dr. Ma noted that VA information was also not included. Jeffrey noted that he can work with his team to see if related data from corrections facilities might be available.

Q: Is there evidence that some hospitalizations are occurring due to opioid epidemic? Would the increase seen in respiratory failure diagnoses and youth hospitalizations, etc. support this?

A: Livia - If HIV is the primary diagnosis, no, but it is possible if HIV is the secondary diagnosis. Nationwide data trends have shown that substance-related hospitalization rates have actually gone down. That rate, however, also includes alcohol and other drugs so it is difficult to determine if there has been an increase in opioid-related hospitalizations.

Q: In regards to the hospitalization rates for non-Hispanic Black men going down dramatically in 2010 - could this have been related to ACA? Before ACA, they may not have had access to primary care.

A: Livia - This may be possible, but it is odd that rates decreased dramatically from 2008 to 2010 and then plateaued as the ACA took effect.

Q Was syphilis included as a diagnosis in the data? It would be interesting to see data for co-infected patients.

A: Livia – STIs were not identified as one of the top 15 diagnoses codes for HIV hospitalizations. It is possible to look for STIs in hospitalization data, but that's not the best data source for STI data.

C: Lesli - People usually do not get hospitalized for STIs.

Q: Why was transgender population omitted in the gender charts?

A: Livia - The transgender population in this sample is most likely a very small number, so it would be hard to determine trends among them. IDPH is working to better collect and identify transgender people in data. There is a gender dysphoria billing code, but it is not consistently used.

Q: Can regional hospitalization data be requested?

A: Livia -Yes, it can be requested either by where PWLH were hospitalized or by where they live.

Q: Is Chicago included in the data set?

A: Livia - Yes, it is statewide data.

Q: What is the hospitalization decrease among PLWH most likely attributed to? What can we do collectively to sustain the trend?

A: Livia - In the general population, hospitalization rates are decreasing, but the rate is still higher among PLWH. It cannot be determined with certainty, but there is hope that it is attributed to better access to Prevention and Care. Livia thought that this was a great question to ask back to the group for contemplation and discussion. One project that the surveillance and evaluation teams at IDPH are working on is to find ways to link this data to eHARS data so that CD4 counts, viral loads, and other information can be reviewed for more concrete analysis.

C: Thanks for the presentation. Access to health care is important for all people- both insured and uninsured. As a group, we should also think about how we can ensure that health care is accessible to all in regards to insurance as well as culturally, etc.

Q: Does any of the data reflect Urgent Care Center visits?

A: Livia - Urgent Care Center data was not included in this presentation. Some other data sets that were not utilized in this presentation expand into urgent cares, so it is something to explore in the future.

C: In the RW program, we have seen that utilization of ACA insurance changes the way that some client receive primary care. For uninsured individuals, the emergency department is often used for primary care. RW has observed that ACA insurance selection is lowest among non-Hispanic Black and Hispanic populations.

Q: Can you please share the HIV Hospitalizations and ED Visits fact sheets website?

A: http://dph.illinois.gov/diseases-and-conditions/HIV-Factsheets

Q: I wonder how many hospital visits were related to anti-retroviral side effects? This would be interesting to know so that we could try to help clients optimize their regimens.

A: Livia - That might be difficult to determine as the treatment status would have to be known by the provider and coded as a side effect. Medical Monitoring Project (MMP) data abstractions, which interviews PLWH and then compares the responses to their medical charts, might be a source that could help determine that.

: NHAS *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); Steps of the HIV Care Continuum: All*

10:00 am: Update: Plans for Regional Getting to Zero Town Halls in 2018 – (10 min)
(Speaker TBD), Getting to Zero Initiative

Valerie Johansen presented on Updates to the GTZ plan- initially presented at last meeting. The Framework focuses on increasing PrEP uptake and VL suppression, both by 20%. Based on projections and goals, new HIV infection could functionally be ended in Illinois by 2027 (see graph in presentation).

The GTZ group is now working on initiating community engagement and feedback. Surveys have begun- committees are still growing- invitation to include. The goal of the town halls is to solicit input from a variety of individuals- both professionals and community members – to learn more about community barriers, successes, and assets in prevention in care. Input on integrated health homes as well as integration between City and State will be important discussion factors.

The first town hall was Dec. 13th - 40 participants. There was intimate discussions about housing, normalization of HIV, employment, peer services, and other modes of support for HIV. Transportation, food, and child care were offered to encourage participants to attend. The next town hall is Dec. 16th at Aunt Martha's in Region 8 (Park Forest). The schedule for other regional town halls was also made available. An effort will be made to present town hall meetings in both English and Spanish. Valerie also included information on the GTZ surveys. Valerie asked that we encourage clients and community members to take the survey… (see slide)… She announced that both CDPH and IDPH are supporting U=U, or undectable= untramsmissable. This campaign blends into the GTZ framework. Eduardo noted that support of U=U is also supported by federal partners.

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

Q: Joan- Was transportation and child care utilized at the first town hall meeting?

A: Bash- Child care- no, transportation- yes

Q: Are these being marketed on websites or social media?

A: Information is available on AFC website. IDPH has also posted information on its website and social media pages. Flyers will also be distributed.

Q: Is a Region 6 town hall being planned? It wasn't listed on the slide.

A: Candi - Yes, in January.

C: Cynthia encouraged everyone to join the Basecamp group to receive updates on the GTZ campaign. Interested participants can also contact Sara at AFC for access. Her contact information is in the slide set.

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10:20 am: Integrated Plan Activities Chart: 2017 Progress Report/Update, and Newly Added Activities- (45 minutes)

Janet Nuss, IDPH ILHPG Coordinator, Integrated Planning Group Co-chair

Janet presented a 2017 progress report/update on the Integrated Plan. She reminded participants of the objectives of the plan, which support collaborative approach to HIV prevention, care, and treatment in alignment with NHAS goals.

There are two steps in monitoring implementation of the Integrated Plan. The first step is done through the planning group process. Each year, IDPH informs and reports to the planning group on its HIV Care and Prevention grants, the updated Illinois HIV and STD epidemiologic profiles, care and prevention service delivery, the updated HIV Care Continuum and Illinois progress in achieving the 2020 NHAS Indicators, as well as multiple other data sources that are used to support planning group activities.

As step two, in the fall of each year, IDPH annually reviews and updates its activities chart for all HIV related programs (planning, training, care, prevention, surveillance, etc.). The activities that are included in the chart range from one-time events to long term, continuous activities. Each program area reviews its tasks and activities on a regular basis and annually reports on progress made in each task/activity, modifying and adding new tasks/activities as needed. Janet explained that the planning group is not only one of the program areas included in that report, but that the full report is made available to the planning group and a summary provided to the group... The timeline used for this report is September 2016 – August 2017.

INTEGRATED PLANNING UPDATE: Activities conducted include updates to the HIV and STD epi profiles included in the integrated plan, completion of 6 integrated meetings and 4 ILHPG meetings, engagement of 100+ stakeholders in planning group meetings, analysis of priority populations and approved prevention strategies for inclusion in the integrated plan. All updates to the integrated plan were presented to the Integrated Planning Group throughout the year and summarized at the August 2017 meeting. Social media uptake for education on HIV was conducted through the ILHPG social media pages, and comprehensive HIV sex education was conducted in the 10 ISBE priority school districts.

New activities for inclusion are: increasing IHIPC awareness and education surrounding the opioid epidemic; including representatives of the PWID community in the IHIPC membership; including language in Prevention and Care grants that supports regional needs assessment and stakeholder engagement activities; and initiating plans for regional focus groups and focus groups among incarcerated youth.

TRAINING UPDATE- Has intensified HIV prevention efforts by giving 19 LHD STD Clinics $20,000 PrEP Demonstration Project grants; Has expanded evidence-based approaches to HIV prevention by providing numerous prevention trainings and through its distribution of risk-reduction supplies.

SURVEILLANCE UPDATE: The Surveillance unit has expanded/improved tracking and data sharing by conducting monthly queries for surveillance based services (SBS) case referrals and conducting monthly data matches between eHARS and the RWPB, ADAP/CHIC, and Prevention databases to identify cases not reported to eHARS and to obtain missing information on eHARS cases. Surveillance has also strengthened coordination across data systems by compiling regional and statewide updated HIV Care Continua and Unmet Need Analyses.

New activities for inclusion are: exploring the collection and measurement of community viral load; developing a jurisdiction-wide cluster and outbreak detection and response plan.

CARE UPDATE: Specific activities of each Care Program sub-unit (Corrections, Housing, Medication and Premium Assistance, Case management Services, etc.) were included in the presentation. Across the Care unit, primary activities included ensuring the continuity of high-quality medical care/health care coverage for PLWH through provision of MAP and PAP; facilitating linkage to care/maintenance of PLWH in care/increased adherence to antiretroviral therapy by enrollment into RWPB medical case management, documentation of client care plans and medical appointment attended, provision of treatment adherence counseling, and provision of services by regional retention specialists; promoted evidence-based public health approaches to HIV prevention and care by facilitating 14 trainings to over 325 Ryan White providers; promoted community engagement and leadership opportunities among PLWH by supporting HIV+ peers in the Community Health Worker Program, Peer navigators and Client representatives; strengthened coordination across data systems to improve health outcomes by conducting quality assurance site visits and client chart reviews and by conducting a cross-match of RWPB clients with the eHARS and STI databases to determine clients in care with recent STIs and to get updated CD4 and viral load results on matched clients.

PERINATAL PREVENTION: UPDATE: Intensified HIV prevention and care efforts among the perinatal population – In this time period, 109 HIV positive women delivered infants, 84 of which received enhanced perinatal case management; 100% of the infants born to these 84 women received HIV medication postnatally; Only one new HIV+ infant was identified during this time period and was immediately linked to care.

PREVENTION UPDATE: Intensified HIV prevention efforts in hardest hit areas and populations by delivering **risk targeted prevention services** – increasing the percentage of services provided to transgender individuals, increasing the number of programs providing prevention for high-risk young MSM, providing HIV partner services; providing effective behavioral and biomedical interventions – 4,758 for prioritized high risk negatives and 4,544 for PLWH; increasing the proportion of approved effective/cost-effective risk reductions activities for high-risk positives to 47% and that for high-risk negatives to 6%. Other prevention activities include maintenance of the HIV/ STD hotlines, referrals of newly diagnosed individuals to Ryan White part B case management, routine testing, surveillance-based services for diagnosed people of out of care, newly diagnosed individuals, and STI co-infected individuals. The POP anti-stigma campaign and the facilitation to linkage to care, and reimbursement through third part billing for HIV testing also remain continuous activities in the prevention unit.

New activities for inclusion are: using Partner Services to facilitate cluster investigation and intervention and to prioritize the referrals of SBS cases with unsuppressed viral loads.

HIV SECTION UPDATE: Supporting the Getting to Zero Initiative explained in the previous presentations was added as a task/activity in the Activities Chart for which we will monitor implementation.

– Questions & Answers, Discussion, Input - (15 minutes)

Q: In regards to education and training on PrEP and Medication Adherence, have there been opportunities for clients and high-risk individuals?

A: Jeff- MATEC is developing a consumer based training. IDPH has also partnered with many others to provide provider trainings. Updates on these trainings for 2018 should be available before the end of March 2018.

Q: Chris: Is there an update on Medical Benefits Management?

A: Jeff - Yes, almost all regions have hired 1-5 medical benefit coordinators. All MBMs are trained in regulations upheld by the State so that they can appropriately assist clients in navigating the Affordable Care Act.

C: Lesli noted that Fetal Infant Mortality Reviews (FIMR) include congenital syphilis. CDC recently awarded nine grants to jurisdictions with increased congenital syphilis rates; CDPH was one of the recipients. The IDPH HIV and STD Sections will partner with CDPH to address this.

C: Janet- Lesli, this is a good opportunity to include a new activity for congenital syphilis in the integrated plan. Can you work with Christi and Eduardo to draft that?

C: Lesli – Yes.

C: Jill- In addition to calls, the HIV/STD hotline engages individuals through texting and social media/ social apps.

Q: Valerie - There continues to be an issue with data on assigned SBS cases that locals have entered into Provide not being updated in eHARS and locals getting those cases reassigned to them.

A: Cheryl- eHARS has the ability to import information from other sources. Unfortunately, there have been barriers to uploading prevention information from Provide into eHARS. Some Surveillance staff members are working to determine which positive tests are newly diagnosed and which have been previously diagnosed from Provide, but larger files (like those for SBS) are not able to be exported at this time….

C: Valerie- I encourage IDPH to make that its highest priority in Provide development.

A: Curt, yes, it is the highest priority.

Q: When will user training be available for uploading prevention information into Provide?

A: Curt- There have been barriers to doing this, including the recent loss of the Data Manager. Dennis stated that he had been working one-on-one with individuals to provide training as requested. He also stated that individuals can still contact him for individual/site training.

Q: Can a procedure manual/work flow chart be developed and distributed to Provide users?

A: Curt and Dennis – We have some things in place but they are in need of u[dating. That is something we will be working on.

C: Valerie: I want to emphasize that the Getting to Zero town halls/engagement activities are for ALL community members, including PLWH not engaged in care, PrEP users, etc.

C: Lesli shared that with the support of the HIV Section, the STD Section has recently rolled out extragenital STD testing for MSM clients.

A: Janet asked Lesli to submit an objective with related tasks/activities for inclusion in the Activities Chart so that we can monitor that initiative.

Q: Jill- cluster identification… missed question… Confidentiality in surveillance is important to uphold.

Q: Can you provide more information about the state's use of data for cluster analysis/investigation?

A: Cheryl - At this point a plan for identification of a cluster has been initiated; a plan for response will be developed throughout 2018. Information will be used for treatment purposes and will be treated to the same confidentiality standards of other services. The purpose of the activity is not to identify transmission on individual levels but to identify clusters and to initiate effective treatment based on information collected from analysis.

Curt- There will soon be a build-out in Provide that allows providers to see that clusters have been identified, but providers are not to share information on clusters with clients, nor will they receive data on the context in which the cluster developed. Any information shared with providers will only enhance their ability to treat the client.

Note: The following questions was submitted remotely after the session ended. The question was forwarded to Curt Hicks after the meeting for response.

Q: Paula: The Partner Services data is not correct. We had a positive case from a Partner Service who was not an existing positive case. It makes me wonder how accurate any of this data is. I also can't believe that only 30 something Partner Services were completed statewide. I would guess that we alone did close to that.

A: Curt: He asked for clarification from Paula before he responded on whether she was referring to Partner Services stemming from SBS or Testing, on the actual date of the services provided, and on the StateNo of the case in question. Knowing those things will help him know which report to follow up on and check to see if it was constructed correctly. Partner Services reports still require some specialized and complicated queries, so it could be that the query code was off a bit. If that's true, knowing this case information could help detect and fix the query error.

C: Paula responded that she was referring to Partner Services stemming from Testing and that she could not provide the other info until after the holidays because the staff person who worked the case was off until after the holidays. Paula stated that we could close the minutes knowing that we will continue to follow up on this and figure out if there is an error with the data.

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11:20 am: Networking Lunch – (40 min) – *The meeting was dismissed for lunch at 11:20. The meeting resumed at 11:55am.*

12:00 pm: Integrated Planning Group Member Recognition – (15 min) – The Co-chairs took this time to thank and to recognize RWPB Advisory Group and ILHPG members as well as Integrated Planning Steering Committee members for their participation and involvement in development of the new IHIPC group over the last few years. This would not have been possible without everyone's input and commitment to the process. Each member of the exiting integrated group was recognized at the meeting with a certificate that read "Through your courageous spirit, kind heart… one day the battle against HIV can be won." Members who were unable to attend the in-person meeting will be mailed their certificate. Pictures were taken of the ceremony and will be available from Janet after the meeting.

12:15 pm: Breakout Group Discussion/Input on 2018-2020 IHIPC Needs Assessment Focus Areas and Activities – (10 minutes intro/50 min discussion)

Janet Nuss, IDPH ILHPG Coordinator, Integrated Planning Group Co-chair

Jeffrey Maras, IDPH HIV RW Part B Administrator, Integrated Planning Group Co-chair

Janet noted that this portion of the meeting was a time to solicit input from the group on the draft plans for 2018-2020 needs assessment activities, in particular, solicit input on the draft needs assessment questions for discussion for the regional community engagement meetings. The community engagement meetings would be geared more for providers, peer navigators, client reps, and other community stakeholders. Janet reviewed the goals of the needs assessment activity, the objectives that were to be met, and a set of draft questions that had been developed with input from the ILHPG Evaluation Committee. Janet noted that the questions were still in draft and would be provided to the respective IHIPC Committees next year for their consideration and further development. She wanted to use this meeting, however, as an opportunity to get feedback from this group. Janet reminded the group that per guidance from federal partners, we need to design the questions to identify needs, gaps, barriers, challenges, and successes in HIV prevention and care. Janet reviewed how CDC and HRSA recommend the information obtained be categorized. Janet said that we could do one of two things: 1) Use this meeting to review the questions as a whole group and individuals could step up to the microphone and provide their comments/input to the whole group, or 2) Break the group out into tables for small group discussion. Input and comments on the questions can be written down then later shared with the whole group. Participants agreed to #1. The input was collected as follows:

- Objective 1 Input
  - It seems that the questions are complicated wording-wise. Can they be simplified?
  - Questions seem very broad topic-wise. Can they be narrowed down?
    - Janet noted that the questions could certainly be made more topic specific, but she reminded the group that this might increase the originally time of one hour allotted for the needs assessment activity.
  - The term "health inequities" might not be familiar one for all participants. Consider writing questions at the 4th or 5th grade level.
  - Should information on some types of gaps be presented before the questions are asked? Then participants could have a better idea of what was being asked and answer based on that information.
    - Janet said she liked that idea. She also clarified that before the needs assessment portion of the meeting, there should be a regional presentation on the epi and identification of some regional gaps could also be included there.

- If there is data presented to support the questions, please make sure that it is simple and understandable for all participants.
- Specific examples of health disparities could be added to prompt conversations on things like racism, stigma, etc. It might also be helpful to preface the discussion on the definition of the highest risk groups (MSM, youth, etc.).
- Be mindful of not using or to be sure to define "insider" terms that might not be known to the public.
- Rocio offered translation services if needed for writing questions in Spanish or being present at meeting.
- When the bullet points talk about HIV prevention, care, and treatment, what is the difference between care and treatment? Consider defining that more.
- Consider asking the question in a way that asks participants to define….(Missed the rest of this one)
- Chris voiced a response that "historical and present racism is a multi-faceted issue that does not prompt more high risk behaviors among people of color…" Janet recommended that he be sure to attend the Region 2 meeting when held to provide his input.
- Consider taking out "us" in questions and replacing it with "people" to try to word the questions in a more positive light.

- Objective 2 Input
  - Consider wording the questions in two ways (one geared towards providers and one geared towards community members) to make the questions more personalized.
  - Be sure to explain PrEP to community. Some may not be aware of what PrEP is and how it can be useful to people who are not living with HIV. More community awareness may be needed before asking about its utilization.
  - In regards to the objectives, they seem very similar. Can they be re-worded?
  - Define terms like "high-risk". The phrase "high-risk" may not be relatable to community members.
  - Can questions be added for harm reduction, behavioral interventions, nPEP and PEP, and treatment as prevention?
  - Can we consider stopping the PrEP question at the word "PrEP"? Is there a need to talk about target populations? This might be stigmatizing.
    - On the other hand, it may be good to include the "targeted populations" language as it relates to our efforts in targeting the most vulnerable populations.
  - Instead of stating the objective before a set of questions is introduced, can a preface of information about the question topics be presented, such as, prior to questions about achieving viral suppression: "In Illinois, only XX% of people diagnosed with HIV infection are known to be virally-suppressed. Viral suppression is key because when a person diagnosed with HIV is virally suppressed, there is almost a zero chance of transmitting HIV to his/her partner."
  - Consider that some objectives and questions seem to be worded in complex ways and can be simplified.
- Objective 3 input
  - If the audience is mixed with providers and community members, please define engaged in Care.
  - Consider giving examples of engagement activities to promote discussion and critiquing of current activities.
  - Can questions address the importance of treatment as prevention and U=U?
  - These questions seem geared toward PLWH. Consider explaining some terms related to linkage and retention in care and viral suppression for people who are not HIV positive and may not be familiar with Care language.
  - Should we consider relooking at points in regional portfolios (number of people diagnosed, tests completed, etc) to include information that would be context prefacers for focus groups/community meetings? Consider making these points relatable to all so that engagement is optimized. This can be done with input from the regional lead agents.
  - Consider giving the questions to participants while the preface information is being presented so that participants can make notes.
  - A brief, simple overview of information may be the best way to compose the prefaces so people are not lost in lingo, terms, etc.

- Consider having a slide up during the discussion questions that lists targeted risk groups, examples of barriers/ disparities, etc., that participants can relate to for optimizing answers.

- Objective 4 input
  - Like with other questions, consider simplifying questions so that they are understandable to all participants in the mixed audience.
  - Consider asking simple questions like "What stops you or your clients from taking their medication?" or "What tools do you or your clients use to help them take their medications regularly and as prescribed?"
  - Be careful using terminology that all community members might not be familiar with. These should either be eliminated from the questions or defined in the preface.
  - Consider not only focusing on barriers, but also adding discussion on benefits as well. Questions about best strategies and tools for viral suppression could be very useful.
  - Be sure to identify if the purpose of the needs assessment is to solicit input on awareness/attitudes/beliefs, etc. This can guide responses to the discussions.
  - Consider using the results reported from GTZ town halls to guide questions in regards to IDPH /regional needs assessments.
  - Consider health literacy by using health literacy tools like charts and pictures to help relay the context of the prefaces.
  - Consider wording questions in a way that might encourage participants to relay new information that can be used in needs assessments. These questions might be too broad; can they be broken down by audience, specific barriers, etc.? We may be trying to get too much information from too many parties in only one hour.
  - Consider taking an approach geared towards sharing success instead of barriers. We all know what the barriers to HIV prevention and care are. New ideas may be identified that could be useful to the community at large.
  - Will demographics of the audience be assessed? Consider taking a demographic survey at the meetings.

Janet thanked the group for everyone's valuable input and insight. She commented that this is an example of why we use community input to guide decisions why we need that input before we finalize development of needs assessment materials prior to piloting or implementing them. Janet proposed creating an ad-hoc committee to further review all of these comments and propose some recommended revisions to the questions and the process. She solicited volunteers from the audience: Jeffery Erdman, Pam Briggs, Susan Rehrig, Jill Dispenza, Livia Navon, Curtis Montgomery, Louis Hobson, and Stacy Grundy volunteers. Janet thanked everyone for their input and told them that she will be in contact with the volunteers after the first of the new year and schedule a first committee call.

1:15 pm: Public Comment Period/Parking Lot/Announcements - (10 minutes)

Public Comment Item 1:

The first request for public comment came from Jonna Cooley and Anthony McDonald. Their comments were specific to medication adherence and related examples and barriers. Anthony is a housing case manager and asked to discuss issues r/t medication adherence that he is noting among his clients. He is finding that there is a disconnect when clients deal with their case managers, pharmacies, and medical providers. As a case manager housed at the agency, Anthony said that clients might be more open with him as he gets to know them on a more personal level. Clients report issues like having difficulties reaching their case managers or prescribers with questions in general or questions about side effects and forgetting to take medication. Reaching providers is difficult for clients. Disconnects with pharmacies is making medication adherence more difficult for clients, especially those that experience shame in provider settings. Anthony reports that he believes that current action for better assisting clients in these regards are not productive or are not working. Some ways that we might begin to combat this is having joint scheduled meetings with CMs, prescribers, and providers to discuss individual client barriers. Anthony asks that it be considered that more time and/or funding be put into to ensuring that medication adherence is accessible to all clients. Anthony hopes that the group can come together to help brain storm new approaches on how to improve outcomes. All processes involved in medication adherence can be very confusing and overwhelming to clients, and more work needs to be done on how and why this might be happening among clients.

C: If issues are happening with mail order through ADAP, please continue to send incident reports to IDPH and program will do their best to resolve. Another strategy that could work for medication adherence is to make sure that private doctors understand that medication assistance, premium assistance, and other services are available through Ryan White. If able, consider going to some appointments with clients. It helps providers understand that these services are available and help empower clients.

C: This is a good example of why peer navigator education is important to medication adherence. Please consider re-introducing this training program so that clients can have a liaison who has also experienced similar challenges. Peer advocate programs can be utilized to help client become empowered and to strategize on how to overcome barriers. Client reps are also trained and should be actively used to counsel clients re: medication adherence.

Note: The above Public Comment was sent to Jeffrey Maras, the IDPH RW Part B Program Administrator, for response.

Jeffrey:

The Department's Ryan White Part B Program recommends several avenues that are available through the Ryan White Part B portfolio for complex health conditions and social determinates that challenge adherence to HIV treatment:

- First and foremost, the Program encourages enrollment into Medical Case Management (MCM). The case managers (CM) of the Ryan White Part B Program are trained to identify and prepare supportive systems for clients that are not virally suppressed. It is important to note for data purposes that Ryan White Part B has a 92% viral suppression rate across all programs.
    - In addition, the MCM would be a critical liaison that would organize and coordinate a medical team intervention team for those clients that are challenged is adherence to prescribed treatment regimens.
- As mentioned at the Integrated Planning meeting, if there are concerns with the shipment of medications from the State of Illinois' contracted dispensing pharmacy, there is an incident report on the enrollment page that can be faxed to the Department and a resolution from the pharmacy will be addressed within 24-48 hours. Website for the incident form is as follows: https://iladap.providecm.net
- All Ryan White Part B Lead Agents also have on staff Peer Navigators and designated Client Representatives that are able to be assigned to complex clients that are challenged with adherence issues and side effects from medications. Access to a peer has proven to be beneficial for strategizing support intervention methods from a client's counterpart/peer.

To avail of the above services, clients should contact their MCM or the Project Director of the Care Consortia in their region.

Public Comment Item 2:

The second request for public comment came from Casey Johnson from ViiV healthcare. She wanted to announce to the group that a new drug, Juluca, which is the only single-pill, two-drug regimen approved for the treatment of HIV in adults who have been virally suppressed for at least 6 months with no history of treatment failure, has been approved by the FDA.

Q: What are the drug classes of the 2 medications in Juluca?

A: Dolutegravir is an Integrase Inhibitor and Rilpivirine is a Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI).

1:30 pm: Adjourn- Janet thanked everyone for attending the meeting and for contributing to a very productive year in HIV planning. Janet reminded ILHPG members to submit their travel vouchers before leaving. The meeting was formally adjourned at 1:25 pm.

: *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.*