Illinois HIV Planning Group (ILHPG)/Ryan White Advisory Group Integrated Meeting Minutes

May 11, 2017, 9:30 am-12:00 pm

- **9:30 am:** Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence
  The Co-chairs welcomed everyone to the meeting, introduced the facilitator and presenters, and led the group in recognizing a moment of silence for our HIV community.
- Review agenda
  The Co-chair reviewed the agenda items with participants. She reminded everyone one that the discussion icon on the agenda identifies how each presentation relates to the National HIV/AIDS Strategy (NHAS) or the HIV Continuum of Care.
- Webinar process; Attendance; Announcements; Updates
  - Webinar meeting, online meeting survey, and online discussion board instructions
    Instructions for the webinar and accessing meeting documents, the online meeting survey, and the discussion board were explained. The survey and discussion board will close on May 18th.
  - Attendance will be taken by announcing members logged in, taking roll call of voting members, and sign-in sheets from host sites
    The names of members who had logged into the webinar were announced and roll call of other voting members was called. Although not announced, representatives from the community and IDPH staff members were recognized as being on the call and will be tracked in the attendance log. The arrival of members who logged in after roll call was announced as it occurred. Members not present have the opportunity to review the presentation slides and view the recorded meeting.
  - Review meeting objectives and Concurrence checklist
    The primary goal of the planning group and its alignment with the goals of the National HIV/AIDS Strategy (NHAS) was reiterated by the Co-chair. The meeting objectives were reviewed. The Co-chair also reviewed the essential elements of concurrence. She informed the group of a change to the concurrence process: CDC no longer associates concurrence letters with IDPH's HIV Prevention funding opportunity announcement (FOA) application; concurrence is now associated with the Integrated Plan. This means that the concurrence vote and letter are no longer required from planning bodies on a yearly basis unless major updates are made to the Plan. The Co-chair assured the group that this new procedure will not change the context of presentations delivered regarding the FOA and that if the group deems any annual changes to the plan as major updates, a concurrence vote will still take place. With that being said, she officially announced that the first in-person meetings of both the Integrated Meeting and the ILHPG will occur as scheduled on August 24th and 25th in Springfield as there is no longer a pressing need to align the concurrence vote with the submission of the FOA. More details about the logistics of those meetings will be forthcoming.
  - Announcements
    - *Participants were reminded that all documents for this meeting are available online at www.ilhpg.org/webinar.*
    - *Previous 2016 and 2017 meetings and their corresponding documents are also available for review on the website.*

- *The draft IHPIC Bylaws and Procedures will be released to the full ILHPG and Integrated group next week for at least 30 days of public review and comment. Everyone was encouraged to review them and provide input.*
- *Articles for the summer edition of the Integrated ILHPG/ RWPB Advisory Group Newsletter are due by May 26th.*
- *It was reported that 30 community/ agency representatives who are not voting members or regular non-voting members had participated in ILHPG/ Integrated meetings as of April 2017.*

- **9:50 am:** Community Services Assessment: Region 2 HIV Care and Prevention Panel Presentation and Discussion - (45 minutes)

  : 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

  Pam Briggs, University of Illinois College of Medicine in Peoria, Region 2 HIV Care Connect Lead Agent

  Jeffery Erdman, Illinois Public Health Association, Region 2 Prevention Lead Agent

  Jeffery began the presentation by informing the group of social and demographic information for Region 2. Region 2 is in NW Central Illinois and is made of 15 counties, four of which have populations over 100,000. Jeffery explained that many counties in Region 2 struggle with issues social determinants of health. Eight counties in Region 2 have higher rates of poverty than Illinois and national averages, and all counties have higher rates of unemployment than Illinois and national averages. These factors can play a role in HIV prevention and care, especially in rural counties where services are limited. Jeffery reported that from 1/1/16- 7/31/16, 10 new HIV cases were diagnosed and reported to IDPH surveillance in 2016 (this number may change as case reporting is not quite complete for 2016). Over the past ten years, Region 2 has averaged approximately 40 new HIV cases per year.

  Jeffery noted that there are currently five prevention providers funded under the Regional Implementation Grant, all which reside in the region's most populous counties. Challenges faced by these providers include service delivery challenges given the SFY16 Budget Impasse; limited services in small counties due to shrinking prevention funding; disproportionate HIV infections among young MSM, especially MSM of color; and high STI rates in Peoria. The budget impasse has greatly affected services in Region 2 as prevention providers went most of SFY16 (7/1/15-6/30/16) without reimbursement. Because of decreased activities and the closing of some sites, testing rates in SFY16 decreased by 53 percent compared to the previous year, and only one new HIV positive case was found among providers (compared to 12 the previous year). Because of limited funding, few services have been offered outside of populous counties. Although it was a difficult year, 2017 plans for use of more federal dollars and for Structural Recovery Funds should be helpful in sustaining services. A new partnership with Positive Health Solutions (PHS) also has the potential to expand services to more rural areas through use of mobile health units. Region 2 also plans to address disparities among YMSM, especially YMSM of color, through focused implementation of behaviorally effective interventions specifically designed for this population. In response to high STI rates in Peoria (which are well above Illinois and national rates for chlamydia and gonorrhea), a special reproductive health task force has been established in the area. RIG-funded prevention providers participate on the task force and have been able to conduct more outreach STI screening in the community and schools as part of the initiative. In addition to these solutions to current challenges, Jeffery also noted that Region 2 has been successful in implementing PrEP throughout the region. PrEP clinics at PHS and Planned Parenthood locations are currently operationalized, and other county health departments and organizations are also considering future implementation of PrEP clinics.

  Pam began her portion of the presentation by introducing PHS (Region 2 Care Lead Agency) and its mission to the group. She reiterated that all work done at the agency ties back to NHAS goals. Pam then explained that 631 unduplicated clients were served in 2016 through the following grants/ programs: IDPH RWPB grant; HRSA RWPC grant for men > 24 years of age; HRSA RWPD grant for women, infants, and youth; HUD/ HOPWA grant; and DHS Home Services Program. 559 of close clients obtained medical services, and 53 were newly diagnosed in 2016. PHS also performed HIV testing in 2016 and found 3 new HIV-positive cases that were all linked to care. Pam also reviewed other PHS projects, which include a Perinatal program, a PrEP Clinic, clinical staff trained in hormone therapy for the benefit of transgender clients, securing a registered dietician (to begin working with clients in the near future), and participation in the Tri-County Partnership for a Healthy Community Group (supports youth testing and support group initiatives).

Pam continued by addressing the region's weaknesses along the continuum of care, which she identified as retention in care and viral suppression. The program currently sits at an overall retention in care rate of 68% (goal: 90%) and viral suppression rate of 88% (goal: 90%). She noted that these challenges are greater among adolescent youth and women (retention in care: 65%; viral suppression, 81%; and higher rates of late diagnosis than the total client population). Other challenges include difficulty engaging clients lost to care and address high STI rates in the region. Despite challenges, PHS has experienced success across programs. Examples of this include a 29 day average of linkage to a medical provider upon diagnosis in 2016 and a decrease to a 12 day average in 2017; plans for implementation of new support groups; success with the Peer Navigator program; potential implementation of the evidence-informed Linkage-Retention-Reengagement in Care strategy "STYLE"; continued collaborations with prevention programs for community outreach; and the implementation of a Plan Do Study Act to address non-adherence to routine medical appointment.

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

Comment: *Janet commended the region for their collaborative work to address challenges.*

Question: *Jeffrey asked Pam to comment on if and how RWPB funded Retention Specialists had been incorporated into PHS strategies to target reengagement of clients into care.*

Answer: *Pam noted that PHS does not have one individual employee who works as a Retention Specialist. Instead, each client is assigned a team (a nurse and case manager) who work together to oversee client engagement and retention. If a client falls out of care, diligent attempts are made by the team as well as assigned peer navigators to contact and work with the client on reengagement.*

Comment: *Janet thanked Jeffery and Pam for their comprehensive presentation.*

- **10:50 am:** Community Services Assessment: FFY2016 HIV Prevention and Care Service Delivery Assessment and Mapping - (40 minutes)

  : 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

  Jeffrey Maras, IDPH Ryan White Part B Program Administrator

  Curt Hicks, IDPH HIV Prevention Program Administrator

  Jeffrey presented an overview of FFY2016 (4/1/16-3/31/17) Ryan White Part B Program Service Utilization. He first informed the group of guidelines/limitations in which the program functions, including the 75%/25% policy for core and supportive services, respectively; HRSA universal monitoring standards/guidance for budgeting and accountability; payer of last resort and safety mandates; HRSA policy clarification notices; and federal poverty level limitations. He noted that the RWPB Program offers 17 core medical and supportive services, which are available on a regional basis according to the results of annual needs assessments. Eligibility is set at 500% household federal poverty line for most services, with exceptions being case management (no income limit) and housing and emergency financial assistance (80% of the area median income). In addition to income requirements, eligibility of clients is also determined by HIV/AIDS diagnosis, residency within Illinois, and 3rd party medical coverage.

  Jeffrey continued by sharing the RWPB Program's funding breakdown for FFY2016 with the group. It included the following funding streams: ADAP, ADAP Supplemental, Part B Care Base, ADAP Rebate, HOPWA, MAI, and GRF (see presentation for specific funding breakdowns). Jeffrey also shared dot density maps with the group that displayed where medication assistance, premium assistance, are care services are being most utilized throughout the state by clients. FFY2016 service delivery among 12,613 clients was reviewed by gender, race, ethnicity, HIV transmission category, type of service (core and supportive), and by primary payer source (MAP)/ insurance type (PAP). Continuum of Care data for Medication/ Premium Assistance clients, Care services clients, and all clients (unduplicated) were presented to the group. Jeffrey noted highly successful linkage to care rates among all groups (overall 93%) and noted that the program is continuing to strive for a viral suppression goal of 90% (overall 88%). Lastly, Jeffrey reviewed how the department has addressed/ is addressing gaps and challenges in service delivery. Some initiatives have included allowing for provider and medical transportation options outside of Medicaid options with justification; working to expand dental services/ access to dental insurance for clients; and directly working with insurance agencies to ensure proper medical coverage for clients.

  Curt then reviewed service delivery of HIV Prevention Services monitored by IDPH and delivered in Illinois in calendar year 2016. Before beginning his presentation, Curt recognized that 2016 was a very difficult year for Prevention providers as nearly 90% of prevention funding relies on Illinois General Revenue funds. In light of the budget

impasse, service delivery significantly declined from 2015 to 2016 as agencies received late and untimely reimbursements. Despite these tremendous challenges, Curt emphasized that each service delivered in 2016 was a triumph for providers and clients and that providers should celebrate their perseverance.

Curt first reviewed 2016 IDPH HIV testing data. He noted that 87% of IDPH-supported testing was conducted through routine testing programs (Perinatal, CAPUS, and Category B), while 13% of testing was risk-based (Direct, AAARA, DASA, MAI, QOL, RIG).Through IDPH testing efforts, 78 newly diagnosed individuals were identified in 2016, which was an approximately 60% decrease in new positives compared to 2014. Breakouts of newly identified positives by funding source/grant were included in the presentation. Curt reported that geographically, testing delivery correlated to regional distributions of HIV incidence among Regions 1-8. In terms of prevention, Region 8 does not include the city of Chicago, since CDPH is directly funded to provide prevention services in the city of Chicago. 2016 risk-based testing proportions by transmission risk and race/ethnicity in Regions 1-8 was also reflective of Illinois HIV Incidence. Although IDPH-monitored testing was not available in every county in 2016 (which was the case in 2014), counties with five or more new HIV diagnoses delivered testing. Statewide, IDPH-monitored testing identified 4.6% of 2016 Illinois HIV incidence, which is only a third of what was found by IDPH funded providers in 2014.

Curt also reported on risk reduction activities (RRA) for HIV-positive and HIV-negative individuals under the 2016 IDPH HIV Prevention Grants. Approximately 3000 RRAs were delivered to HIV-positive individuals in 2016, most of which occurred through the RIG and QOL grants. RRAs for HIV –positive individuals were delivered in 20 counties (compared to 40 counties in 2015), and all counties with 10 or more new HIV diagnoses in 2016 received positive RRA services. Approximately 7000 RRAs were delivered to HIV-negative people (the majority of which were also delivered through the RIG and QOL grants).Similar to RRAs for Positives, RRAs for Negatives were delivered in 19 counties, and all counties with 10 or more new HIV diagnoses in 2016 received services. Overall, delivery of RRAs for Positives and Negatives somewhat reflect HIV incidence by risk and race/ethnicity as PWID and HRH were slightly overserved and MSM were slightly underserved. Over 400,000 sexual risk reduction materials, 250,000 clean syringes, and 3,600 overdose reversal tools were distributed to clients through RRAs. Lastly, Curt reported on Surveillance-based and Partner Services in 2016. Although both program suffered losses due to staff vacancies and lack of funding (see specific data/reporting in the presentation) , Curt commended providers for continuing this difficult work despite challenges.

Based on the information presented, Curt recommended the following: work to rebuild capacity to serve lower incidence regions; increase testing among Black and Latino MSM; increase cost-effective RRA activities for Positives; and continue to improve SBS and Partner Services. Curt thanked several IDPH staff for their contributions to the presentations and noted that data sets for charts and graphs in the presentation were available in the meeting documents.

– Questions & Answers, Discussion, Input

Question: *Casey asked if we could speak to the differences in the overall Illinois HIV Continuum of Care and the RWPB Program Continuum.*

Answer: *Janet noted that although the statewide Continuum was not included in this meeting's slide set, 2015 data was made available at the February meeting. Janet was not sure on the specific statewide numbers but knew that the RWPB Continuum had higher rates at each step.*

Answer: *Jeffrey explained that he hopes that the service portfolio that he presented demonstrates positive engagement with clients, which in turn improves outcomes along the Continuum. Discussions with clients and strategic planning have allowed the program to address challenges associated with reaching Continuum goals. Jeffrey also noted that the RWPB program most likely helps improve the overall Illinois Continuum of Care as it serves nearly 1/3 of people living with HIV in Illinois.*

Comment: *Jill thanked Curt for placing human context in his presentation and agreed that budget issues have been devastating to staff and programs. She appreciated that Curt recognized that each small success is fought hard for by providers.*

Comment: *Curt again thanked providers for their diligent work despite challenges.*

Comment: *Janet reminded the group that updated Continuum of Care data for 2016 (including Regional Continuums) are scheduled to be presented at the August Integrated Meeting.*

Comment: *Curt commended Jeffrey and the RWPB Program for their success in viral suppression of clients.*

Question: *Chris asked Jeffrey and Curt if IDPH is at a place where it is ready to publically say "undetectable equals untransmittable".*

Answer: *Curt replied that "undetectable equals untransmittable" can be said with caveats as undetectable has been previously defined as a nearly 0% chance of transmission of HIV unless there is at spike in an individual's viral load. He went on by saying that risk reduction plays an important role in viral*

suppression. Risk reduction methods also play an important role of preventing dual diagnosis of other conditions like STIs or HCV. Abandonment of those tools would not be effective in keeping our communities as healthy as possible.

Answer: *Jeffrey agreed that there are caveats to "undetectable equals untransmittable", but he also does not want to diminish the role that undetectable viral loads play in getting to zero new infections. Jeffrey stated that an official IDPH statement on this should come from the HIV Section Chief or the Director, not administrators, but it is worth bringing the idea forward.*

Answer: *Janet noted that there are plans for a presentation on the work of the Getting to Zero Taskforce by Valerie Johansen at an upcoming Integrated meeting. Eduardo is on this taskforce as well and this group should be able to provide input on this topic.*

Answer: *Chris thanked everyone for their responses to is question and for the presentations.*

- **11:45 am:** Community Services Assessment: 2017 Illinois HIV Care/Prevention Resource Inventory Update

  : *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*

  Marleigh Voigtmann, IDPH HIV Community Planning Intern

  Marleigh gave a brief presentation on the 2017 Illinois HIV Care/Prevention Resource Inventory Update. She reminded participants that the resource inventory is a component of the Integrated Plan. In 2016, all Illinois HIV grants and awards (including other Ryan White Part Programs in Illinois, St. Louis (Illinois portion) and Chicago area funding, and foundation awards) were included in the inventory. The 2017 update only includes IDPH grants and contracts, which include awards from federal partners in Care and Prevention, Illinois Special Fund awards, expected GRF awards, and all grantees and sub-grantees in conjunction with said awards. Each award in the inventory is listed by funding source, funding amount, funding term, funded agency, services delivered, and prevention activity/ Care Continuum step. Marleigh noted that funding streams are dynamic, and awards can change over time. The resource inventory is therefore meant to be a snapshot of how our current funding streams are utilized and is presumed to be accurate as of 5/1/2017. Marleigh included a table and pie graph of funding by source (see presentation for details); 82.6% of funded dollars were allocated to Care, and 17.4% to Prevention/Surveillance. Marleigh invited everyone to review the full update in the meeting documents. She thanked the many people who provided information on their grants for the update.

  – Questions & Answers, Discussion, Input

    Comment: *Jeffrey noted that the sub-grantees for the Regional Care awards will be updated June 1. These grants are not quite executed, and a resource inventory updated with those additions will give a more accurate and robust picture of the program.*

- Public Comment Period/Parking Lot

  There were no requests for public comment and there were no items in the parking lot.

- **12:02 pm:** Adjourn

  The meeting 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.*