Our Mission:

Together, with the Health Department and community, work to achieve our mission to reduce the number of new HIV infections, to increase access to HIV care and improve health outcomes for people living with HIV (PLWH); to reduce HIV-related health inequities and disparities; and to serve as a role model and central advisory body for HIV prevention and care planning activities throughout the State of Illinois.

WELCOME AND CONGRATULATIONS!

The Illinois Department of Public Health thanks you for your interest in and commitment to the Illinois HIV Integrated Planning Council (IHIPC).

The purpose of the IHIPC is to promote effective integrated HIV prevention and care planning in the state of Illinois that is in alignment with the goals of the National HIV/AIDS Strategy.

The IHIPC participates in an HIV planning and public advisory process, representing and advocating for the HIV prevention, care, and treatment needs of people living with HIV and communities and populations at highest risk for HIV infection.

Throughout the time you serve as an IHIPC member, you will receive support from the co-chairs, committee chairs, other members of the IHIPC, and IDPH support staff. This training has been designed as an introduction to the HIV integrated planning process.

The IHIPC process is dynamic and involves many steps. You are not be expected to know everything there is to know immediately. Be patient with yourself as you become familiar with the planning process.

Thank you for accepting this responsibility!
WHY IS COMMUNITY INVOLVEMENT IMPORTANT?

- The HIV epidemic is very diverse - Who is infected varies from community to community.

- With community planning, people infected/affected by HIV and providers of HIV prevention, care, treatment, and other support services can assist in identifying the needs of the communities and populations in the jurisdiction and can provide recommendations for effective HIV prevention and care services.

- In order to be successful, planning for HIV prevention and care needs to reach people where they are and take into consideration personal, societal, structural, and systemic factors that influence the epidemic in multiple ways.
HISTORY OF HIV PREVENTION PLANNING IN ILLINOIS

▶ The Centers for Disease Control and Prevention (CDC) required jurisdictions funded for HIV prevention to establish an HIV planning group.

▶ In 1994, the Illinois Prevention Community Planning Group (PCPG) was created.
  ▶ Community prevention planning reflected the belief that HIV prevention priorities & needs could best be determined at the local community level.

▶ The primary goal of the PCPG was to develop an HIV Prevention Plan that would contribute to the reduction of HIV infection in the jurisdiction.
  ▶ A diverse membership, representing the populations in the jurisdiction at highest risk for HIV helped the group design a jurisdictional prevention plan that focused on real-life, specific needs of people at risk of, or living with HIV.

REQUIRED COMPONENTS OF THE PREVENTION PLAN

▶ Epidemiologic Profile Review/Assessment
▶ Community Services Assessment
▶ Prioritized Target Populations
▶ Priority List of Interventions

In addition, the PCPG was required to draft and sign a letter to CDC that was to accompanied the annual IDPH Prevention Grant Application
  ▶ Letter of Concurrence
  ▶ Concurrence with Reservations, or
  ▶ Non-concurrence
THEN, IN 2012 …

- In response to the National HIV/AIDS Strategy, CDC released its High Impact Prevention (HIP) approach to guide Health Departments’ HIV prevention programs.
- CDC also released updated guidance for HIV Community Planning Groups – now called HIV Planning Groups (HPGs).
- And…The Illinois HIV Planning Group (ILHPG) was created.
- The primary goal of the ILHPG was now to inform the development of the health department’s HIV Prevention Plan that would contribute to the reduction of HIV infection in the jurisdiction (Illinois outside of Chicago).

DIFFERENCES FROM PREVIOUS GUIDANCE

- The new HPGs were more advisory in nature.
- Needs assessments, resource inventory, and gap analysis were made HD responsibilities, with input from ILHPG.
- HPGs were no longer required by CDC to prioritize populations and define a set of prevention activities & interventions. These were made HD responsibilities.
- Guidance provided new requirements for monitoring the planning process (shared CDC, HD and HPG responsibility)
  - Participation in the development/update of the JP
  - Documentation/monitoring of the engagement process
  - Analysis of HPG membership and community stakeholders
DIFFERENCES FROM PREVIOUS GUIDANCE

- Planning process should align with the National HIV AIDS Strategy (NHAS) and High Impact Prevention (HIP).
- Encouraged broader collaboration and coordination across HIV prevention, care, and treatment.
- Required the establishment of a formal engagement process to ensure PLWH, representatives of communities at highest risk for HIV, service providers, and key stakeholders inform the jurisdiction’s HIV prevention plan.
- Offered more flexibility in terms of membership, frequency of meetings, meeting participation, and engagement strategies.

PRIMARY TASK OF THE ILHPG

- To partner with the Health Department (HD) to address how the jurisdiction could collaboratively accomplish the activities set forth in the Jurisdictional Plan for HIV Prevention Care and monitor the HIV planning process to ensure that effective HIV prevention services are reaching populations most at risk.
- In truth, the ILHPG continued to play a key role in all planning activities that were now the responsibility of the HD.
The Illinois HIV Planning Group (ILHPG) consisted of approximately 30 voting members, including representation from:

- People living with HIV (PLWH) and people representing populations at highest-risk for HIV
- HIV care and prevention lead agents
- Youth and Transgender individuals
- Service areas/areas of expertise: HIV prevention and care, Substance abuse treatment/prevention, Housing, Corrections, STD clinics, CBOs and FQHCs
- Chicago HPG (CAHISC)
- Every region in the state represented
  - 2-3 members per region, with more in the high density regions (4, 7, and 8)
  - Region 9 was not prioritized for membership but we may accept members from that region if no other applicants or if needed to fill gaps.

There were also approx. 10 non-voting members, including IDPH HIV Section support staff and other state agency liaisons.

- STD Program
- Minority Health Services
- Corrections
- IL State Board of Education

The ILHPG had 4 standing committees that provide input and complete the tasks and activities identified in the planning group’s annual strategic plan. These tasks and activities all aligned back to the goals of the NHAS or the CDC guidance for HPGs.

- Epidemiology Profile/Needs Assessment Committee
- Evaluation Committee
- Interventions and Services Committee
- Membership Committee

The Executive Committee, composed of the IDPH ILHPG Coordinator, elected leadership of the ILHPG and the co-chairs of the standing committees provided direction and oversight of all ILHPG activities.
HISTORY OF HIV CARE PLANNING IN ILLINOIS

- The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) required its funded jurisdictions to establish an advisory or planning body.
- The Illinois Ryan White Part B Advisory Group was formed after the inception of the HIV Care Program in Illinois.
  - RWPB planning bodies are not defined in the RW Care Act legislation. As such, their structure and membership are varied and are shaped by the HD.
  - Legislation does not require RWPB recipients (the HD) to have an ongoing statewide planning body, but to engage in a “public advisory process” to conduct important needs assessment, priority setting, and resource allocation processes.
  - IDPH has chosen to have HIV care planning conducted through the regional planning bodies or consortia.

OVERVIEW OF RW PART B ADVISORY GROUP

- The statewide RW Part B Advisory Group is advisory in nature and meets quarterly to discuss program and procedural issues and to provide input on other issues pertaining to the care and treatment of PLWH.
- The Ryan White (RW) Part B Advisory Group is comprised of IDPH RW Program staff, lead agents, case managers, and consumer representatives from each of the eight HIV Care Connect regions in the state, and other directly-funded projects (i.e., FCAN, HIV Care Connect website, Re-entry Program, MATEC).
- There is cross-representation from IDPH HIV Section Program administrators, as needed.
OVERVIEW OF RW PART B ADVISORY GROUP

The Ryan White (RW) Part B Advisory Group has standing subcommittees that will continue to be in effect to discuss and provide recommendations on RWPB and HOPWA-specific programmatic issues to the RWPB Program.

- Medical Case Management Subcommittee
- Quality Management Subcommittee
- Consumer Representative Subcommittee
- Direct-funded Projects Subcommittee
- Project Directors Subcommittee

AND NOW.....INTEGRATED PLANNING IN ILLINOIS!

Integrated planning is not new to Illinois.

- The Illinois HIV Planning Group (ILHPG) and the Ryan White Advisory Group have always collaborated on development/conduct of needs assessment/planning activities.
- CDC and HRSA sent several letters to Grantees between 2014 and 2016 strongly encouraging RWHAP and HIV Prevention programs at the state level to integrate planning activities and to develop one Integrated Plan for HIV Care and Prevention that would take the place of both the Jurisdictional Prevention Plan and the Comprehensive Care Plan.
- In late 2014, the groups kick-started a more formal integrated planning process by meeting together quarterly and forming a “hybrid” Integrated Planning Group.
- The first Integrated Planning Steering Committee was formed in 2015 to help guide the integrated planning process and to guide development of our first Integrated Plan.
- In 2015-2016, Integrated Planning Group meetings continued to be used as a venue to engage the planning groups and regional care/prevention stakeholders in a thorough review/assessment of all needs assessment activities conducted in 2012-2015.
  - Each meeting included a region-specific panel presentation/discussion focusing on the HIV epidemic, services, and challenges/issues specific to that region.
  - We then broke out into regional groups to identifying needs, gaps, barriers, challenges, and successes, and to discuss innovative ways that had been implemented to address the challenges. Some discussions were catalysts and sparked new collaborations.
  - Throughout the meetings, participants were asked to make recommendations, then prioritize and rank strategies to address the identified gaps, barriers, and challenges. This input was included in development of Illinois’ first Integrated Plan for HIV Prevention and Care.
INTEGRATED PLANNING IN ILLINOIS...WHAT HAPPENED NEXT

- In October 2016, the “hybrid” Integrated Planning Group met to review a “Crosswalk” of CDC & HRSA roles of planning bodies in integrated planning and needs assessment activities and a model proposed for a fully integrated care and prevention planning group in Illinois.
  - Decision was made to proceed with plan to formally establish one Integrated Planning Group (to take the place of the ILHPG and the RWPB Advisory Group) to be in place by January 1, 2018.
  - Between November –December 2016, a second Integrated Planning Steering Committee was formed to guide development of the integrated body.

NEW INTEGRATED PLANNING GROUP

- 2017:
  - Reached consensus on proposed name for the new group – Illinois HIV Integrated Planning Council (IHIPC)
  - Finalized proposed Model for the IHIPC including functions, committee structure, member composition, and leadership.
  - Using Model, drafted bylaws and procedures for the IHIPC
  - April - presented a summary of bylaws and procedures to Integrated Planning Group for input
  - May - posted the draft bylaws and procedures on the IHIPC website and solicited public comment through the end of June
    - June – July – Steering committee considered all comments and suggestions received and discussed/agreed upon recommended modifications.
    - August - Final draft of the IHIPC Bylaws and Procedures was provided to ILHPG and RYPB Advisory Group membership for review, discussion and vote. All but “Membership Composition: component was approved.
NEW INTEGRATED PLANNING GROUP

2017:

- **September** – Membership Composition component of the Bylaws was approved and 2018 membership recruitment/selection process officially began.
- **October** – First slate of IHIPC Membership for 2018 was selected.
- **December** – Here you are for New Member Orientation!

OVERVIEW OF NEW ILLINOIS HIV INTEGRATED PLANNING COUNCIL (IHIPC)
IHIPC MISSION AND PURPOSE

- **Mission:**
  Together, with the Health Department and community, work to achieve our mission to reduce the number of new HIV infections, to increase access to HIV care and improve health outcomes for people living with HIV (PLWH), to reduce HIV-related health disparities, and to serve as a role model and central advisory body for HIV prevention and care planning activities throughout the state of Illinois.

- **Purpose (includes expectations for both Prevention and Part B Care advisory bodies as specified by CDC and HRSA):**
  - Participate in HIV planning and public advisory processes, representing and advocating for the HIV prevention, care, and treatment needs of communities and populations at risk for HIV infection and people living with HIV.
  - Develop and monitor the stakeholder engagement process.
  - Participate in Statewide Coordinated Statement of Need activities.
  - Inform the development of the state’s Integrated Plan for HIV Prevention and Care (many components).
  - Annually review and update, as needed, the state’s Integrated Plan and if there are major changes to the Integrated Plan, submit a new letter of concurrence, concurrence with reservation, or non-concurrence to CDC and HRSA.

IHIPC PRIORITIES

- **Be the voice of PLWH, populations at highest risk for HIV infection, and service providers about HIV-related issues and needs of individuals from our respective regions.**

- **Focus on strategizing to improve health equity by addressing service gaps in HIV prevention and care, fostering seamless entry into the HIV care system, and eliminating barriers to primary prevention services, linkage, retention, reengagement, and viral suppression, including social and structural barriers, legislative and policy barriers, organizational and program barriers, provider barriers, and client-level barriers.**

- **Promote collaboration between prevention and care organizations to improve the quality of HIV prevention and care services and to enhance our network of services through integration.**

- **Engage the community in needs assessment activities such as surveys, focus groups, community forums, engagement meetings, etc. to get much needed community input on successes, challenges and barriers faced in the integration and delivery of care and prevention services.**

- **Remain focused on increasing the utilization of PrEP (pre-exposure prophylaxis) among populations vulnerable to HIV infection and suppressing viral load among PLWH to support our goal of Getting to Zero new HIV infections in Illinois.**
IHIPC STRUCTURE: COMPOSITION

The IHIPC will be composed of 25-35 voting members, with a maximum of 35 voting members. The elected IHIPC leadership: IDPH IHIPC Co-chair, Community Co-Chair, Community Co-Chair Elect, Parliamentarian, and Secretary.

Mandatory Appointed Voting Seats on the IHIPC: To ensure proper representation and functioning of the IHIPC, eight (8) membership seats will be held for appointed representatives, participating as experts in their designated areas, from the following key programmatic, governmental, and/or other HIV planning/advisory council institutions:

- Health Care and Family Services (Medicaid)
- IDPH IHIPC Coordinator/Co-chair
- IDPH Center for Minority Health Services (CMHS)
- IDPH – Illinois Department of Corrections (IDOC) HIV Project
- IDPH Sexually Transmitted Diseases (STD) Section
- Illinois State Board of Education (ISBE)
- St. Louis Area (Part A and Prevention) Service Planning Council
- Chicago Area Integrated Services Council (Part A, Housing, and Prevention)

IDPH HIV Section appointees will abstain from votes related to concurrence.

Elected Regional Voting Membership: The remaining voting membership of the IHIPC will be composed of up to 27 additional voting members, representing every region of the state, representing both HIV care and prevention, and elected through the approved application and selection process. The targeted composition of elected voting membership, also guided by regional representation and the membership gap analysis, should at minimum strive to include, but is not limited to the following:

a. Four (4) client representatives or persons living with HIV (PLWH). These may include affiliated and non-affiliated RW Part B HIV-positive consumers who are positive.

The remaining voting seats (b-l) may also be filled by PLWH if they meet the area of expertise targeted for these seats.

b. Five (5) members representing direct care service providers -including one care lead agent, one RW case manager, and three providers -at least one representing a Federally-Qualified Health Center (FQHC)

c. One (1) member representing a Housing Opportunities for People with HIV/AIDS (HOPWA) or other HIV Housing entity

d. One (1) member representing Part C entity

e. One (1) member representing Part D (WICY) entity

f. One (1) member representing Part F (MATEC)
IHIPC STRUCTURE: COMPOSITION

*(Continued)* Elected Regional Voting Membership:

**g.** Four (4) members self-identifying as representing those at highest risk for HIV infection in the jurisdiction (may have positive or negative status)

**h.** Five (5) members representing direct prevention service providers—including one (1) prevention lead agent, one provider from a County or Municipal Certified Health Department, two regional prevention providers, and one surveillance-based services (SBS) grantee

**i.** One (1) substance abuse direct service provider

**j.** One (1) youth or youth direct services provider

**k.** One (1) transgender individual or transgender direct services provider

**l.** One (1) community-based organization directly-funded by CDC for high impact prevention services

IHIPC STRUCTURE: COMPOSITION

❖ **Elected Non-voting At-large Members:**

The slate of new voting members presented each year to the IHIPC can include up to three alternate at-large members. These members will have gone through the same application/selection process as those being recommended for new voting membership, but will not included on the list of applicants recommended to begin their terms as voting members the next CY. Instead, they will be approved/not approved to serve as alternate at large members should voting members vacate their seats before the next election. At large members will be held to the same meeting attendance/committee participation requirements as voting members. They will be required to seek an IHIPC committee assignment and as a committee member, will have voting rights on their assigned committee. At large members aren’t able, however, to vote at meetings of the full IHIPC. When voting seats are vacated on the IHIPC, we will communicate with the at large member(s) to determine their continued interest and ability to take on the responsibilities of voting membership. The Membership/Steering Committees will review their meeting attendance and committee participation history and vote on filling the open seat(s).

❖ **Other IDPH HIV Section administrators, program staff, and community members providing HIV planning support to the IHIPC**
OVERVIEW OF GUIDANCE THAT DRIVES THE IHIPC PLANNING PROCESS

HIGH IMPACT PREVENTION

- CDC’s approach to maximize limited resources and more effectively reduce rates of new HIV infection by providing a combination of proven effective public health strategies and interventions
  - Most cost-effective at reducing overall HIV infections
  - Practical to implement on a large scale at reasonable cost (cost-effective and population-level impact)
  - Able to reach a large number of the target population
  - Able to effectively interact when combined with other strategies/interventions to reach the most affected populations
  - Have the greatest potential to reduce HIV infections

“One of the great mistakes is to judge programs and policies by their intentions and rather than their results.” – Milton Friedman
HIGH IMPACT PREVENTION

- Identifies Populations at Greatest and Disproportionate Risk
  - Gay and bisexual men of all races and ethnicities
  - African Americans
  - Hispanics/Latinos
  - People who Inject Drugs
  - Youth

- Utilizes Proven HIV Strategies and Interventions
  - HIV testing and linkage to care
  - Antiretroviral therapy
  - Access to condoms and sterile syringes
  - Prevention programs for people living with HIV and their partners
  - Substance abuse treatment
  - Screening and treatment for other sexually transmitted infections
  - Prevention programs for HIV negative people at highest risk of HIV infection

NATIONAL HIV/AIDS STRATEGY

- Guides collective national response to HIV epidemic in the U.S.
- Goals include:
  - Preventing new HIV infections
  - Increasing access to care and improving health outcomes along HIV Care Continuum for PLWH
  - Reducing disparities among populations most disproportionately impacted by HIV
  - Achieving a more coordinated national response to the HIV epidemic

- Contains 13 indicators to measure progress
- Updated in 2015; 2020 goal date
MEASURING 2020 NHAS INDICATORS IN ILLINOIS

- Guidance on measurement and data sources to be used provided by White House Office on National HIV/AIDS Policy
- Specifically measured for Illinois
- Baseline measures determined and used to set some goals
- 2020 final goal divided into annual targets
- Progress anticipated to be measured yearly (except indicator 3: every 2 years)
- 2020 NHAS Document and 2017 Report on Illinois’ NHAS Progress included in Member Orientation folder

USE OF INDICATORS IN HIV PLANNING

- Measurement of Illinois NHAS indicators can reveal gaps in efforts and need for improvement in various aspects of HIV prevention, care, and treatment services.
- Annual assessment of Illinois’ progress in reaching the targets set for each indicator will assist in goal setting and prioritizing our HIV planning.
- Our HIV planning efforts will be directed to helping us reach the targets set for each NHAS indicator.
MEASURING 2020 NHAS INDICATORS IN ILLINOIS

- Indicator 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%, from the baseline of 85.6%.
- Indicator 2: Decrease the number of new HIV diagnoses in Illinois by at least 25%, from the baseline of 1,572.
- Indicator 3: Reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by at least 10%.
- Indicator 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%, from the baseline of 78.8%.

MEASURING 2020 NHAS INDICATORS IN ILLINOIS

- Indicator 5: Increase the percentage of persons diagnosed with HIV infection that are retained in HIV medical care to at least 90%, from the baseline of 44.3%.
- Indicator 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%, from the baseline of 46.4%.
- Indicator 7: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%, from the baseline of 6.1%.
- Indicator 8: Reduce the death rate among persons with diagnosed HIV infection by at least 33%, from the baseline of 14.9 per 1,000 persons to 10.0.
- Indicator 9: Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young black gay and bisexual men, and black females.
MEASURING 2020 NHAS INDICATORS IN ILLINOIS

- Indicator 10: Increase the percentage of youth and persons who inject drugs (PWID) with diagnosed HIV infection who are virally suppressed to at least 80%, from the baseline of 41.5% for youth and 40.4% for PWID.

- Indicator 11: Increase the percentage of transgender women in HIV medical care who are virally suppressed to at least 90%.

- Indicator 12: Increase the number of persons prescribed PrEP by at least 500% from the baseline of 1,234 in 2014 to at least 7,404 by 2020.

- Indicator 13: Decrease stigma among persons with diagnosed HIV infection by at least 25%.

WHAT IS THE HIV CARE CONTINUUM?

- A model that visually shows the proportion of individuals living with HIV who are engaged at each stage from initial diagnosis to achieving the goal of viral suppression

- Often referred as the Treatment Cascade or Dr. Gardner’s Cascade

- Assists program planners and service providers to identify where gaps may exist in connecting people living with HIV to sustained, quality care

- Enables us to evaluate our progress over time and to implement system improvements and service enhancements that better support individuals as they move from one stage in the continuum to the next
WHAT IS THE HIV CARE CONTINUUM?

- Stages of HIV care are based on CDC’s “Continuum of HIV Care: Guidance for Local Analyses”
  - Linked to care: estimates based on cases diagnosed in 2016 who had 1 or more CD4 or VL test result ≤ 1 months of diagnosis
  - Engaged in care: At least 1 CD4 or viral load (VL) lab in 2016
  - Retained in care: 2 or more CD4 or VL test results at least 3 months apart during a 12 month period in 2016
  - Viral Suppression: VL ≤ 200 copies/mL at most recent lab draw in 2016
- Estimates are based on reported Illinois HIV/AIDS surveillance data (eHARS)

GETTING TO ZERO INITIATIVE

- In order to support the goal of Getting to Zero new HIV infections, our focus is on two outcomes, rooted in the successful use of anti-retroviral (ARV) medications (HIV treatment and PrEP), that provide the greatest potential and impact for reducing HIV transmission.
  - Suppress viral load in the population of persons living with HIV, leading to “zero people with HIV not receiving treatment”
    - Treatment of HIV with ARV medications is the foundation of individual-level HIV care.
  - Increase utilization of PrEP and other emerging biomedical technologies among populations vulnerable to HIV infection, leading to “zero new HIV infections”
    - PrEP is an HIV prevention method in which HIV-negative people take ARV medication to reduce their risk of becoming infected.
OTHER GUIDANCE AND DOCUMENTS IMPORTANT TO HIV PLANNING

- RW Part B Manual
- CDC's 2012 “Guidance for HIV Planning Groups”
- RWPB and CDC Prevention Grant Guidance
- CDC and HRSA's “Integrated HIV Prevention and Care Plan Guidance, CY2017-2021”

OVERVIEW OF 2017-2021 ILLINOIS INTEGRATED PLAN FOR HIV PREVENTION AND CARE
The 2017-2021 Integrated Plan is our roadmap that guides HIV prevention and care planning. As a dynamic document, it should be annually reviewed and updated, as needed. Needs assessments and the Statewide Coordinated Statement of Need (SCSN) are core components of the Integrated Plan.

COMPONENTS OF IL INTEGRATED PLAN FOR HIV PREVENTION AND CARE: 2017-2021

- Introduction and Overview
  - Acknowledgements
  - Laying the Groundwork for Integration
  - Collaborations, Partnerships, and Stakeholder Engagement
- Statewide Coordinated Statement of Need
  - Epidemiological Overview
  - HIV Care Continuum
  - Financial and Human Resources Inventory
  - Assessing Needs, Gaps, and Barriers
  - Data Sources and Systems
- Integrated HIV Prevention and Care Plan
  - Goals, Objectives, Strategies
  - Activities and Metrics
  - Challenges and Barriers
  - Partners and Participants
  - PLWHA and Community Engagement
- Monitoring and Improvement
  - Monitoring and Evaluating Goals and Objectives
  - Using Data to Improve Health Outcomes
IL INTEGRATED HIV PREVENTION AND CARE PLAN

- Appendices
  - Acronyms
  - Letter of Concurrence
  - Participating Agencies and Organizations
  - Unmet Need Analysis
  - Summary of 2016 HIV-HCV Co-infection Match
  - 2017 Prioritized Populations for Risk-Targeted Prevention
  - 2017 Risk Group Definitions and Considerations
  - 2017 HIV Prevention I&S Guidance Recommendations
  - IL 2016 HIV Resources Inventory
  - MATEC Illinois and City of Chicago Workforce Assessments
  - Integrated Planning Meetings
  - Regional Stakeholder Engagement Meetings and Focus Group Questions
  - RW and HOPWA Regional Client Satisfaction Survey Summaries
  - 2017-2021 Integrated Plan Activities Chart (Implementation Plan)
  - NHAS and Illinois 2020 Indicators – Baselines and Monitoring Plan
  - Letter from Section Chief

IL STATEWIDE COORDINATED STATEMENT OF NEED

- Epidemiological overview developed using Illinois HIV incidence through 2014 and living with HIV through December 31, 2015 data - Narrative, charts, and graphs focus on:
  - Social-demographics of PLWHA and new HIV diagnoses
  - Indicators of HIV risk and Populations and geographic areas with the highest burden of HIV
  - Disparities and trends in HIV
  - HCV Co-infection
  - Unmet need analysis

- Illinois HIV Care Continuum developed and updated using Illinois HIV incidence through 2014 and living with HIV through December 31, 2015 data
  - Continuum - updated using HRSA’s definition of retained in care
  - Disparities along each bar of the Continuum
  - Comparisons with RW Part B Program Continuum

- Financial and Human Resource Inventory
  - 2016 comprehensive Resource Inventory – Prevention vs Care, Steps of the Continuum
  - Workforce Capacity Assessment

- Assessing Gaps, Needs, and Barriers
  - Description of Needs Assessment and Stakeholder Engagement activities and processes
  - Description of identified HIV care and prevention gaps, barriers, and anticipated challenges
IL INTEGRATED HIV PREVENTION AND CARE PLAN

Guided by the IL Statewide Coordinated Statement of Need, a Plan was developed that incorporated a high impact prevention (HIP) approach:

- Prioritized Populations (each exposure category sub-ranked by region and race/ethnicity)
  - MSM
  - IDU
  - HRH
- Key Strategies and Interventions
  - HIV testing
  - Linkage to Care
  - Antiretroviral Therapy
  - Access to condoms and syringe services
  - Prevention services for PLWH
  - Partner services
  - Prevention services for populations at highest risk of HIV infection
    - Approved Prevention strategies and interventions
    - Screening and treatment for other STIs

IL INTEGRATED HIV PREVENTION AND CARE PLAN

Guided by the IL Statewide Coordinated Statement of Need, the Plan includes:

- Goals based on sound science and aligning with the NHAS
- 2017-2021 SMART objectives and strategies identified by each program area
- Goals, objectives, strategies, and activities/metrics are detailed in Appendix P: 2017-2021 Integrated Plan Activities Chart
- Ongoing Efforts to Address Needs, Gaps, and Barriers
- Monitoring and Improvement Plan
  - Update annually:
    - HIV Epi profile, State/Regional Care Continuum, and Unmet Need analysis
    - Prioritized populations for prevention, Risk group definitions, Approved services and interventions for targeted populations, and the Resource inventory
    - Other updates, as identified
  - Progress reported annually:
    - Integrated Plan Activities Chart will be monitored by IDPH HIV Program Administrators and progress reported to Integrated Planning Group at end of each CY.
    - IDPH will monitor Illinois’ progress in achieving NHAS Goals by measuring annual benchmarks set for each Indicator and reporting on these each year during the concurrence process.
OVERVIEW: 2017-2021 IHIPC TIMELINE

- February 2018: Establish IHIPC committees and committee objectives
- April 2018: Select Committee Co-chairs, Elect IHIPC leadership, and Establish IHIPC Steering Committee
- 2017-2021: Annually review/update Integrated Plan; Conduct concurrence process, as needed
- 2018-2020: Conduct regional needs assessment activities, analyze results, prioritize needs, identify innovative practices, and develop strategies to address gaps, barriers, and challenges
- 2021: Develop new 5 year Integrated Plan

DRAFT PLAN: 2018-2020 IHIPC NEEDS ASSESSMENT ACTIVITIES

- Draft Protocols and Discussion Guides for IHIPC needs assessments are in initial stages of development.
- Youth Surveys/Focus Groups
  - Juvenile Justice System (plan to pilot in late 2017 or early 2018)
- Eight Regional Focus Groups with High Risk Populations (*2-3 in 2018*)
  - PLWH, MSM, Young MSM of color, HRH, PWID, transgender individuals, etc.
- Eight Community Engagement Meetings to be conducted by Regional Care/Prevention Lead Agencies (one in each region)
- Getting to Zero Town Halls
WHAT WE DO: STEPS, GUIDING PRINCIPLES, AND RESPONSIBILITIES OF THE IHIPC HIV PLANNING PROCESS

HIV PLANNING PROCESS STEPS

- Step 1: Stakeholder Identification
- Step 2: Engagement Process
- Step 3: Integrated Plan Development, Implementation, and Monitoring
STEP 1: STAKEHOLDER IDENTIFICATION

- Each project year, IDPH and the IHIPC identifies and implements strategies to recruit/retain IHIPC members and to target community participants in HIV planning meetings and activities that represent the diversity of HIV-infected populations, other key stakeholders in HIV prevention and care and related services, and organizations that can best inform and support the development and implementation of the Illinois Integrated Plan for HIV Prevention and Care.
  - Membership gap analysis
  - Recruitment, interview and selection
  - New member orientation and training
  - Membership Committee objectives

STEP 1: PRINCIPLES

- The HIV planning group should reflect the local epidemic by involving representatives of populations with increased occurrence of HIV, and should include service providers representing HIV care and prevention, mental health, substance abuse, community health centers, etc.

- IDPH and the IHIPC should regularly assess representation and participation of HPG members, HIV service providers, and key stakeholders involved in the planning process to ensure optimal participation and input.
STEP 2: ENGAGEMENT PROCESS
THAT IS RESULTS-ORIENTED

- Each project year, the IHIPC develops and IDPH implements an HIV planning engagement process that includes specific strategies to ensure a coordinated, collaborative, and seamless approach to accessing HIV prevention, care, and treatment services for the highest risk populations – particularly those disproportionately affected by HIV across the jurisdiction
  - All IHIPC Committee objectives
  - IDPH HIV Engagement Plan

STEP 2: ENGAGEMENT PROCESS

- The 2018 Engagement Plan itself will be mostly narrative.
  - Description
  - Goals
  - Key stakeholders
  - Engagement and Retention (of stakeholders) strategies
  - Guiding principles for engagement
- The 2018 Updated Integrated Plan Activities Sheet (to be finalized at the December 14th Integrated Planning Group meeting) will serve as the foundation for IHIPC and HIV Section Engagement Plan activities in 2018.
- The final plan will be distributed to the IHIPC by February 2018.
STEP 2: PRINCIPLES

- Community engagement is not an IHIPC only process. IDPH and the IHIPC must work collaboratively to develop, implement and monitor the strategies that will increase access to HIV services.

- IDPH and the IHIPC should identify and facilitate the participation of key stakeholders and HIV service providers.

- IDPH and the IHIPC must actively engage other planning groups and federally funded grantees in the HIV planning process (PLWH, Ryan White Parts A-F, HOPWA, CDC-direct funded prevention, SAMHSA, etc.)

- Stakeholders are engaged so that in the planning process there is discussion of the following:
  - Development of services where they don’t exist but need is evident
  - Enhancement of services in content, format, or delivery so that consumers are more willing or able to use them (availability, acceptability, accessibility)
  - Removal or mitigation of various structural barriers that currently impede access to existing services

STEP 3: INTEGRATED PLAN
DEVELOPMENT, UPDATE, MONITORING

- Each project year, IDPH and the IHIPC identify and employ various methods to elicit input on the development, update, and implementation of the Integrated Plan) from IHIPC members, other stakeholders, and providers.
  - Epidemiological analyses
    - Trends and disparities in the epidemic
    - Social determinants of health
  - Needs assessments
    - Health inequities that are driving the epidemic
  - HIV service delivery analyses

- These things all inform the development and update of the Integrated Plan as well as the engagement process.
STEP 3: INTEGRATED PLAN
DEVELOPMENT, UPDATE, MONITORING

- IHIPC will provide input into and inform the following Updates to the Integrated Plan in 2018:
  - February: HIV/STD Epidemiology Update (focus on identifying significant trends and disparities/inequities)
  - April: Linkage of 2018 HIV Care grant/budget to Integrated Plan
  - June: Recommendations for Prioritized Targeted Populations, Risk Group analyses/definitions, and Services and Interventions for targeted prevention services
  - August: Linkage of 2018 HIV Prevention grant/budget to Integrated Plan; Regional Prevention services gap analyses
  - October: IL Continuum of Care/Progress on 2020 NHAS Indicators
  - December: Overview of 2018 Progress on Integrated Plan Activities

STEP 3: PRINCIPLES

- The IHIPC is primarily responsible for informing the development and update of the Integrated Plan.
- IDPH is primarily responsible for implementing and monitoring the Integrated Plan.
- IDPH and the IHIPC should engage key stakeholders and providers since their participation in the planning process is vital to informing the development and implementation of the Integrated Plan.
- IHIPC members should promote and support, as appropriate and feasible, implementation of the Integrated Plan.
HIV PLANNING PRODUCTS AND MONITORING INDICATORS

- Membership profiles
- Documentation of the monitoring process
  - IHIPC website
    - IHIPC information
    - Meeting schedule and notices
    - Presentations and meeting materials
- Documentation of implementation of the engagement process
  - Engagement Plan
  - Public comment periods on agendas
  - Calendar/timeline of activities
  - Membership gap analysis, recruitment, and selection
- Documentation of how the IHIPC provided input in the development/update of the Integrated Plan
  - IHIPC meeting minutes and voting logs
  - IHIPC Committee minutes
  - Updates to the Integrated Plan
- Letter of concurrence, concurrence with reservations, or non-concurrence

SNAPSHOT OF IHIPC RESPONSIBILITIES

- **Step 1: Stakeholder Identification**
  - Assist IDPH in identification of key HIV planning community stakeholders.
  - Establish procedures to ensure stakeholders are regularly identified.

- **Step 2: Engagement Process**
  - Develop a process to engage stakeholders in HIV planning activities.
  - Review HIV epidemiologic trends and other data sources such as social determinants that may be of importance in developing the engagement process.
  - Document the engagement and the planning process.

- **Step 3: Integrated HIV Prevention and Care Plan**
  - Inform the development and update of the Integrated Plan (IDPH is responsible for the actual development and update of the Plan).
  - Assist IDPH with ongoing engagement strategies, and as needed, the JP.
  - Submit letter of concurrence, concurrence with reservations, or non-concurrence, as needed.
  - Assist IDPH with ongoing monitoring, documentation and updating of the Engagement Plan and required documentation.
RESPONSIBILITIES
SHARED BETWEEN IDPH AND IHIPC

- Develop operating procedures that address membership, roles, and decision-making.
- Provide an orientation for all new members as soon as possible after their appointment.
- Develop and apply criteria for selecting IHIPC members.
- Determine the most effective input method for the community engagement and HIV planning process.
- Determine the amount of funds necessary to support HIV planning.
- Evaluate the planning process to ensure it meets the objectives of HIV planning.

Shared Community, Health Department and IHIPC Steps in HIV Planning Process

- Provide input on prioritized populations for HIV prevention based on analysis of Illinois' Epi and social determinants of health data.
- Assess prevention and care needs of PLWH and the prioritized prevention populations.
- Inventory HIV prevention and care services available.
- Analyze the gaps between needs and services available.
- Identify strategies and interventions for prioritized populations.
- Evaluate and review outcomes of Integrated Plan activities and NIDAS Indicators and update Integrated Plan priorities, as needed.
- Monitor and evaluate the community engagement and HIV planning process.
The Integrated Planning Group has reviewed the jurisdiction’s Integrated HIV Prevention and Care Plan.

The Plan describes and IDPH has explained to the satisfaction of the IHIPC how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease in the jurisdiction.

The Plan fulfills the requirements set forth by the federal Prevention grant and the Ryan White HIV/AIDS Program legislation and program guidance.

The Plan demonstrates a collaborative and coordinated approach for HIV prevention, care, and treatment.

The IHIPC provides input in the development (or update) of the Plan.
CONCURRENCE CHECKLIST

- Tool initially developed by the Integrated Planning Steering Committee (that the IHIPC will continue to use).
- The checklist is included in the slides for each meeting and the elements of concurrence are reviewed with members at meetings.
- The checklist is used to verify the essential elements of concurrence have been met throughout the year.
- On the agenda for each meeting, we also include a symbol and a notation next to each topic identifying the NHAS Indicator(s) or Continuum of Care step(s) that will be the focus of that presentation/discussion to assist with this verification.

SAMPLE AGENDA

Illinois HIV Planning Group (ILHPG) Meeting Agenda
May 12, 2017, 9:30 am – 12:00 pm

- Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)
- Review formally adopted agenda
- Webinar process, Attendance; Announcements; Updates (15 minutes)
  - Webinar meeting, online meeting survey, and online discussion board instructions
  - Announce logged in members and take roll call of other voting members to verify quorum
- Review meeting objectives
- Member updates
- 2017 Cumulative voting and non-voting member meeting attendance log
- Posted Reports/Updates:
  - Committee, Liaison and Regional Lead Agent, RIG Rep, and IDPH HIV Section reports
- Review meeting objectives and Concurrence checklist
  - Present, Discuss, Vet, and Vote on Updates to Recommended Priority Populations for Targeted Prevention Services for 2018 (30 minutes)
    - 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
    - Questions & Answers, Discussion, Input, and Vote - (15 minutes)
  - Present, Discuss, Vet, and Vote on Recommended Changes to the Prioritized Risk Group definitions for 2018 (20 minutes)
    - 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
    - Questions & Answers, Discussion, Input, and Vote - (10 minutes)
  - Present, Discuss, Vet, and Vote on Current and Proposed Changes to HIV Prevention Interventions and Services Guidance for 2018 (30 minutes)
    - 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
    - Questions & Answers, Discussion, Input, and Vote - (15 minutes)
- Public Comment Period/Parking Lot (10 minutes)
- Adjourn
REQUIRED STEPS IN CONCURRENCE PROCESS

**Step One:** The Integrated HIV Prevention and Care Plan has been informed, reviewed by, and explained to the HIV planning group. The plan should show that programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

**Step Two:** A letter is drafted and signed on behalf of the HIV planning group, stating that the Plan (and significant updates thereof) sent forward by the health department demonstrates a collaborative and coordinated approach for HIV prevention, care, and treatment and ensures that prevention and care services and resources are directed to the areas with the greatest HIV disease burden.

**Note:** Once the HIV planning group submits a letter of concurrence with the Integrated Plan, a new letter of concurrence is no longer an annual requirement. *(This is different from past CDC guidance).* A new letter of concurrence is only required if significant updates to the Integrated Plan have been made.

CONCURRENCE LETTER

- The following is included in the letter:
  - Documentation that the Integrated Planning Group informed the development of the Plan
  - Description of the process used to review and educate the Integrated Planning Group on the Plan
  - Within the perimeters of the elements of concurrence, as defined by CDC and HRSA, the Integrated Planning Group can concur, concur with reservation(s), or not concur with the Integrated HIV Care and Prevention Plan.
  - If there is concurrence with reservation(s) or non-concurrence, the letter must provide in detail the specific reason(s) why.
  - The letter of concurrence, concurrence with reservation(s), or non-concurrence should be signed by the Integrated Planning Group Co-chairs and the ILHPG Community Co-chair on behalf of the Integrated Planning Group.
LETTERS OF CONCURRENCE

- **Concurrence:** The HIV Planning Group agrees that it has informed and reviewed the Integrated HIV Prevention and Care Plan that will be submitted to CDC and HRSA and concurs that the Plan describes how HIV care and prevention programmatic resources and activities are allocated to populations and areas with the greatest HIV disease burden.

- **Concurrence with Reservations:** The HIV Planning Group agrees that the above has occurred but has an appropriate statement of concern/issues (relevant to the purviews of the group).

- **Non-concurrence:** The Integrated Planning Group disagrees that it has been informed and involved in the development/update of the Plan or that the Plan describes how HIV care and prevention programmatic resources and activities are allocated to populations and areas with the greatest HIV disease burden.

MEMBER ROLES AND RESPONSIBILITIES
TERMS OF VOTING MEMBERSHIP

- Initial two year term
- **Note:** The only exception to this will occur during the initial implementation of the IHIPC. All IHIPC membership terms cannot end at the same time; otherwise, there would not be a stable source of experienced membership on the IHIPC to mentor new members and to carry on the functions of the IHIPC and its committees. So, after selected, individuals on the first membership roster of the IHIPC were randomly assigned by the IDPH IHIPC Coordinator – half to two-year terms and half to three-year terms, ensuring that the distribution was balanced across regions, areas of representation, and expertise.
  - Additional two year term permitted for those assigned to two-year terms (subject to reappointment, at the request of the member through an established written request/approval process).
  - No additional term permitted for those assigned to three-year terms during the initial implementation of the IHIPC.
  - After serving 48 consecutive months, a member must wait 12 months before reapplying.

MEMBER MEETING ATTENDANCE AND COMMITTEE PARTICIPATION REQUIREMENTS

Meeting Attendance:
- Meeting schedule for each year (combination of trainings, webinars, and face-to-face meetings) will be provided to members and posted by the end of the preceding year.
- Planned 2018 schedule:
  - Monthly 2 ½ hour webinars the third Thursday in February, April, August, and December (each webinar counts as a half-day meeting)
  - Two 2-day in-person meetings (each 2 day meeting counts as four half-day meetings) in June and October
- Trainings are required for all new members and recommended for current members.
  - January-February – several online or webinar trainings
  - May – one webinar training

- Committee Participation:
  All voting members (elected and appointed) are required to be assigned to a standing committee and to actively participate in committee meetings
MEETING ATTENDANCE PROCEDURE

Attendance and participation are very important!

- Trainings don’t count toward attendance but are still required.
- Each day of an all day in-person meeting counts as two half days.
- Each webinar meeting counts as one half day meeting.
  - Members receive credit for participating in live webinars and in-person meetings.
  - They may also receive credit for viewing the recorded meetings (webinar or in-person) that will be posted and can be viewed from the IHIPC website usually within 24-48 hours after the meeting.
  - Members will receive credit for viewing the recorded meetings only when no scheduled votes take place during the meeting. Members must participate in live webinar meetings with scheduled votes in order to receive attendance credit.
- Combined, there will be 12 increments of ½ day meetings in 2018.
- Members will be allowed 3 half-day absences. Without an approved temporary suspension of membership, more than 3 will result in termination by absence from the ILHPG.

ILHPG MEMBER ROLES & RESPONSIBILITIES

- Be prepared for and attend meetings.
- Participate on assigned committee and complete assigned tasks.
- Respond to requests for information from IHIPC Co-chairs and assigned committee co-chairs.
- Collect and/or review data and information, as needed, on specific HIV care and prevention issues.
- Participate in group discussions, decision-making, and problem solving.
- Reflect the perspectives of diverse population group(s).
- Commit to the group’s Bylaws and Policies, as adopted.
  - Commit adequate time to fulfill the above.
  - Commit to the group’s planning process and results.
  - Take on a leadership role or lead a committee or workgroup, if elected.
MAJOR DUTIES/TASKS OF MEMBERS

- Provide input on HIV issues and other information presented to the IHIPC for development/update of the Integrated Plan.
- Assist in assessing resources and determining the jurisdiction’s capability/capacity to respond to the HIV epidemic.
- Assist in identifying priority populations for targeted HIV prevention services.
- Assist in identifying unmet HIV care and prevention needs within defined populations and recommending effective strategies and interventions to address gaps, barriers, and challenges.

IHIPC 2018 CALENDAR AND MEETINGS
2018 IHIPC ACTIVITIES CALENDAR

- **Trainings (each 60-90 minutes)**
  - Jan –Feb:
    - Open Meetings Act (online)
    - Understanding Basic HIV Epidemiology/Using Data for HIV Planning (webinar)
    - Meeting Rules for Respectful Engagement/Robert's Rules of Order/Conflict of Interest (webinar)
    - Overview of IHIPC Website and Access to IHIPC Webinars/Trainings
  - May:
    - High Impact Prevention and Approved Prevention Strategies & Interventions (webinar)

- **In-Person Meetings**
  - Two 2-day face-to-face meetings (Springfield)- each full day counts as 2 half-day meeting increments
    - Thursday, June 28th and Friday, June 29th
    - Wednesday October 10th and Thursday October 11th

- **Webinars**
  - Four 2 ½ hour webinar meetings
    - Thursdays Feb. 15th, April 19th, Aug. 16th, Dec. 13th
  - Total of 12 half day meeting increments – voting members will be allowed to miss no more than 3
  - Meetings will be recorded and members can receive credit (within designated time period) for meetings they miss unless scheduled votes took place at the meetings.
2018 IHIPC ACTIVITIES CALENDAR

Meetings (continued)

- More time on agendas for discussion, committee breakouts, and solicitation of input from full planning body
- Data drives decision-making, but……. We will continue to ask presenters to summarize and highlight data and significant trends and patterns in the state’s HIV epidemic, service delivery, and co-existing issues so we can focus more on discussion and planning pertinent to integration, achieving the NHAS 2020 goals, and Getting to Zero.
- Meeting documents and slides will always be posted online prior to meetings with limited hard copies of documents provided at face-to-face meetings

### 2018 Annual Illinois HIV Integrated Planning Council (IHIPC) Calendar of Activities_12.03.17

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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<tbody>
<tr>
<td>February</td>
<td>Webinars and Online Trainings (weekend)</td>
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<tr>
<td>March</td>
<td>Needs Assessment Activities</td>
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<tr>
<td>April</td>
<td>Face-to-face meetings:</td>
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<td>Webinars and Online Trainings (weekend)</td>
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<td>Online Required Trainings</td>
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<td>Needs Assessment Activities</td>
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#### Notes
- Meetings (Discuss & Vote)
- Webinars and Online Trainings
- Online Required Trainings
- Needs Assessment Activities
- Face-to-face meetings
- Webinars and Online Trainings (weekend)
- Online Required Trainings
- Needs Assessment Activities

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*Due to the sensitive nature of the information, some dates and details have been redacted for privacy and confidentiality.*
2018 Annual Illinois HIV Integrated Planning Council (IHIPC) Calendar of Activities

Members and Community stakeholders: You will need to register at the specified link below for each webinar meeting in which you wish to participate. After registering, the participant will receive a confirmation email containing information about joining the webinar. You may participate in the webinar either from your personal or office computer or go to one of the specified host sites in each region. The list and addresses of host sites will be updated as they are confirmed.

Standing Committees

<table>
<thead>
<tr>
<th>Standing Committee</th>
<th>Preventive Strategies</th>
<th>Epidemiology/Needs Assessment</th>
<th>IHIPC Member</th>
<th>Data Profile and Health Disparities Data</th>
<th>Community Services Assessment (CSA) Activities</th>
<th>Gap Analyses</th>
<th>Priority Populations</th>
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</table>
| Monthly conference calls, break-out meetings during face-to-face IHIPC meetings; work to complete committee objectives; present findings to IHIPC. | IHIPC presentations and discussions about prevention strategies and interventions and associated recommendations to address the NHAS goals for consideration in the Integrated Plan. | Epidemiology/Needs Assessment
1. Epidemiology/Needs Assessment
2. Primary Prevention
3. Linkage, Retention, Reengagement, Antiretroviral Therapy, and Viral Suppression
4. Membership | Description of the NHAS and HIV/STD co-infection epidemic in Illinois. Epi Profile data is updated annually by the HIV and STD-Sections and supplemented with data such as Unmet Need, MMWR, Continuum of Care, social determinants, and applicable research. | Process to determine jurisdictional needs, gaps, barriers, and challenges associated with HIV prevention and care services for PLWHA and populations at highest risk of HIV infection. Includes review of the current resource inventory, analyses of needs assessment activities conducted during the year, review of other applicable needs assessment data from other agency/program areas, and identification of strategies to address needs, gaps, barriers, and challenges. | Process led by IDPH, with input from the IHIPC Committees, to 1) Determine gaps between the HIV/AIDS epidemic and HIV prevention and care service delivery in the jurisdiction, and 2) Determine gaps in IHIPC membership. IDPH presents the results of the gap analysis to the full IHIPC and solicits recommendations and input. | The multi-step process to identify the populations prioritized for targeted prevention strategies and interventions efforts in the upcoming year. |

RELATIONSHIP OF IHIPC ACTIVITIES TO NHAS AND CONTINUUM OF CARE

- All IHIPC meeting presentations, discussions, committee objectives, and needs assessment activities are relevant to these three things:
  - Achieving the National HIV/AIDS Strategy 2020 goals and respective indicators for Illinois
  - Raising the bars on the Illinois HIV Care Continuum
  - Meeting CDC High Impact Prevention (HIP) Guidance and HIV Planning Group (HPG) tasks
2018 IHIPC MEETING
SCHEDULE/PLANNED ACTIVITIES

- Draft meeting schedule/calendar of activities
  - Timeline for essential annual updates of 2017-2021 Integrated HIV Prevention & Care Plan
  - More time on agendas for discussion, committee breakouts, and solicitation of input from full planning body
  - Data still drives decision-making, but our presentations will focus more on providing overviews of issues, highlighting significant trends and patterns in the state’s HIV epidemic, service delivery, and co-existing issues so we can focus more on discussion and planning pertinent to integration, achieving the NHAS 2020 goals, and Getting to Zero.
  - In 2018, we will also focus on establishing our committees, electing our leadership, and beginning a cycle of needs assessment activities.

2018 IHIPC MEETING
SCHEDULE/PLANNED ACTIVITIES

- January 2018 (dates TBD):
  - New IHIPC Member trainings (online and webinar)

- Thursday, February 15th IHIPC webinar meeting:
  - HIV/STD Epi Update – focusing on disparities identified among MSM of color, AA and Latina women, youth (ages 13-24 years), transgender individuals, etc.
  - Overview of membership composition
  - Overview of IHIPC Committees, functions, and objectives
  - Present draft plans/Solicit input into 2018 Needs Assessment activities

- Thursday, April 19th IHIPC webinar meeting:
  - Liaison Update
  - LHD 2018 PrEP Project Update and Plans for 2019
  - 2018 HIV care grants, budgets and linkage to Integrated Plan

- May 2018 (date TBD) IHIPC Webinar training
  - High Impact Prevention and Approved 2019 Prevention Strategies and Interventions

- Tuesday, June 19th (tentative date) - IHIPC Focus group in Region 2
2018 IHIPC MEETING
SCHEDULE/PLANNED ACTIVITIES

Thurs. and Fri., June 28th and 29th, 2018 *IHIPC in-person meeting* (Springfield):
- Present, discuss, and vote on priority populations for HIV prevention.
- Present, discuss, and vote on risk group analyses and definition changes.
- Present, discuss, and vote on proposed changes to I&S Guidance
- Review Delivery and Mapping of FFY2017 HIV Care Services
- Review 2018 Prevention and Care Resource Inventory
- Review Membership gap analysis, new membership application/selection process, and open recruitment for 2018

Thursday, August 16th *IHIPC webinar meeting* face-to-face meeting (Springfield):
- HIV prevention regional gap analysis
- Linkage of 2018 Prevention grant/budget to Integrated Plan
- FY2017 RWPB Client Satisfaction Survey
- Sept-Oct: New member application/selection process will take place.
- Weds., Oct. 10th (tentative) *IHIPC Focus group* in Region 3

Thurs., Dec. 13th *IHIPC Webinar meeting*:
- 2018 IHIPC evaluation
- 2-19 Committee objectives
- Monitoring Progress on Integrated Plan Activities
- 2019 leadership selection

Thurs., Dec. 13th *IHIPC New Member Orientation*
MEETING SPECIFICS

- For the 2-day in-person meetings, the IDPH IHIPC Coordinator will correspond with members two months prior to the meeting to determine their need for lodging.
- The IDPH IHIPC Coordinator will send the agenda to voting membership for approval the month prior to the meeting.
- After the agenda is approved, a formal meeting notice will be sent to members with details on registration. A notice will also be sent to community stakeholders.
- A public meeting notice and the final approved meeting agenda will be posted on the IHIPC website at least 48 hours prior to the meeting.

MEETING SPECIFICS

- Meetings will be conducted according to basic meeting rules of Robert’s Rules of Order and all provisions of the Illinois Open Meetings Act (both explained later).
- A public meeting notice and the final approved meeting agenda will be posted on the IHIPC website at least 48 hours prior to the meeting.
- A quorum (majority) of voting members must be present at IHIPC meetings to conduct any business.
- Members must be present (in person or by live remote) at meetings to cast their votes. No proxy votes will be allowed.
- Members will be expected to follow professional code of conduct at all IHIPC meetings.
EXPENSES

For face-to-face meetings:

- Lodging will be provided to authorized members through an agreement with a hotel.
- We may or may not provide refreshments and box lunches at meetings. Members will be made aware in advance.
- Members will be reimbursed for the “most reasonable” transportation to attend face-to-face meetings of the IHIPC.
  - “Coach” seats on Amtrak
  - Mileage reimbursement only for driver of vehicle (car-pooling is encouraged)
- Allowable costs to attend meeting will be reimbursed by member submitting a signed and completed travel voucher with all required receipts. The travel vouchers will be collected by the Secretary after each meeting.

**Example 1: Itemization of Non-State Employee Travel**

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Grand Total: $0.00 + $39.00 + $24.00 = $65.00

I certify that I incurred the above expenses while traveling on or for official State of Illinois Business.

Mail Completed Form to:
Janet Nuss
Illinois Department of Public Health
525 West Jefferson, 1st Floor
Springfield, Illinois 62761

We cannot accept electronic signatures.

Total Reimbursement

Return to Janet at meeting or by fax or email. Janet will collect, verify, and submit to IDPH.
Example 2: Itemization of Non-State Employee Travel

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Grand Total: 320 $171.20 $39.50 $18.00 $228.70

Total:

I certify that I incurred the above expenses while traveling on or for official State of Illinois Business.

Mail Completed Form to:

Janet Nuss
Illinois Department of Public Health
525 West Jefferson, 1st Floor
Springfield, Illinois 62761

Traveler Signature Date

We cannot accept electronic signatures.

IHIPC COMMITTEES AND LEADERSHIP
IHIPC COMMITTEES

- In addition to the Steering Committee that oversees all IHIPC processes, a considerable amount of the work of the IHIPC will be conducted in four standing committees that will each specifically address one of the four goals of the National HIV/AIDS Strategy. These committees will provide input/feedback to IDPH in the development of a comprehensive plan for prevention and care as well as take on other roles as required by federal programmatic guidance legislation and suggested by best practices.
- IDPH HIV Section staff provide support to the four standing committees.
- Committees meet one hour monthly by scheduled conference call.
- Completion of any assigned committee tasks and selection as a committee co-chair will require an additional time commitment.
- Ad-hoc committees or workgroups may be formed as needed.

Primary HIV Prevention Committee:
- Focus: NHAS Goal 1: Reduce New HIV Infection.
- Prevention for Negatives

Linkage, Retention, Reengagement, Antiretroviral Therapy, and Viral Suppression Committee:
- Focus: NHAS Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV (PLWH).
- Prevention, Care, and Treatment for Positives

Epidemiology/Needs Assessment Committee:
- Focus: NHAS Goal 3: Reduce HIV-related disparities and health inequities.

Membership Committee:
- Focus: NHAS Goal 4: Achieve a more coordinated, collaborative response to the HIV epidemic.

Steering Committee:
- Focus: Overall leadership and direction of the IHIPC
LEADERSHIP OF THE IHIPC

- The Steering Committee is the collective leadership of the IHIPC. Included in this committee will be 13 members:
  - The appointed IDPH IHIPC Co-chair
  - The elected Community Co-Chair (1 year term)
  - The elected Community Co-chair Elect (1 year term), the elected Parliamentarian (2 year term), and the elected Secretary (2 year term)
  - The co-chairs of the four standing IHIPC committees

Please note: The Integrated Planning Steering Committee that was formed in Oct 2016 to guide development of the IHIPC will function as the IHIPC Steering Committee until new IHIPC leadership is elected and committee co-chairs are selected.

YOUR 2018 IHIPC APPOINTED AND ELECTED LEADERSHIP

Janet Nuss
IHIPC Coordinator/Co-chair
Illinois Department of Public Health

| Community Co-Chair | Secretary | Parliamentarian | Community Co-Chair Elect |
PRIMARY HIV PREVENTION COMMITTEE

Focus - NHAS Goal 1: Reduce New HIV Infection

- Uses epidemiological profile to identify populations at greatest risk for HIV transmission and acquisition *
- Annually reviews emerging national and local data on high impact prevention, public health strategies, scalability of services, and effective interventions*
- Makes recommendations for revisions to the prioritized list of cost and behaviorally effective prevention services and interventions for high risk populations and make recommendations on guidance for approved interventions and services to be included in the development/update of the Illinois Integrated Plan for HIV Prevention and Care
- Identifies issues that may constitute barriers for accessing or delivering prevention services and make recommendations to address those barriers*
- Recommends, plans, evaluate needs assessments and gap analyses to assess factors contributing to new infections in Illinois and to identify practical solutions to address inhibitors and barriers to prevention*
- Evaluates prevention strategies and interventions and identifies best practices*
- Provides feedback and input to IDPH in HIV prevention priority setting*
- Reviews data presentations on current HIV prevention service utilization and regional needs and gaps in prevention services before presentation to the full IHIPC*
*Roles shared with IDPH or other IHIPC Committees

LINKAGE, RETENTION, REENGAGEMENT, ANTIRETROVIRAL THERAPY, AND VIRAL SUPPRESSION (LTC, RRC, ART, VS) COMMITTEE

Focus - NHAS Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV (PLWH)

- Uses the updated Illinois HIV epidemiological profile and Continuum of Care to identify populations with the greatest burden of the epidemic and assess their access to HIV care and treatment services and health outcomes *
- Identifies opportunities and assists in the planning of needs assessments; reviews results and makes recommendations re: improving Linkage to Care (LTC), Retention and Reengagement in Care (RRC), Antiretroviral Therapy (ART), and Viral Suppression (VS) bars along the statewide continuum of care *
- Uses epidemiological, needs assessment, and service delivery analyses to provide feedback and input to the HIV Care Program into the HIV care priority setting and resource allocation process*
- Reviews all data presentations to the IHIPC that provide information on current HIV care service utilization and regional needs and gaps in HIV care and treatment services before presentation to the full IHIPC*
*Roles shared with IDPH or other IHIPC Committees
EPIDEMIOLOGY/NEEDS ASSESSMENT COMMITTEE

NHAS Goal 3: Reduce HIV-related disparities and health inequities.

- Makes recommendations to the IDPH HIV and STD Sections on data to include in presenting the Illinois HIV Epidemiological Profile to the IHIPC*
- Provides input and assist the HIV/AIDS Section in the analysis of epidemiological data and other data sources and information related to the HIV epidemic in Illinois, utilization and delivery of HIV prevention and care services, resources, and gaps in services*
- Reviews all analyses and data presentations to the IHIPC that identify emerging trends, social determinants, and disparities; information on current prevention and care service utilization, and regional services needs and gaps in prevention and care services before presentation to the full IHIPC*
- Reviews the Illinois HIV Continuum of Care/NHAS Indicators Report and provides recommendations to the IHIPC and the HIV Section on activities to enhance PrEP utilization, ART treatment engagement, and viral suppression by race/ethnicity, risk, and age.
- Provides input to the Health Department to ensure the IHIPC informs HD decisions on prioritized populations and funded services and interventions, and that the HIV/AIDS Section demonstrates to the IHIPC the linkage of these decisions to the Illinois Integrated Plan for HIV Prevention and Care in preparation for the concurrence process*
- Assists the HIV/AIDS Section, as requested and as able, in the planning, conduct, and analysis of needs assessment activities (focus groups, town hall meetings, surveys, etc.)*

*Roles shared with IDPH or other IHIPC Committees

MEMBERSHIP COMMITTEE

Focus - NHAS Goal 4: Provide a collaborative response to the HIV epidemic.

- Assists with the recruitment and selection of new IHIPC members - The recruitment and selection cycle is conducted annually beginning in June and concluding with the election of new members at the last in-person calendar meeting of the full planning group.*
- Assists with annual collection/analysis of member surveys; monitors/assesses the demographic, regional, risk, and expertise composition of IHIPC membership; and reports to the IHIPC annually on IHIPC membership gaps and implements procedures to fill the gaps through the next IHIPC recruitment cycle*
- Develops, participates in, implements a mentoring/orientation process for new IHIPC members*
- Conducts and analyzes surveys of IHIPC meetings and trainings to determine effectiveness of HIV planning activities and continued training needs of members*
- Identifies and develops improved ways to conduct IHIPC meetings and activities*
- Assesses technical assistance needs of IHIPC member.*
- Assists IHIPC Coordinator in analysis of key stakeholders who participate in IHPC meetings/activities*
- Assists in the development, documentation and monitoring of the IHIPC and annual HIV stakeholder engagement process as specified in the CDC HIV Planning Guidance*
- Assists the HIV/AIDS Section, as requested and as able, in the planning, conduct, and analysis of needs assessment activities (focus groups, town hall meetings, surveys, etc.)*
- With guidance from the IHIPC Coordinator and the IHIPC Steering Committee, develops, reviews, and maintains the Bylaws for the IHIPC and assists the Health Department in the revision or drafting of procedures, based on identification of need for new procedure or clarification of existing procedure by IHIPC members or committees.*

*Roles shared with IDPH or other IHIPC Committees
MENTORING

- Ideally, each new IHIPC member would be assigned a mentor—a more senior member of the IHIPC who would assist in guiding new members as they get acquainted with the planning process and the planning group system.
- Since this is a new group with all new membership, the IDPH IHIPC Coordinator will be everyone’s mentor this year.

STEERING COMMITTEE

Summary of Roles:

- Manages business of the IHIPC; follows-up on issues within the purview of the IHIPC; and makes recommendations for resolution of issues or referral to appropriate parties (e.g., IDPH or IHIPC committee).
- Develops agendas for full IHIPC meetings in conjunction with the IHIPC Co-chairs
- Reviews proposed amendments to the IHIPC Bylaws and Procedures Manual before presentation for vote to the full IHIPC.
- Oversees and coordinates the work of the IHIPC and its committees, task forces, and working groups, in accordance with their already established scopes of work
- Makes recommendations to the IHIPC about HIV prevention, care and IHIPC process issues
- Makes decisions about member dismissal for reasons other than absenteeism
- Approves/denies recommendations from committees to add community members to committee rosters as members
- Reviews requests for letters of support submitted by agencies or researchers
- Facilitates the annual IHIPC concurrence process with the Integrated Plan
Questions???

Always feel free to contact:

Janet Nuss
IHIPC Coordinator/Co-chair
217-524-6796
janet.nuss@illinois.gov

NEXT REQUIREMENTS

- Trainings to Complete Before February 15th:
  - IHIPC Meeting Process, Robert’s Rules of Order, Conflict of Interest
    - Should receive an email notice with details by the end of this week
  - Understanding HIV Epidemiology and Using Data for HIV Planning
    - Should receive an email notice by January 12th
  - IHIPC Website and Webinar Instruction
- IL Open Meetings Act Training and Certification
- Complete/submit Disclosure of Interest/Code of Ethics Statement