Hi, everyone!

On July 31, 2017, the Illinois Department of Public Health’s (IDPH) Ryan White Part B HIV/AIDS Program and HIV Prevention Program received a Cover Letter and Summary Statement from the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) detailing the results of their joint review of the Illinois Integrated Plan for HIV Prevention and Care and Statewide Coordinated Statement of Need: 2017-2021 that we submitted last September.

I am pleased to inform you that in general, the review of the state’s Integrated Plan was very favorable. We should all take pride in that as development of the plan was definitely a collective effort among IDPH, the HIV planning groups, and our HIV stakeholder HIV community. One of the remarks in the Overall Summary actually states that “The integrated plan is a model that should be duplicated across the nation and territories.”

Most of the components of our Integrated Plan were identified as “strengths”. The only “weakness” referenced was in regard to the impact of our lack of a state budget, which has since been resolved. There was one “recommendation” for future updating of the Plan – that we conduct analyses of unmet need and community viral load data for each region in Illinois. Those analyses were actually something for which we had already planned. The regional HIV continua of care and unmet need analyses were presented at our August 24th Integrated Planning meeting.

The soon to be established Illinois HIV Integrated Planning Council (IHIPC) will work with the HIV Section to continue to monitor implementation and make updates and improvements to the Integrated Plan, as needed. The full Cover Letter and Summary Statement are available for viewing at the following link: https://onedrive.live.com/?authkey=%21AK7h9Z5WzNDfHk8&id=453592C0C72968E0%212208&cid=453592C0C72968E0
INTEGRATED PLANNING GROUP AND ILHPG UPDATES

INTEGRATED PLANNING GROUP

Thanks to all of the members of the Illinois HIV Planning Group (ILHPG), Ryan White Part B (RWPB) Advisory Group, Integrated Planning Steering Committee, and other community stakeholders and partners who attended the Integrated Planning Group workshop meeting in Springfield, August 24th. This was the group’s first in-person meeting in nearly a year and it was very well attended. Sixty-four people attended in person and another 16 people attended remotely by webinar.

These meetings are vitally important to informing, engaging, and seeking input from our membership and stakeholder community in discussions about issues relevant to HIV in Illinois and our ability to meet the goals of the National HIV/AIDS Strategy (NHAS). The August 24th meeting was of particular importance for several reasons.

First, the meeting included a presentation from members of the Illinois Getting to Zero (GTZ) Initiative. The workgroup has been developing a GTZ framework to eliminate HIV in Illinois. While the state has been making progress in the prevention of new cases of HIV and in achieving viral suppression for people living with HIV who are in care, there remain significant challenges and inequities. Workgroup members used the Integrated Planning Group meeting as an opportunity to share the framework, gather feedback, and garner support for GTZ from our membership and community participants.

Second, we summarized updates to the Illinois Integrated Plan for HIV Prevention and Care: 2017-2021. The 2018 Prioritized Prevention Populations, Risk Group Definitions, and Interventions and Services Guidance had been updated by ILHPG Committees and formally approved by the full ILHPG earlier this year. An overview of the progress made in 2017 by Illinois in achieving the NHAS indicators and an updated Illinois HIV Care Continuum and Unmet Need Analysis, including regional variations of both, were presented at the meeting. Curt Hicks then presented a summary of IDPH’s 2018 HIV Prevention Grant application and budget, demonstrating their linkage to and alignment with the priorities identified in the Integrated Plan. Jeff Maras had provided a similar overview of IDPH’s 2017 RWPB HIV Care and Treatment Grant application and budget at the group’s meeting in May, demonstrating how the program’s resources and activities were also in alignment with the priorities identified in the Integrated Plan.

Third, the Steering Committee Co-chairs provided an overview of the concurrence process and the essential elements of concurrence. The group agreed that because no major updates had been made to the Integrated Plan this year, there was no need to call for a new concurrence vote.

Finally, this meeting was the venue for final discussion and vote by Integrated Planning Group members on the bylaws and procedures for the soon to be established Illinois HIV Integrated Services Council (IHIPC) that will take the place of both the ILHPG and the RWPB Advisory Group effective January 1, 2018. The draft bylaws and procedures had been developed by the Integrated Planning Steering Committee and had gone through months of editing, draft revisions, and public comment prior to being presented for a formal vote. I am pleased to announce that the draft Bylaws and Procedures were approved with one exception. The group asked that the proposed composition of membership go back to the steering committee for discussion and clarification. After recommendations are received from that committee, we will schedule a webinar call with voting membership to approve that remaining portion of the bylaws. Once that happens, we will formally kickoff our process for recruitment and selection of membership for the new IHIPC. Please follow the http://ilhpg.org website for future notices and instructions about submitting membership applications.

(continued on page 3)
INTEGRATED PLANNING GROUP AND ILHPG UPDATES

(Continued from page 2)

The webinar slides and related handouts for the above meetings can be found at the following link: http://ilhpg.org/docs_082417

ILHPG

Thanks also to ILHPG members and other community stakeholders who attended the August 25, 2017 ILHPG workshop meeting. The slides and other handouts from that meeting can be found at http://ilhpg.org/docs_082517. Fifty-three ILHPG voting and non-voting members and community representatives participated in the in-person meeting and 13 people participated remotely via webinar.

We took advantage of the opportunity to have a face-to-face meeting and asked the HIV Section leadership, ILHPG Liaisons, and our regional Prevention Lead Agents to provide oral reports and facilitate group discussion. Eduardo Alvarado, IDH HIV/AIDS Section Chief provided an overview of the Section and key HIV initiatives. Andrea Danner provided an overview of Illinois’s FY18 HIV Pre-exposure Prophylaxis (PrEP) Demonstration Project with 19 local health department STD clinics. Dan Frey from the AIDS Foundation of Chicago presented an update on federal and state legislation and HIV-related policy. Jill Dispenza, an ILHPG member and the Director of the Illinois AIDS/HIV and STD Hotline provided an update on that initiative. Jennifer Koechle from the RWPB Program provided an overview of the results of the RWPB FY16 Client Satisfaction Survey, which included a section assessing satisfaction and needs for prevention services.

The final presentation, provided by Curt Hicks, the IDPH HIV Prevention Administrator, described the results of the regional gap analysis that the HIV Section had conducted to determine the distribution of regional funding and service scopes for 2018 prevention activities.

As always, we appreciate the community’s interest and participation in our HIV planning meetings. We truly value the discussion and input that we have received from our stakeholders and have used that input to guide program decisions and direction. We certainly hope that you will all remain engaged as we transition to our new IHIPC group in 2018!

Submitted by Janet Nuss, HIV Planning Coordinator, ILHPG/Integrated Planning Steering Committee Co-chair, Illinois Department of Public Health
Illinois is making dramatic progress against HIV. New HIV cases have dropped by 28% from 2006 to 2015, mother-to-child HIV transmission has been nearly eliminated, and there are fewer than 1,000 cases a year in Chicago for the first time in two decades.

However, not all groups are benefiting equally. HIV disproportionately affects Black and Latino individuals. Black gay men are experiencing an increase in HIV cases, particularly among youth. Black women account for more than three-quarters of women who are newly diagnosed and women who are living with HIV. New HIV cases among Latinos of all genders rose 16% outside Chicago between 2006 and 2015.

Illinois has what it takes to Get to Zero. Thanks to the Affordable Care Act, nearly everyone in Illinois vulnerable to or living with HIV has access to comprehensive, more affordable insurance. We have pre-exposure prophylaxis (PrEP), a prevention pill and program that is up to 99% effective at preventing HIV infection when utilized consistently and correctly. Finally, powerful antiretroviral medications mean that people living with HIV on successful antiretroviral treatment — meaning their viral load is undetectable for at least six months —cannot transmit HIV sexually to their HIV-negative partners.

With focused investment and attention, we can do even better. Illinois must focus on strategies that provide the greatest potential for reducing HIV transmission. Scientific modeling suggests that with increased investments in HIV treatment and PrEP, Illinois could see fewer than 100 new HIV cases each year by 2027.

The fiscal benefits for the state are substantial. Lifetime medical care costs for a person living with HIV is over $350,000. If Illinois takes no action, it will cost an estimated $5.2 billion to provide lifetime care for the 15,000 people projected to be infected between 2018 and 2027.

How will Illinois Get to Zero? If Illinois increases current rates of PrEP and HIV treatment by 20%, we would expect fewer than 100 new HIV cases per year to reach “Functional Zero” by 2027: the point where the HIV epidemic can no longer sustain itself.

What’s next? Since the summer of 2016, a workgroup of 12 organizations has been developing a Getting to Zero framework. The group is working with City and State Leadership to appoint a statewide taskforce. Comprised of key agency officials and community stakeholders, the taskforce will develop the plan, to be implemented over a five-year period beginning in 2019.

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People visit the emergency department (ED) for a variety of reasons. To understand trends in ED utilization among people living with HIV/AIDS (PLWHA), we analyzed visits to the ED both specifically for HIV and for all other causes. If a patient visited an ED for the treatment of an HIV-related illness, the ED visit was considered a primary HIV ED visit. If a patient living with diagnosed HIV disease visited the ED for an unrelated condition, the ED visit was classified as a secondary HIV ED visit.

- In 2014, there were an estimated 480 total ED visits (primary and secondary) per 1,000 PLWHA living in Illinois for a total of 17,401 ED visits
- From 2009 to 2014, the rate of primary HIV ED visits declined (49 to 41 ED visits per 1,000 PLWHA), however, the rate of secondary HIV visits among PLWHA increased (386 to 438 ED visits per 1,000 PLWHA)
- Among PLWHA who had either primary or secondary ED visits during 2009–2014, 58.3% were discharged from the ED and 41.7% were hospitalized for further treatment
- Among the ED visits that were outpatient only (i.e., patient was not hospitalized for further treatment):
  - During 2009–2014, less than 10% of outpatient ED visits among PLWHA had HIV listed as the primary reason for the visit
  - The most common reason for PLWHA to have an outpatient ED visit during 2009–2014 was for chest pain (~6% of visits), followed by abdominal pain (~5% of visits)
  - Among PLWHA, females had a higher outpatient ED visit rate than males during 2009–2014
  - During 2009–2014, the rate of outpatient ED visits was highest among NH blacks followed by NH whites
  - During 2012–2014, PLHWA <25 years of age had the highest ED visit rate

**Summary**

Overall ED visit rates among PLWHA increased during 2009–2014, with higher ED visit rates among young adults <25 years, women and NH blacks. HIV as a diagnosis in the emergency department setting may be underreported. It is important that ED providers keep in mind that PLWHA may present with a variety of conditions and that patients may not self-disclose their HIV status during an ED encounter.

*Submitted Livia Navon, IDPH HIV Section, CDC Epidemiology Field Officer*
POLICY STATEMENT: RISK OF SEXUAL TRANSMISSION OF HIV FROM VIRALLY SUPPRESSED PEOPLE LIVING WITH HIV

By Murray Penner

This article was originally published by NASTAD (National Alliance of State & Territorial AIDS Directors) on February 28, 2017. Excerpts are listed here. The original article can be viewed at the following link: https://www.nastad.org/blog/statement-risk-sexual-transmission-hiv-virally-suppressed-people-living-hiv

Submitted by Janet Nuss, IDPH, HIV Community Planning Coordinator

OVERVIEW

NASTAD joins public health experts and leaders in affirming that there is now conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy (ART) and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV. This statement accelerates our longstanding work to end the dual epidemics of HIV and HIV-related stigma and to dramatically reduce new HIV infections, and is supported by policies and public health practice grounded in science.

WHY IT'S IMPORTANT

Conclusive evidence about the highly effective preventative benefits of ART provides an unprecedented opportunity to improve the lives of people living with HIV, improve treatment uptake and adherence, and advocate for expanded access to treatment and care.

People living with HIV who are on ART and are durably virally suppressed are not only less likely to develop HIV-related complications; they also do not transmit the virus to others. The new evidence will help ameliorate decades of HIV-related stigma and discrimination by confirming that treatment is a powerful preventive intervention. The added preventive benefit of treatment encourages people living with HIV to initiate and adhere to a successful ART regimen, closely monitor their viral load, and stay in regular medical care. It is important to note that while viral suppression prevents the transmission of HIV, consistent and correct condom use and pre-exposure prophylaxis (PrEP) also prevent the transmission of HIV, and condoms provide additional protection for other STIs and pregnancy.

Despite our efforts to achieve universal viral suppression, many people living with HIV face immense barriers in achieving viral suppression that must be addressed, including social determinants of health (e.g., inadequate health systems, poverty, racism, denial, stigma, discrimination, and criminalization) and previous ART treatment that may have resulted in resistance or ART toxicities. Some people may choose not to be treated or may not be ready to start treatment.
WHAT WE KNOW AND WHAT IT MEANS

At the International AIDS Society (IAS) Conference in 2015 in Vancouver, the final results of the HPTN 052 trial studying whether ART can prevent sexual transmission of HIV demonstrated:

♦ A 93% reduction in the risk of HIV transmission within mixed-status couples when the HIV positive partner started treatment early

At the International AIDS Conference in 2016 in Durban, data presented from the PARTNER study showed:

♦ A refined estimate from two years ago that established the chance of an HIV-positive person with an undetectable viral load (defined as <200 copies/ml for the purposes of this study) transmitting HIV to be very low, if not zero. These final results are based on experiences from 888 couples, 38% of them same sex male couples, which encompassed an estimated 58,213 sex acts. While 11 people did acquire HIV during the study, none of these transmissions were phylogenetically linked (i.e., linked to the HIV-positive partners in the study)

The evidence demonstrates:

Zero new linked transmissions in the PARTNER study and zero transmissions from virally suppressed partners in HPTN 052 equates to there being effectively no chance of sexual HIV transmission from people living with HIV who are on ART and durably virally suppressed.

ACTION STEPS

NASTAD and its members will widely share this new scientific understanding of the risk of sexual transmission of HIV from virally suppressed people living with HIV to both promote optimal health outcomes and reduce stigma. We will continue to support efforts to examine and support evidence-based public health policies, approaches, and resources to promote and reduce barriers to HIV prevention and care. NASTAD members will also continue to emphasize the importance of providing comprehensive prevention and care services for people living with HIV to improve their quality of life and reduce risk of transmission to others. NASTAD will continue to advocate at the national level to raise awareness about the latest science of HIV transmission risk and implement policies and practices grounded in our best science void of stigma and discrimination. Finally, NASTAD will continue to monitor the scientific landscape for advances that will enhance our understanding of how to reduce new HIV infections and optimize the quality of life for people living with HIV.
The U.S. Food and Drug Administration has approved the first generic version of Truvada®, a combination pill used for both HIV treatment and prevention, but it will not soon hit pharmacy shelves, advocates said.

"While the FDA approval reminds us that generic versions of commonly used HIV drugs are coming, we still have some time to figure out how to embrace the cost-saving potential of generics while minimizing the headaches that can accompany their arrival," Tim Horn, deputy executive director of the Treatment Action Group, told the Bay Area Reporter.

On June 8 the FDA announced that it had approved a generic version of Gilead Sciences' Truvada® co-formulation containing tenofovir disoproxil fumarate and emtricitabine. Truvada® is one of the most widely used components of antiretroviral therapy and is the only product approved for PrEP. The generic version is produced by Teva Pharmaceuticals.

Appearance on the FDA's approved generic drug list indicates that the agency considers generic tenofovir/emtricitabine to be "bioequivalent and therapeutically equivalent" to the branded Truvada® pill – meaning equally safe and effective – but it does not override patent protections.

Gilead's patent on tenofovir disoproxil fumarate expires in July, but the patent on emtricitabine remains in effect until 2021. The company also has a longer patent on tenofovir alafenamide, a newer formulation that causes less bone loss and kidney toxicity.

"It's important to note that there are a number of factors involved in commercialization that are not tied directly to FDA approval," Gilead associate director Ryan McKeel told the B.A.R. "A generic version of Truvada® will not be immediately available."

Last week's FDA announcement took many experts by surprise, given that the emtricitabine patent still stands, but others
noted that certification of generic products sometimes comes months or years before patents run out.

Some have suggested that a legal settlement between Teva and Gilead could dictate when generic tenofovir/ emtricitabine will become commercially available, but advocates are not privy to the details of such an agreement.

"It's hard to know exactly when the generics may be registered and sold, but it may be awhile," longtime medication access advocate Ethan Guillen told the B.A.R. "We know that in other countries generic Truvada® is well under a hundred dollars – the system here is built to keep prices artificially high. As a community we need to fight for a just system that gives us the drugs we need at affordable prices."

While many people living with or at risk for HIV look forward to the availability of cheaper generic products, advocates caution that this could lead to discontinuation of patient assistance and co-pay programs that help people pay for Truvada® for treatment or PrEP.

"The potential for cost savings with generic contenders is considerable, but they also come with challenges, such as public and private insurers tightening restrictions on access to brand-name drugs, and an end to co-pay assistance programs for brand-name drugs with generic competitors," Horn told the B.A.R.

For the time being, no changes to Gilead's payment assistance programs appear imminent. "Gilead believes Truvada® for PrEP is an important HIV prevention tool and we remain committed to helping ensure access to our medications for people both at risk of or living with HIV," McKeel said.

Submitted by Marleigh Voigtmann, IDPH, HIV Community Planning Intern
WALGREENS HEALTHCARE CLINIC ABLE TO PRESCRIBE PrEP FOR HIV PREVENTION IN 17 ADDITIONAL MARKETS


Company broadly expands prevention efforts following successful rollout in April

DEERFIELD, Ill. – July 10, 2017 – Walgreens today announced that beginning July 13, providers at Walgreens Healthcare Clinic locations in 17 new markets will be able to prescribe PrEP (Pre-Exposure Prophylaxis), a medication protocol for people who don’t have HIV to help proactively protect against HIV infection. The markets include Cincinnati, Cleveland, Columbus (Ohio), Dallas, Denver, Kansas City, Knoxville, Las Vegas, Louisville, Memphis, Nashville, Orlando, Philadelphia, Phoenix, Tucson, Washington D.C., and Wichita.

“In late April, we began prescribing PrEP at our Walgreens Healthcare Clinic locations in the Houston area,” said Pat Carroll, MD, chief medical officer for Walgreens Healthcare Clinics. “Over the past few months, local AIDS organizations across the Houston area have referred patients to our clinics. In addition, our patients in Houston have commended us for giving them an easy option to learn more about PrEP and, if applicable, after a consultation, to get a prescription from one of our providers.”

In addition, also in late April, Walgreens Healthcare Clinics in these and other locations began offering evaluation and testing for sexually transmitted infections (STIs), including HIV, Hepatitis B and C, chlamydia, gonorrhea and other conditions, as well as treatment, counseling and referral, as applicable.

Following an initial PrEP consultation with a patient, Healthcare Clinic providers will be able to conduct tests for HIV and other STIs, as needed. Upon review of test results, providers will conduct a follow-up visit and may prescribe PrEP, as necessary. When taken daily as directed, PrEP can reduce the risk of HIV infection by more than 90 percent when used consistently.

“As we continue to help improve the comprehensive health and wellbeing of our patients, while also supporting communities across the nation that are impacted by HIV, we are looking forward to rolling out our prevention initiative more broadly,” said Dr. Carroll.

Walgreens operates 8,175 drugstores with a presence in all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands, along with its omnichannel business, Walgreens.com. Approximately 400 Walgreens stores offer Healthcare Clinic or other provider retail clinic services.

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WALGREENS HEALTHCARE CLINIC ABLE TO PRESCRIBE PrEP FOR HIV PREVENTION IN 17 ADDITIONAL MARKETS

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About Walgreens

Walgreens (www.walgreens.com), one of the nation's largest drugstore chains, is included in the Retail Pharmacy USA Division of Walgreens Boots Alliance, Inc. (NASDAQ: WBA), the first health and wellness services and advice. Walgreens operates 8,175 drugstores with a presence in all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands, along with its omnichannel business, Walgreens.com. Approximately 400 Walgreens stores offer Healthcare Clinic or other provider retail clinic services.

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Nationwide PrEP Coordinator,
Senior Director, Virology, Walgreen Co.

Please note: Walgreens locations in Chicago and Illinois are not yet included in the new markets providing PrEP prescribing.

Submitted by Janet Nuss, IDPH, HIV Community Planning Coordinator
STARTLING health and economic disparities between transgender people and the rest of the US population have been brought to light by the US Transgender Survey (USTS), an anonymous online study of more than 27,700 trans people.

Mara Keisling, Executive Director of the National Center for Transgender Equality, the organization that conducted the survey, said: “Despite achieving some significant policy advances and increased visibility over the past few years, transgender people continue to face enormous obstacles in almost every area of their lives...This survey demonstrates that there is a lot of work ahead to achieve simple parity and full equality for transgender people.”

HIV prevalence stood at 1.4% of respondents — nearly five times the rate in the US population as a whole (0.3%). A staggering one in five (19%) Black trans women who took part in the survey were living with HIV. American Indian (4.6%) and Latina (4.4%) women also reported higher rates. Of those living with HIV, 87% were on antiretroviral treatment compared to the US’s national treatment rate of 94%.

The survey paints a troubling picture of the impact of stigma and discrimination on the health of many transgender people in America. A third (33%) of those questioned had experienced at least one negative health care situation in the past year which acted as a barrier to treatment. Common experiences were being refused treatment, being verbally harassed, physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care. Transgender people of color experienced deeper and broader patterns of health discrimination than white respondents and the US population as a whole. Respondents also reported substantial economic barriers to receiving health care such as financial constraints and lack of health insurance.

Experiences of harassment and violence, both of which compound HIV vulnerability, were reported at alarmingly high rates. Nearly half (47%) of respondents had been sexually assaulted at some point in their lives and 10% had been sexually assaulted in the past year. Around 13% of respondents who were ‘out’ or perceived as transgender while in school reported being sexually assaulted as students. More than half (54%) had experienced some form of intimate partner violence.

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The survey’s results also demonstrate a clear association between HIV risk and economic instability, housing instability and poor education, with high levels of poverty, homelessness and sex work reported. Nearly one-third (29%) of those taking part in the survey were living in poverty, with roughly the same proportion reporting experiencing homelessness at some point in their lives. One in eight (12%) reported engaging in sex work for income at some point in their life, and 5% had done so in the past year. 32% of respondents who were living with HIV and 29% of undocumented residents had participated in sex work in the past year – substantially higher rates than among other respondents. Transgender women of color reported higher rates of sex work in the past year, particularly Black transgender women 24% of whom had engaged in sex work for income in the past year.

An overwhelming proportion of those who had engaged in sex work – nearly nine out of ten (86%) – reported high rates of police harassment, abuse and mistreatment, including violence and sexual assault. More than half (57%) of all respondents said they would feel uncomfortable asking the police for help if they needed it. Respondents who were held in jail, prison, or juvenile detention in the past year faced high rates of physical and sexual assault by facility

The USTS, which was released in December 2016, serves as a follow-up to the US’s groundbreaking 2008–09 National Transgender Discrimination Survey (NTDS). Authors of the USTS hope it will provide researchers, policymakers, and advocates with a better understanding of the experiences of trans people over time. For those working in America’s HIV response, it provides important evidence to inform the implementation of effective HIV prevention, treatment and care programs for this key population.

Current trials of new prevention technologies such as self-testing for HIV, treatment as prevention and pre-exposure prophylaxis (PrEP) have largely excluded transgender people, or have not included them in a meaningful way. A literature review focusing on the use of PrEP for trans people published by the Journal of the International AIDS Society in October 2016 urged those implementing PrEP programs to “better consider and address trans women’s unique barriers and facilitators to uptake and adherence.”

The USTS’s authors hope their findings will provide this key insight. Sandy James, USTS’s lead author, said: “We hope that the survey’s breadth and in-depth examination of transgender life in the United States will serve as an important resource that prompts dialogue and leads to a greater understanding and acceptance of transgender people.”

Submitted by Janet Nuss, IDPH, HIV Community Planning Coordinator
INCREASING EARLY SYPHILIS CASES IN ILLINOIS—STAGING AND TREATMENT

This article is Part 2 of a three-part series on Syphilis provided by the IDPH STD Section. Please see the next edition of the newsletter for Part 3: Syphilis Labs and Interpretation.

Syphilis is a sexually transmitted disease (STD) caused by the Treponema pallidum bacterium. It can be staged into four different stages: primary, secondary, early latent, and late latent. Ocular and neurologic involvement may occur during any stage of syphilis.

During the incubation period (time from exposure to clinical onset) there are no signs or symptoms of syphilis, and the individual is **not infectious**.
- Incubation can last from 10 to 90 days with an average incubation period of 21 days.
- During this period, the serologic testing for syphilis will be non-reactive but known contacts to early syphilis (that have been exposed within the past 90 days) should be preventatively treated.

**SYphilIS STAGES**

**Primary 710 (CDC DX Code)**
- A chancre (sore) must be present.
- It is usually marked by the appearance of a single sore, but multiple sores are common.
- A chancre appears at the spot where syphilis entered the body and is usually firm, round, small, and painless.
- The chancre lasts three to six weeks and will heal without treatment.
- Without medical attention the infection progresses to the secondary stage.
- **This is when a Patient is most infectious.**

**Secondary 720**
- This stage typically begins with a skin rash and mucous membrane lesions.
- The rash may manifest as rough, red, or reddish brown spots on the palms of the hands, soles of the feet, and/or torso and extremities. **The rash does usually not cause itching.**
- Rashes associated with secondary syphilis can appear as the chancre is healing or several weeks after the chancre has healed.
- Other possible symptoms of secondary syphilis may include fever, swollen lymph glands, sore throat, patchy hair loss, muscle aches, fatigue, and flu-like symptoms.
- **The patient is infectious.**

**Early Latent 730**
- No symptoms (latent) were identified at time of medical visit.
- The infection has been identified to have occurred within the past 12 months.
- This stage may occur between primary and secondary stages; and after the secondary stage.
- **The patient is infectious.**

**Late Latent 745**
- No symptoms (latent) were identified at time of medical visit.
- Infection has been identified to have occurred at least after 12 months (i.e., no evidence of any of the above stages in the past year).

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INCREASING EARLY SYPHILIS CASES IN ILLINOIS—STAGING AND TREATMENT

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NEUROLOGICAL AND OCULAR INVOLVEMENT

Neurologic involvement may occur at any stage of syphilis. Once the syphilis infection has invaded the nervous system, there may be a wide range of symptoms. These include headaches, altered behavior, having difficulty coordinating muscle movements, paralysis, sensory deficits, and dementia.

Ocular involvement may occur at any stage of syphilis, but eye involvement tends to occur most frequently in secondary and late syphilis stages. Ocular syphilis may occur regardless if the patient is HIV positive or HIV negative. Below is a list of symptoms and manifestations of ocular syphilis, however, not all have to be present to be ocular syphilis.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Manifestations</th>
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<tbody>
<tr>
<td>Redness and eye pain</td>
<td>Conjunctivitis, scleritis, and episcleritis</td>
</tr>
<tr>
<td>Floaters</td>
<td>Uveitis</td>
</tr>
<tr>
<td>Flashing lights</td>
<td>Elevated intraocular pressure</td>
</tr>
<tr>
<td>Visual acuity loss</td>
<td>Chorioretinitis, retinitis, and vasculitis</td>
</tr>
<tr>
<td>Blindness</td>
<td></td>
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<tr>
<td>Blue tinge to vision</td>
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</table>

TREATMENT

Syphilis is the only STD where treatment is dependent upon the stage of the infection (see chart below for CDC recommended treatment regimen). Currently there is also a national shortage of Benzathine penicillin G (bicillin). This makes it critical to stage syphilis accurately and treat accordingly. Any non-pregnant patients should be considered for the alternative treatment with doxycycline.

The CDC 2015 STD treatment guidelines indicate patients regardless of HIV status should be treated according to the stage of syphilis they are diagnosed with. HIV positive patients diagnosed with early syphilis (i.e., primary, secondary, or early latent stages) should therefore be treated with only a total of 2.4 million units of bicillin, i.e., one dose. In patients living with HIV infection, providing additional doses to treat early syphilis does not enhance treatment efficacy.

Syphilis during pregnancy must be treated with the penicillin regimen appropriate to their stage of syphilis. If a pregnant woman is allergic to penicillin, she must be desensitized and treated with penicillin according to the stage at time of diagnosis. There is no alternative treatment for pregnant females. Benzathine penicillin G is the only known effective antimicrobial for prevention of maternal transmission of syphilis to the fetus.

Syphilis cases with neurologic and ocular involvement should be treated with Aqueous Crystalline Penicillin G 18-24 million units per day administered as 3-4 million units IV every four hours or continuous infusion for 10-14 days. Clients diagnosed with syphilis with neurologic and or ocular involvement may consider consultation with an Infectious Disease specialist especially in complex scenarios.

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INCREASING EARLY SYPHILIS CASES IN ILLINOIS—STAGING AND TREATMENT

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<table>
<thead>
<tr>
<th>Symptom Stage</th>
<th>Symptoms</th>
<th>Description</th>
<th>Treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Chancre</td>
<td>Single or multiple firm, round and painless lesions occur at site of infection</td>
<td>Benzathine penicillin G 2.4 million units IM in a single dose OR *Doxycycline 100 mg orally BID x 14 days</td>
<td>Partner management – If exposed within the last 90 days of diagnosed case, partner should be tested AND treated per CDC guidelines. If exposure is greater than 90 days testing is sufficient.</td>
</tr>
<tr>
<td>Secondary</td>
<td>Rash or Mucous Membrane Lesions</td>
<td>Generalized body rash, palmar/plantar rash, mucous patches (highly infectious), alopecia, condylomata lata (highly infectious)</td>
<td>Benzathine penicillin G 2.4 million units IM in a single dose OR *Doxycycline 100 mg orally BID x 14 days</td>
<td>Partner management – If exposed within the last 90 days of diagnosed case, partner should be tested AND treated per CDC guidelines. If exposure is greater than 90 days testing is sufficient.</td>
</tr>
<tr>
<td>Early Latent</td>
<td>No Symptoms</td>
<td>Identified by one or more of the following facts: ◆RPR negative within the preceding 12 months ◆symptoms of primary or secondary syphilis in the preceding 12 months ◆named as partner to primary or secondary syphilis with no current symptoms ◆a sex partner of patient who had symptoms of primary or secondary syphilis in the preceding 12 months ◆an increase of two dilutions in the RPR titer, with no current symptoms, indicating re-infection</td>
<td>Benzathine penicillin G 2.4 million units IM in a single dose OR *Doxycycline 100 mg orally BID x 14 days</td>
<td>Identified by one or more of the following facts: RPR negative within the preceding 12 months, symptoms of primary or secondary syphilis in the preceding 12 months, named partner to primary or secondary syphilis with no current symptoms, a sex partner who had symptoms of primary or secondary syphilis in the preceding 12 months, or an increase of two dilutions in the RPR titer which indicates re-infection (and no current symptoms).</td>
</tr>
<tr>
<td>Late Latent</td>
<td>No Symptoms</td>
<td>Infection occurred greater than 12 months or exact date of exposure unknown</td>
<td>Benzathine penicillin G 7.2 million units total, administered as three doses of 2.4 million units IM each at 1-week intervals OR *Doxycycline 100 mg orally BID x 28 days</td>
<td>Infection occurred greater than 12 months or exact date of exposure unknown. Partners within the previous 12 months should be referred for testing. Additionally, it is crucial that all partners of pregnant females are offered partner services, testing, and treatment.</td>
</tr>
</tbody>
</table>

*Doxycycline is contraindicated and does not apply to pregnant women.

Resources

CDC 2015 STD Treatment Guidelines
CDC Call to Action: Let’s Work Together to Stem the Tide of Rising Syphilis in the United States.
CDC Syphilis page
CDC Syphilis Physician’s Pocket Guide
CDC Clinical Advisory: Ocular syphilis in the U.S.

Submitted by Lesli Choat, IDPH, STD Counseling and Testing Coordinator
The Illinois Department of Public Health STD Section has finalized the chlamydia, gonorrhea, and syphilis data for 2016. All three diseases increased for the third year in a row in 2016 with the highest percent increase seen in gonorrhea cases.

In 2016, there were 72,201 chlamydia cases, 21,199 gonorrhea cases, and 2,398 early syphilis cases. The rates per 100,000 population were 562.7 for chlamydia, 165.2 for gonorrhea, and 18.7 for early syphilis.

Below are the percent increases in cases from the 2016 data:

**Chlamydia cases increased 4% from 2015**

**Gonorrhea cases increased 24% from 2015**

**Early Syphilis cases increased 21% from 2015**

In the last five years (2012-2016):

**Chlamydia rate increased 7%**

**Gonorrhea rate increased 17%**

**Early Syphilis rate increased 60%**

The 2016 STD data will be uploaded to the following locations:

- IDPH STD Section Website under Publications: [http://dph.illinois.gov/topics-services/diseases-and-conditions/infectious-diseases/STDs](http://dph.illinois.gov/topics-services/diseases-and-conditions/infectious-diseases/STDs)
- data.illinois.gov: Search “STD” for a list of reports: [https://data.illinois.gov/](https://data.illinois.gov/)
- IQEry: [https://iquery.illinois.gov/iquery/](https://iquery.illinois.gov/iquery/)

The IDPH STD Section is always available to address any questions or concerns you have about STDs in your jurisdiction by calling our main line at 217-782-2747.

Submitted by Lesli Choat, Illinois Department of Public Health, STD Counseling and Testing Coordinator
The following infographic was produced by the Illinois Department of Public Health. To learn more about the opioid epidemic in Illinois, please visit [http://dph.illinois.gov/topics-services/prevention-wellness/prescription-opioids-and-heroin](http://dph.illinois.gov/topics-services/prevention-wellness/prescription-opioids-and-heroin) on the IDPH Website.

Submitted by Janet Nuss, IDPH, HIV Community Planning Coordinator
The Central Illinois HIV Care Connect (Region 3) located at Southern Illinois University (SIU) School of Medicine held its first ever day long client retreat for persons living with HIV from the Springfield, Decatur, and Quincy areas on July 14, 2017 in Springfield. The idea for the retreat grew from the concept of bringing together members of the HIV-positive community for a day of empowerment, education, and outreach, all focusing on enhancing retention in HIV care. The organizers wanted this program to be in a retreat format with the theme of “Taking a Day Off”. Instead of having program staff plan the event, persons living with HIV were engaged to guide all aspects of the planning; therefore, a planning committee was formed made up of persons living with HIV. This first question the committee was asked to address was: “What should we incorporate into the development of the retreat that would really encourage people to come out to the event?” Their reply was: “Seeing others tell their stories and learning about new treatment”. Thus our planning had begun!

After numerous meetings, the committee identified topics and speakers for the program. The Keynote Speaker was Sonya Jones, the Finalist on Season 16 of NBC’s “The Biggest Loser”. Her presentation was very motivational and focused on setting and reaching personal goals. It was also empowering as she related her own struggles and successes.

An important component of the retreat was having persons living with HIV share their stories, so a panel composed of persons living with HIV was formed. The presenters on the panel shared their personal experiences of being in Care, how long it took them to get into Care after they were diagnosed with HIV, any experiences they had ever had falling out of Care, what got them back into Care, and what resources were available to them or what mechanisms they have used to keep them retained in Care. This was a powerful session and something the organizers would like to continue in future retreats.

Some of the other sessions/topics at the retreat included HIV Stigma and Healthy Eating. A person who was a brain tumor survivor also spoke. Knowing that there are others who have overcome such huge obstacles in their lives was so empowering.

Thirty-two persons attended the retreat and the feedback received from participants was very positive. They felt that the retreat was informational as well as motivational and felt enlightened and empowered by the sessions. There were many comments about the HIV positive panel and the ability provided for everyone throughout the retreat to share their input and feelings.

The organizers have already begun the planning for another retreat in the region!

Written by Marcy Ashby, SIU School of Medicine, Region 3 HIV Care Consortia Coordinator
The HIV section is happy to be offering the following trainings in 2017 (Please note: if not already, registration for trainings in the fall/ winter will open at a later date.):

**ARTAS Illinois (2 days)**
- November 16-17, Suburbs

**Surveillance Based Services (1 day)**
- September 26, Peoria

**Risk-Based Testing (4 days)**
- October 3-6, Collinsville Area
- December 5-8, Suburbs


*Schedule is subject to change.*

**ARTAS Illinois:** This course teaches the core elements and skills necessary to provide the ARTAS (Anti-Retroviral Treatment and Access to Services) intervention, which is intended to be implemented by agencies that conduct case management services for persons living with HIV/AIDS or are engaged in linking persons who are recently diagnosed with HIV to primary care providers and/or ancillary support services. Grounded in the strength-based case management model, ARTAS helps clients build on strengths they already have to successfully connect to medical care and treatment. ARTAS Illinois will focus specifically on Illinois-specific linkage to care processes.

**Surveillance-Based Services:** This one-day course will prepare local health department staff to use HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and offer assistance with notifying their sex and/or needle-sharing partners of their potential exposure. This course is recommended for any health department employee who may be reaching out to HIV positive clients discovered through surveillance activities.

**Risk-Targeted HIV Testing:** This new course replaces “Fundamentals of HIV Counseling and Testing”, and it is required for all new HIV counselors who provide HIV testing to targeted populations. It will teach participants how to provide HIV testing in accordance with the new CDC guidance to persons most at risk for HIV infection, including men who have sex with men (MSM), high risk heterosexuals (HRH), and injection drug users (IDU). The course focuses less on counseling and more on testing and linkage to biomedical prevention and care services. The training also includes hands on practice with Partner Services.

Submitted by Karen Pendergrass, IDPH, HIV Training Administrator

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**UPCOMING STD COUNSELOR TRAINING**

**STD New Counselor Training** will be held at the Sangamon County Health Department (2833 South Grand Avenue East, Springfield, IL, 62703) on September 19-22, 2017. If you have questions concerning the training, please contact Lesli Choat in the IDPH STD Program at 217-782-2747.

Submitted by Lesli Choat, IDPH, STD Counseling and Testing Coordinator
SPRINGFIELD LGBTQ TRAINING

LGBTQ. What You Need To Know
Presented By: Jonna J Cooley PhD, Phoenix Center Executive Director

Want to know more, better understand and help your LGBTQ clients, patients, students, customers, and friends? Have questions about what it means to be transgender? Want to know what you can do in your own agency, business, school or office to help? If yes, this is the training for you.

2017 Dates & Locations

April 25  Lincoln Land Community College | Trutter Room
August 2  Phoenix Center | MT Vann Room
November 8 Lincoln Land Community College | Trutter Room

8:30 a.m. - 12:30 p.m.
Check In begins at 8 a.m.

For more information or to register contact Jonna at 217-528-5253 or jcool.phoenix@comcast.net

Training is FREE / $25 for 4 Continuing Education Credits

Oakton Community College, Alliance for Lifelong Learning, Continuing Education for Health Professionals has been approved as a sponsor of continuing education by the Illinois Department of Financial and Professional Education for the following health professions: Licensed Social Worker/Licensed Clinical Social Worker, Professional Counselor/Clinical Professional Counselor, Marriage and Family Therapist, Psychologist, Registered Nurse. Continuing Education credits will be available for the above professions as well as teacher credits from the Illinois State Board of Education and universal credits.

Submitted by Jonna Cooley, Executive Director, Phoenix Center
MEMBER PROFILE: MARCY ASHBY

Marcy Ashby began her career in HIV/AIDS Services about 25 years ago. Prior to that time she worked for Independent Living services for persons with various disabilities. During her time in that position, Marcy met a staff member from the IDPH HIV/AIDS Section who was volunteering at her Center for Independent Living. They discussed the work that IDPH was doing with and for persons living with HIV/AIDS. At that time “HIV Consortia” were just being developed and only a few (service?) regions existed in the State. The work sounded exciting to Marcy as it was similar to the independent living model, a regional community based program built on the strengths of the local community and empowered the consumer to live as independently as possible.

In 1993, Marcy became the HIV Care Consortia Coordinator for the Illinois Department of Public Health. She was responsible for coordinating the Statewide HIV Care Consortia Program. Although a difficult period of loss during the AIDS Epidemic, it was an exciting time in the arena of service development. The number of regions was expanded and providers were being identified. By the end of her tenure, there were HIV services throughout the state in all counties.

In 1997, Marcy left IDPH to take a position as the Project Director for the Central Illinois HIV Care Connect at SIU School of Medicine in Springfield, IL, where she continues her tenure today. The Central Illinois Care Connects provides a comprehensive range of medical and support services for persons living with HIV/AIDS in an 18 county region. Specifically, Care Connect offers medical case management, oral health care, mental health counseling, housing and utility assistance, nutritional supplements, transportation and legal services. Recently, a Retention Specialist was recruited to further enhance services for those at-risk for, and living with HIV/AIDS. This new staff person is actively engaging those that have been lost to or have never been in HIV care.

Marcy is a voting member on the ILHPG, and member of its Evaluation Committee. She convenes a local advisory board that assists in establishing service priorities, identifying gaps in services, addressing needs of specific populations, and planning for future service needs of the Central Illinois HIV Care Connect. She is active with the Families’ and Children’s AIDS Network and is one of the original planners of Red Ribbon Trails, a retreat program for Illinois families affected by HIV/AIDS. It is unique in that it is designed for the entire family impacted by HIV/AIDS. She is also active with the Illinois Department of Correction’s Re-entry and Summit of Hope programs.

Marcy has her Master’s Degree in Rehabilitation Administration and Rehabilitation Counseling from Southern Illinois University. She has a Bachelor’s Degree in Child, Family and Community Services from Sangamon State University.

It is with great honor and gratitude that IDPH HIV/AIDS Section acknowledges Marcy’s contributions and passion to the State’s HIV Epidemic.

Submitted by Eduardo Alvarado and Janet Nuss, Illinois Department of Public Health, HIV Section