Illinois HIV Integrated Planning Council (IHIPC) Meeting Minutes

June 27, 2019, 11:00 am – 4:30 pm

11:00 am: Working lunch: Welcome; Introductions; Meeting process/instructions; Review of agenda/meeting objectives; Moment of silence

Co-Chairs J. Nuss and M. Benner welcomed all members/guests to the meeting. The Co-Chairs reviewed webinar and housekeeping instructions. Following this, the group was led in a moment of silence for all people living with HIV past and present and for all those working to end the epidemic in Illinois.

All in-person participants introduced themselves, and webinar participants were announced.

The following announcement were made at the meeting:

- Member updates: Appointed members S. Frank and J. DeLaFuente will be transitioning out of their roles as IHIPC members. R. Wheeler (present at meeting) will replace J. DeLaFuente as the Center for Minority Health liaison, and S. Frank will be identifying a new Substance Use and Prevention and Recovery liaison soon.
- The Spring issue of the IHIPC newsletter was released in May. The Summer issue is currently being finalized.
- The online trainings for High Impact Prevention and HIV Care Interventions that were initially scheduled for May have been postponed until August/ September. More details will be forthcoming.
- Regional Community Engagement Meetings will be conducted throughout the state July-October. Please refer to the Care and Prevention Lead Agent reports below for respective dates and locations. Anyone interested in attending meetings should reach out to the regional lead agents for more details.
- Undoing Racism Trainings will be conducted for IDPH HIV Section staff, IHIPC members, Regional lead agents, and selected IDPH HIV Care and Prevention Grantees in August and September. Registration is by invite-only, and a "save the date" has been sent out to participants.
- As of April 2019, 25 community/ agency representatives have participated in IHIPC meetings and trainings.
- All documents for the June 27 and 28 meetings are posted on the registration page: https://www.regonline.com/June2019ihipcmeetings .
- Meeting surveys for the June 27 and 28 meetings can be submitted until Friday, July 5 at the following link: https://www.regonline.com/IHIPCmeetingsurvey .
- All IHIPC documents, including full body and committee meeting agendas and minutes, are available on the IHIPC website: http://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg .

After Announcements, the Co-Chairs reviewed the meeting objectives, meeting agenda, and the IHIPC concurrence checklist.

11:30 am: Community Services Assessment: Regional Care and Prevention Lead Agent Brief Reports to the IHIPC/Discussion

Region 1: Prevention: M. Maginn reported for Illinois Public Health Association (IPHA). In FY19, five agencies were funded in Region 1. Five new positives were found, resulting in a regional seropositivity rate of 1.0%. Social media messaging and budgeting for administrative costs related to hiring of MSM of color peers continue to be challenging in the region. IPHA is completing the RFA process for FY20 in all funded regions. Care: C. Boyd reported for Winnebago County Health Department (WCHD). WCHD saw a significant number of referrals from Corrections in the last quarter, resulting in many successful linkages to care through partnership with UIC. WCHD hosted a National HIV Testing Day on June 27. It was also reported that Rockford recognized June as Pride month for the first time. The Region 1 Community Engagement Meeting will take place on October 8 from 5:30-8:30 pm at the Klehm Arboretum (Rockford, IL).

Region 2: Prevention: J. Erdman reported for IPHA. In FY19, six agencies were funded in Region 2. Seven new positives were found, resulting in a regional seropositivity rate of 1.2%. Previously, the region found it challenging to establish syringe exchange services in Peoria due to the city's storefront policy/ordinances. Jolt foundation, however, successfully met this need in FY19. IPHA is completing the RFA process for FY20 in all funded regions. A. Cruz will be the new Lead Agent for Region 2 in FY20. Care: L. Roeder reported for Positive Health Solutions (PHS). In the last quarter, PHS has completed 27 intakes, with 11 clients being newly

diagnosed. PHS is looking to hire a new case manager and a medical benefits coordinator. PHS is also assisting in planning efforts for Peoria's Pridefest in August. The Region 2 Community Engagement Meeting will take place on October 15 from 4-8 pm at First Christian Church (Peoria, IL).

Region 3: Prevention: M. Maginn reported for IPHA. In FY19, five agencies were funded in Region 3. Four new positives were found, resulting in a regional seropositivity rate of 1.0%. Two agencies funded in FY19 have decided not to reapply for FY20. IPHA is completing the RFA process for FY20 in all funded regions. A. Cruz will be the new Lead Agent for Region 3 in FY20. Care: C. Laskowski reported for SIU School of Medicine. SIU has hired recently hired two new case managers after losing experienced staff. Since April, three newly diagnosed clients have been linked to care. In the past 12 months, ten newly diagnosed individuals have been linked to care in Macon County, so work is being done there to identify partners. In May, SIU hosted a successful client retreat with 40 participants. The Region 3 Community Engagement Meeting will take place on August 22 from 5-8:30 pm at the Cancer Institute at SIU School of Medicine (Springfield, IL).

Region 4: Prevention: J. Erdman reported for IPHA. In FY19, eight agencies were funded in Region 4. Eleven new positives were found, resulting in a regional seropositivity rate of 2.0%. Two agencies funded in FY19 have decided not to reapply for FY20, but new agencies have been applying. IPHA is completing the RFA process for FY20 in all funded regions. Care: S. Rehrig reported for St. Clair County Health Department (SCCHD). SCCHD will soon be implementing a new co-ed support group for clients, which will be conducted by a client-trusted LCSW. SCCHD is partnering with Southern Illinois Healthcare Foundation on a social media/ marketing campaign called "In the Know". They are also working on a new retention project. The Region 4 Community Engagement Meeting will take place on August 28 from 10 am- 2 pm at the Double Tree Hotel (Collinsville, IL).

Region 5: Prevention: M. Maginn reported for IPHA. In FY19, five agencies were funded in Region 5. IPHA is completing the RFA process for FY20 in all funded regions. Care: S. St. Julian reported for Jackson County Health Department (JCHD). JCHD currently has a 93% viral suppression rate among Ryan White clients. A new infectious disease doctor will soon be hired in the region, for a total of seven infectious disease doctors serving clients. JCHD is also working on the following projects: expanding PrEP services through a new grant; collaborating with local jails to train staff on HIV testing; and continuing HCV initiatives. The Region 5 Community Engagement Meeting will take place on September 17 from 5:30 pm- 8:30 pm at the Carbondale Civic Center (Carbondale, IL).

Region 6: Prevention: J. Erdman reported for IPHA. In FY19, six agencies were funded in Region 6. Three new positives were found, resulting in a regional seropositivity rate of 0.7%. One agency funded in FY19 has decided not to reapply for FY20. IPHA is completing the RFA process for FY20 in all funded regions. Care: C. Crause reported for Champaign-Urbana Public Health District (C-UPHD). C-UPHD has recently gained one new case manager. They are working with peers to identify ways to advertise U=U and Getting to Zero in the overarching community. The Region 6 Community Engagement Meeting has been postponed. A new meeting date is yet to be announced.

Region 7: Prevention: J. Erdman reported for IPHA. In FY19, nine agencies were funded in Region 7. Thirty-seven new positives were found, resulting in a regional seropositivity rate of 2.0%. IPHA is completing the RFA process for FY20 in all funded regions. Care: B. Olayanju reported for AIDS Foundation of Chicago (AFC). AFC has been meeting regularly with their prevention and care advisory board. They are working on filling identified gaps in services, including food. There also been concerns from clients about medication assistance, so AFC has been working with J. Maras and CVS to resolve these issues. The Region 7 Community Engagement Meeting will take place on July 24 from 10 am- 2 pm at Dupage County Health Department (Wheaton, IL).

Region 8: Prevention: W. Allen reported for Public Health Institute of Metropolitan Chicago (PHIMC). In FY19, 15 agencies were funded in Region 8. Six new positives were found in the region through routine testing, and six new positives were found through risk-targeted testing (resulting in a 0.22% seropositivity rate). Through the region, there have been challenges for agencies including turnover and needs for training. PHIMC is completing the RFA process for FY20. Care: B. Olayanju reported for AFC. AFC has working on the following initiatives: working on an out of office visit model for clients; implementing electronic client screeners and referrals within Provide™; and providing trainings to clients on topics like housing and Medicaid/ managed care. The Region 8 Community Engagement Meeting will take place on September 4 from 10 am- 2 pm at Aunt Martha's (Park Forest, IL).

Discussion:

Q: There has been several mentions of providers falling off or not reapplying for Prevention grants. What are the implications of this for access to services?

A: Prevention providers have voiced that this is a challenging grant. The work/ scopes are very specific and require certain skill sets of staff. The fee-for-service model can also be challenging if payment is late. The Prevention Lead Agents do their best to anticipate these challenges and the potential exiting of funded agencies from the grant, so plans are made to have other agencies step in to take on additional services as needed. This can be difficult though, especially if additional training is needed for staff or if agencies must receive approval from their administrators/boards to perform specific activities (specifically harm reduction activities).

A: From a rural perspective, the Prevention grant award is very small and can be hard to manage if one staff person is also running non-HIV related programs. At local health departments (LHDs), however, HIV testing is completed by request regardless of whether the LHD is funded by this particular grant.

C: I think good work is being done throughout the state, but this grant requires more and more of providers each year. This was evident in this year's application process as it seemed very complicated. IDPH should try to keep the application process as simple as possible. It is just becoming too much to complete for small grant awards.

C: I agree that the application process needs to be re-examined by leadership at IDPH. Some of said leadership is not present at the meeting today, and this is a problem. Please work to make this a more provider-friendly program.

C: I agree that the application process was cumbersome and burdensome. Also, IDPH needs to address challenges around trainings. They are short on staff and not able to conduct a quantity of trainings that satisfy regional needs. IPHA does the best they can to provide technical assistance, but IDPH should re-examine requirements of these grants so that they are less challenging to complete, especially for agencies with small staffs.

12:15 pm: IHIPC Appointed Liaison and HIV Section Updates

C. Tucker gave the Chicago Area HIV Integrated Services Council (CAHISC) liaison report. CAHISC has been working on community engagement activities to ensure that people with lived experiences are included in their planning process. They are currently collecting progress reports from organizations that are funded by CDPH to conduct structural interventions within the following communities: trans women of color, black gay men, Latinx population, and black women. CAHISC is also working on priority setting and resource allocation activities which are to be completed by the end of the summer.

M. Gaines gave the Corrections liaison report. So far in 2019, four Summit of Hope events have been conducted. There have been no new HIV positive tests at these events, but new diagnoses of HCV continue to be identified. Additionally, naloxone kits are now being distributed as Summit of Hope event. As previously, reported Illinois Department of Corrections is continuing work on establishing their own permanent HIV unit/program. UIC's telemedicine program also continues to be a strong partner in linking recently released individuals to care (72% linkage to care rate). M. Gaines then invited W. Johnson to share his experiences as a HIV peer educator while in an IDOC facility, and now as an HIV testing counselor at an HIV service agency.

There was no report from the Illinois Primary Health Care Association liaison at this meeting.

L. Choat gave the IDPH STD Section liaison report. It was noted that the 2018 STD data has been finalized and continues to trend upward for gonorrhea, chlamydia, and syphilis. The 2018 report will be released by the STD section soon. There are/ will be new STD webinars recordings available online through the STD section webpage. This includes webinars conducted for STD awareness month as well as syphilis reporting form, lab interpretation, and staging webinars. In May, the STD conducted an Antibiotic Resistance Gonorrhea Tabletop Exercise in partnership with CDC and C-UPHD. The STD's section corresponding response plan is now being updated based on tabletop findings. The next STD counselor's training will be held September 17-20 in Springfield.

W. Bradley gave the St. Louis Regional HIV Health Services Planning Council liaison report. Five Illinois counties are associated with the Council. The Council is currently working on priority setting and resource allocations. They are also working to restructure their case management system, which includes a sliding fee scale for services. MAI services are also being restructured to ensure effective targeting.

S. Frank gave the Substance Use Prevention and Recovery liaison report. Over the last three years, SUPR has received $73 million dollars in grant funding. The following services have been provided through this: initiation of the opioid crisis help line and website, and naloxone distribution and trainings for first responders. SUPR has been able to identify rural areas in the state that do not have access to substance use services. They are using a Hub and Spoke Model (partnerships with existing health centers, etc.) to fill service gaps.

R. Wheeler gave the IDPH Center for Minority Health Services report. The CMHS Minority AIDS Initiative (MAI) grants for FY19 have now been executed.

A Danner gave the IDPH HIV Section report. Care update: Symtuza has been added to the ADAP Formulary. Prevention: The Regional Implementation Grant has been renewed for two years; African American AIDS Response Act and the Direct grants have been renewed for one year; and the Routine Testing grant, supported by General Revenue Funds (GRF: state funding), will resume in 2021. PrEP update: The PrEP grant is now in its third year with 17 sites funded. Goals for grantees in this funding year include increasing client enrollment in PrEP and nPEP services. Work is being done to establish a PrEP4Illinois logo. All in-person participants were asked to vote on logo designs by ballot. Other business: E. Alvarado is no longer the HIV section chief. H. Clark is the acting section chief until the role is filled.

Discussion:

Q: Is there data available that shows HIV/ STD co-infection rates?

A: This information was presented at the February IHIPC meeting. Please go back to those presentation slides for more information. Syphilis continues to be the most concerning STD co-infection among people living with HIV (approximately a 50% co-infection rate).

Q: Regarding the IDOC HIV unit, do these staff work in all facilities?

A: The unit includes two HIV educational specialists and one HIV data tracker. These individuals work to train peer educators in facilities, track the needs of people living with HIV in facilities, and work with discharge planners to initiate linkage to care after release. One position has been filled so far.

1:00 pm: Community Services Assessment: FFY2018 HIV Prevention/Care Service Delivery Assessment and Mapping; Q & A, Discussion, Input

C. Hicks, the IDPH HIV Prevention Administrator, presented the FY18 Prevention Service Delivery Assessment. The following 2018 activities were reported on: HIV testing (categorized by grant, region, and priority population); risk reduction activities (RRA) (categorized by client HIV status, grant, region, priority population, gender, and age); HIV Surveillance Based Services (SBS); Partner Services; and PrEP services. Service delivery for HIV testing and RRA was also demonstrated through county mapping. Please see the presentation slides for specific information about each service delivery category.

The recommendations and outcomes for 2018 were reviewed. The following recommendations have been established for 2019:

- Increase the number of health care providers that routinely screen for HIV in high incidence areas.
- Increase the percentage of all risk-based testing going to Black, White, Latino & Other MSM.
- Increase the number of testing-identified new HIV diagnoses to CY17 levels (>=162).
- Increase the number of HIV testing clients linked to care to CY17 levels (>=301).
- Increase RRA for positives in Regions 6 & 8.
- Increase the percentage of RRA delivered to HIV+ Black, Latino & Other MSM over CY18 levels.
- Increase the percentage of RRA delivered to HIV- Black MSM & HRH, & Latino MSM over CY18 levels.
- Increase the number of Not-in-Care SBS cases linked to HIV Care over CY18 levels (>70).
- Increase the number notifiable partners elicited from SBS & testing clients.
- Increase the percentage of all named undiagnosed partners tested over CY18 (>12.5%).

Discussion:

Q: What is being done to address stigma, especially among Black and Hispanic MSM?

A: C. Hicks responded: As part of the RIG grant, agencies are funded to hire MSM of color for peer outreach services. These peers often have lived experiences that enable them to better understand client issues and to combat stigma. RIG grantees also work to support social marketing/ social media campaigns to break through stigma and encourage people to get HIV testing and care as needed. Lastly, training opportunities help us to combat stigma. Particularly, IDPH is working to support a series of Undoing Racism trainings through the state for IDPH staff, IHIPC members, and selected IDPH HIV care and prevention grantees.

Q: What is the strategy for increasing routine/ opt-out screening with providers?

A: C. Hicks responded: When the routine screening grant is re-established, a gap analysis will be done to determine which zip codes in Illinois have the least access to routine testing providers (i.e. IDPH or Medicaid). Partnerships will be made with existing health care providers/organizations to establish routine testing sites where there are gaps.

J. Maras, the IDPH Ryan White Part B/ADAP Administrator, presented the FY18 Care Service Delivery Assessment. The following program components/ activities were review: federal guidelines/ limitations of the Ryan White Part B (RWPB) program; RWPB program overview, including criteria for client eligibility; RWPB program funding; and services delivered (categorized by gender, race, risk factor, and service category (core or supportive). Detailed information about the medication assistance, premium assistance, Corrections, and housing programs were also shared. Additional, service delivery information about PrEP4Illinois clients and RWPB clients receiving HCV medication assistance was reviewed (both categorized by gender, race, risk, and region). Please see the presentation slides for specific information about each service delivery category.

Discussion:

Q: Why is there a federal poverty line (FPL) cap on case management if the client is not requesting monetary help/ resources?

A: J. Maras responded: The cap of 800% FPL for case management has been recently established per Health Resources Service Administration (HRSA) guidance. At the last IDPH site visit, the lack of a cap on case management was a finding that needed to be addressed. HRSA asked IDPH to set a reasonable cap. The 800% FPL was selected after reviewing client information and seeing that this cap would leave most clients' case management services undisturbed.

Q: How many HUD dollars were received for housing?

A: J. Maras responded: 1.7 million dollars in HOPWA funding was distributed among the Care lead agents and directly funded housing facilities, although this will change next year (there will be no directly funded housing facilities next year- all grantees will be funded through the Care lead agents). About $300,000 additional RWPB dollars were used to support housing efforts.

Q: What is 800% FPL in dollars?

A: B. Walsh responded: For a single person, it is about $92,000 of income per year. This amount increases based on household size.

Q: Why are their gender categories for trans men and trans women but not gender non-binary/ non-conforming people?

A: J. Maras responded: It is HRSA's reporting standard to only collect information in 4 gender categories: cis men, cis women, trans men, and trans women. IDPH could add other gender categories for state purposes, but there would have to be a way to make non-binary or other gender categories "fit" into HRSA standards for data reporting. If there are recommendations on how this can be done, the RWPB program would be happy to hear them.

Q: When a RW eligible client is above the 80% median income, but at or below the 500% FPL, is there a possibility to use the HRSA RW housing line item to assist those clients with short term housing assistance?

A: J. Maras responded: No, all housing assistance and emergency financial assistance is set at the 80% area medium income regardless of funding source (HOPWA or RWPB).

Q: Is HCV testing a standard activity for all RW clients?

A: J. Maras responded: Now that the contract with Groupware contract is complete, the RWPB program will be working to establish a new HCV and STD protocol for reporting within Provide™. This will help case managers to better connect clients to appropriate services. The program has also been reviewing HCV cure rates among RWPB clients and have found that the cure rate is at approximately 93%.

2:00 pm: Community Services Assessment: 2019 Illinois HIV Care/Prevention Resource Inventory Update

M. Andrews-Conrad presented the FY19 IDPH HIV Resource inventory. It was noted that this document is a component of the Integrated Plan that is updated annually. The primary funding sources for IDPH HIV prevention, care, and surveillance grants/ contracts were reviewed and totaled approximately $91 million dollars in FY19. All participants were encouraged to view the full the resource inventory on the IDPH IHIPC website or the meeting registration link.

There was no discussion on this topic during the meeting.

2:15-2:30 pm: Break

2:30 pm: Presentation & IHIPC Discussion: Recommended Prioritized Prevention Populations for 2020 based on Epi Data and Trends

M. Andrews-Conrad presented the recommended Prioritized Prevention Populations for 2020 on behalf of the Epi/NA Committee. Rationale for prioritization and the methods for the prioritization data analysis (weighted analysis: 90% incidence data, 5% prevalence data of virally unsuppressed people only, and 5% late diagnosis data) were discussed. The 2020 recommendations for prioritization were then reviewed in comparison to the 2019 prioritizations. The following populations were prioritized and were proposed to receive their respective proportions of Prevention services in 2020: MSM (72.6%), Heterosexual exposure (20.2%), PWID (3.9%), MSM/WID (3.3%). During the presentation, recommendations within each transmission category were broken down by race and gender (where applicable). It was noted that all HIV+ individuals are prioritized for prevention services regardless of transmission category.

Points of consideration were reviewed to support the prioritization of each population listed above. Please see the presentation for more details.

Discussion:

Q: The transmission categories are broken down by race, but can they be broken down by age? If youth incidence is increasing, should try to better target there?.

A: J. Nuss responded: Information about age is included in the Epidemiologic HIV update in February, but it was not used for the purposes of this document.

A: Many new diagnoses are happening among young people aged 13-24. We also, however, look at prevalence, which is mostly composed of older people who have been living with HIV for a long time. Increases of viral suppression and PrEP usage among all groups will help us in lowering the amount of new transmissions.

Q: What is the recommendation for testing of PWIDs? I thought I had understood that the previous prevention presentation pointed to de-emphasizing HIV testing among them, but they are still recommended as a priority population in this presentation.

A: C. Hicks responded: Yes, this was mentioned in the previous presentation as a foreshadowing of what will be an on-going discussion about a future potential shift of prioritized HCV testing instead of HIV testing for PWID. If this is to occur, HIV testing would still be available to this population through supplemental services. Please note that this is not a formal recommendation for 2020. The recommendations for PWID have not changed from 2019.

C: It was mentioned that Black women had a much higher rate of new diagnosis compared to White and Hispanic women. My concern is that many young Black women cannot bring their voices to meetings like this because they don't have access to child care. This is a barrier along with education, housing, food needs, etc.

Q: Could you please clarify the parameters for viral suppression? I understood that virally suppressed individuals were not included in the prevalence data set. How long would someone have to be virally suppressed to be excluded from the data set? How did this weighting with virally unsuppressed people change the analysis?

A: M. Andrews-Conrad responded: The weight of prevalence of virally unsuppressed people only in the analysis was only 5%. The committee reviewed this and a total prevalence data set, and the proportions among populations was relatively similar when compared to one another. When compared within the full weighted analysis the difference was very small. This could have changed, however, if prevalence was given a higher weight.

A: F. Ma responded: Anyone who had a viral load lab that indicated viral suppression in 2017 was excluded from the prevalence data used in the weighted analysis.

Q: Regarding the rates of new diagnoses HIV among differing race/ethnicity groups among women, was this inclusive of trans women (particularly black trans women)?

A: M. Andrews-Conrad responded: In this particular data set, trans women were not included. Because there is only a small number of clients who have identified as transgender among people living with HIV in Illinois, this type of data interpretation for trans women might not be possible.

It was decided that the Epi/NA Committee would review/discuss these comments during its committee meeting tomorrow prior to asking the IHIPC to vote on its recommendations.

3:00 pm: Presentation & IHIPC Discussion: Recommended Changes for 2020 to Risk Group Definitions

N. Holmes and M. Maginn presented the recommended changes for the 2020 Risk Group Definitions on behalf of the Epi/NA Committee. Rationale for prevention prioritization and an explanation of the data sets that were analyzed to determine the risk group definitions were reviewed. As previously noted, the committee had many discussions about continuing to prioritize PWID for HIV testing. Although the PWID risk group definition and prioritization is not recommended to be changed from 2019-2020, this topic will continue to be looked into and discussed by the committee with input from community members and service providers for future recommendations.

The Epi/NA committee recommended that the risk group definitions remain the same from 2019 to 2020. The definitions for each priority population are listed below:

- MSM: any male (cis- or transgender) aged 12 years or older who has ever had anal sex with a male (cis- or transgender).
- PWID: any person who does not meet the MSM definition and discloses ever injecting non-prescribed drugs or drugs not as prescribed
- MSM/WID: any male (cis- or transgender) who discloses ever having anal sex with a male (cis- or transgender) and ever injecting non-prescribed drugs or drugs not as prescribed
- HRH: a person lacking PWID or MSM risk and meets at least one of the following criteria: transgender female who has ever had vaginal or anal sex with a male (cis- or transgender); male (cis- or transgender) who has ever had vaginal or anal sex with an HIV positive female (cis- or transgender); or female (cis- or transgender) who has ever had vaginal or anal sex with an HIV positive male (cis- or transgender)

Discussion:

Q: I just want to clarify; is it proposed that the risk group definitions stay the same from 2019 to 2020?

A: Yes.

Vote: At 3:35pm, a motion was made to accept the 2020 Risk Group Definitions for the Priority Populations as recommended and presented by the Epi/ NA committee by M. Williams and was seconded by J. Charles.

Discussion for vote:

C: For the past few years, HIV disparities have been evident among Black women, and I don't think these risk group definitions address that problem. This might stem from a lack of acknowledgement of HIV within the community due to stigma. I think that opportunities for testing and prevention interventions for Black women are limited by this HRH definition. Many women do not know the status of their partners. This is a disservice to a population that continues to have disproportionate rates of new HIV diagnoses when looking at the data.

C: Are you suggesting that we include a phrase in the HRH definition that broadens it to include a partner's HIV status known or unknown to be positive?

A: I am suggesting that it be broadened even further to include Black women regardless of their partner's HIV status. Their partners might not know or disclose their status. This would help us Get to Zero for all populations.

A: C. Hicks responded: Please keep in mind that risk targeted testing is only about 9% of all testing completed by IDPH. Routine testing, which includes perinatal testing, is a strategy that can be used to serve Black women regardless of if they meet the HRH definition. You are describing efforts that could be implemented under the routine screening model. For risk targeted testing, we must reach populations that produces a 1.0% or greater sero-positivity rate according to CDC guidelines. Black women as a general population do not meet this target. It is important to know that routine testing and risk targeted testing can be used together to ensure that all people have access to services.

A: This might be true under the assumption that providers are offering/ providing routine testing to Black women, including Black trans women. There are many social determinants of health that create barriers to health services within this community. The main challenge we are facing is finding ways to really push people to get tested. We know this is more difficult in communities of color, and this should be considered when setting priorities.

A: C. Hicks responded: When we start breaking out race/ ethnicity groups in the risk definitions, it starts adding more and more questions about cause and effect. Could targeting based on race/ethnicity cause more stigma among these populations? When we are trying to meet a sero-positivity goal, we must look to the data to see what has been indicative of this in the past. The data has shown that having a known HIV+ partner reaches this goal, while generally, unprotected sex does not.

A: J. Nuss responded: In the past, the RIG testing data has shown that they are able to reach high sero-positivity rates because their scopes are guided by data-driven risk group definitions. Programs that perform HIV testing without prioritization often produce low sero-positivity rates.

Q: I want to make sure that we consider the huge disparities of new diagnoses of HIV among Black women compared to White and Hispanic women. How can we address this? It is too important to be ignored.

A: J. Nuss responded: You might remember from last year that there is a preface to the risk group definitions that explains that HIV disparities among communities of color are evident and require urgent attention and prioritization.

A: C. Hicks responded: This will also be prioritized when new routine testing sites are implemented (sites are targeted towards high incidence neighborhoods).

A: It needs to be addressed in the context of the priority populations. It needs to be clearly written so providers understand how disparities are being addressed.

A: C. Hicks responded: This is documented in each RIG service delivery plan. Regional providers work on priorities based on their region's transmission category and race/ethnicity proportions. Last year, nearly 11,000 of 15,000 targeted tests were delivered to Black or Hispanic people, so agencies are focusing strongly on these disparities. The same is true for other Prevention grants as well.

A: You can also see how disparities among communities of color are being addressed by funding. If you look at the Priority Population recommendations, the highest proportion of funding goes to Black women after MSM categories. This is directly related to the proportion of scopes that are allocated to serving Black women.

C: Please consider revising language in the risk group definitions from "male" and "female" to "man" and "woman". The former are indicative of sex, while the later are indicative of gender identity.

Vote: In consideration of this discussion, the motion was made to postpone voting on the risk group definitions until the Day 2 meeting (therefore repealing the previous motion to accept the definitions as presented and recommended by the Epi/ NA committee). The motion passed by consensus vote with none opposed and none abstaining.

3:30 pm: Presentation & IHIPC Discussion: Proposed Changes and Addition of Care Compendium to the Interventions and Services Guidance for 2020

J. Erdman presented the proposed changes to the Interventions and Services Guidance for 2020 on behalf of the LRAV and PP committees. The follow components of the Guidance were defined and reviewed: Recruitment Strategies; Key Public Health Strategies; Behavioral Risk Reduction Interventions; and Biomedical Risk Reduction Interventions.

The committees recommended the following updates for the 2020 Guidance:

- Incorporating CDC's new "Ending the Epidemic" plan into the Guidance and attempting to organize the guidance around this framework.
- Adding an HIV Care "Best Practices" Compendium as a complementary document to this Guidance.
- Adding three new strategies/interventions to the guidance: Couples HIV Testing/Testing Together, Taking Care of Me, and STEPS to Care.
- Removing the unsupported TWISTA intervention and adding the CDC-supported TWIST intervention to the Guidance.

Each of the recommendations above was explained in detail. The committees will continue to work on the Guidance and will present the draft recommendations at the October IHIPC Meeting.

Discussion:

Q: Are all of the interventions listed in this presentation available on effectiveinterventions.org?

A: Yes, that is correct. They are organized on the website by category. The website also has factsheets available for each intervention.

Q: One recommendation that I would like to make is building in components of community development through structural interventions. This is important in light of our efforts to combat racism and improve social determinants of health like education, employment, and the justice system.

A: This sounds like a great idea and adding a Structural Intervention component to the Guidance would be feasible. These could change year to year depending on priorities, political climates, etc.

Q: Regarding the behavioral interventions listed in the presentations, which have been proven to be effective? How can we get more community-based organizations to conduct more effective behavioral interventions?

A: All interventions in the Guidance are proven to be behaviorally effective and cost effective by the CDC/ intervention researchers. More information about effectiveness of each intervention can be found in the factsheets on effectiveinterventions.org. There are trainings associated with all interventions. Community-based organizations can participate in intervention trainings as needed.

Q: Regarding the 4 pillars for the Ending the Epidemic plan, I do not see how stigma is being addressed. It is such an important piece to focus on because it is a huge barrier to testing and treatment. Can we implement something that specifically addresses stigma?

A: IDPH has supported campaigns that specifically address stigma, and there are other organizations/ boards/committees in the HIV field whose sole purpose is to study and find ways to combat stigma. Additionally, stigma is also addressed with clients in some of the behavioral and biomedical interventions.

4:00 pm: Final GTZ Plan Pillars and Objectives/Vote of IHIPC Support

J. Nuss and M. Benner briefly reviewed the final Getting to Zero Plan, including the Plan's background/ timeline, objectives for 20% increases of viral suppression and PrEP usage, the Plan's guiding principles, and the Plan's primary domains. It was noted that the final Plan also included information about a new GTZ Implementation Committee. Co-chair M. Benner will represent the IHIPC on this committee for one year.

At a previous meeting, the IHIPC had been asked to formally support the Plan. All IHIPC members were asked to review the entire Plan prior to this meeting in preparation for voting on this matter.

At 4:25, a motion was made by J. Nuss and seconded by M. Benner for the IHIPC to formally voice its support of the Getting to Zero Plan. The motion passed by consensus vote with none opposed and none abstaining.

4: 20 pm: Announcements/Instructions for Day 2

It was announced that the IHIPC meeting committees will begin promptly on Day 2 at 8:30am. Community guests were invited to join any committee meetings that interested them or to join the full body meeting at 9:15am.

4:30 pm: Adjourn

The meeting adjourned at 4:35pm.

2019 Illinois HIV Integrated Planning Council (IHIPC) Vote Log: June 27 Meeting

Member Name	Member Type	Date: April 26, 2019 Time: 5:00 pm	Date: June 27, 2019 Time: 3:35 pm	Date: June 27, 2019 Time: 4:18 pm	Date: June 27, 2019 Time: 4:25 pm
		Motion 1: A motion was made by Janet Nuss on 4/19/19 at 8:19 am and seconded by C. Tucker at 9:36 am to adopt the agenda for the June 27-28, 2019 IHIPC meeting as approved by the Steering Committee. The motion was sent to the full IHIPC at 1:12 pm on April 19, 2019. Members were given until 5:00 pm on April 26, 2019 to submit their votes.	**Motion 2:** A motion was made by M. Williams and seconded by J. charles to accept the 2019 Risk Group Definitions for the Prioritized Populations as recommended and presented on behalf of the IHIPC Epi/NA Committee. The vote was postponed until 6/28. See Motion 3 for details	**Motion 3: A** motion was made to postpone voting on the 2020 Risk Group Definitions until 6/28/19.	**Motion 4:** A motion was made by J. Nuss and seconded by M. Benner for the IHIPC to formally voice its support of the Getting to Zero Illinois Plan.
IHIPC Voting Members					

Y: In favor; N: Opposed; A: Abstain; X: Absent or No vote cast/received TS: temporarily suspended

Benner, M.	Voting	Y			
Bradley, W.	Voting	Y			
Charles, J.	Voting	Y			
Choat, L.	Voting	Y			
Crause, C.	Voting	Y			
DeLaFuente, J.	Voting	X			
Dispenza, J.	Voting	X			
Erdman, J.	Voting	Y			
Filicette, J.	Voting	Y			
Fletcher, S.	Voting	*TS*			
Frank, S.	Voting	Y			
Gaines, M.	Voting	Y			
Guzman, L.	Voting	Y			
Hendry, C.	Voting	Y			
Holmes, N.	Voting	X			
Hoots, C.	Voting	Y			
Hunt, D.	Voting	X			
Johnson, R.	Voting	Y			
Jones, S.	Voting	Y			
Laskowski, C.	Voting	Y			
Lewis, K.	Voting	Y			
Maginn, M.	Voting	Y			
Meirick, A.	Voting	X			
Meyer, L.	Voting	Y			
Nuss, J.	Voting	Y			
Olayanju, B.	Voting	X			
Paesani, T.	Voting	Y			
Rehrig, S.	Voting	Y			
Roeder, L.	Voting	Y			
Stevens-Thome, J.	Voting	Y			
St. Julian, S.	Voting	X			
Tucker, C.	Voting	Y			
Williams, M.	Voting	X			
Williamson, M.	Voting	Y			
Zamor, Sara	Voting	Y			
Type of Vote: Hand Count, voice, electronic		**electronic**	**x**	**consensus**	**consensus**
Results: Carried/Defeated		**carried**	**x**	**carried**	**carried**
Results: Vote Count		**26 in favor , 0 opposed, 0 abstentions, 8 members absent or "no vote cast/received"**	**__ in favor , __ opposed, __abstentions,__ members absent or "no vote cast/received"**	**All in favor, none opposed, no abstentions**	**All in favor, none opposed, no abstentions**