Illinois HIV Planning Group (ILHPG)

May 20, 2016, 10:00 am-12:30 pm Approved Meeting Minutes

- Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)

  The meeting formally began at 10:00 am. The government Co-chair and Parliamentarian welcomed everyone to the webinar; reminded everyone about the primary goal of the HIV planning group and why we are here, including recognizing the importance of the valuable input we receive from membership and community stakeholders throughout the process of developing and updating our state's HIV prevention plan; and introduced the Co-chairs, facilitator, and presenters. The government Co-chair acknowledged a moment of silence for everyone past and present living with HIV and everyone working to stop new HIV infections and improve the health and lives of PLWH. She also gave special recognition to LeeVon Harris and his family as they recently suffered the loss of LeeVon's husband, Ken. We want him to know that our thoughts are with him and his family.
- Review formally adopted agenda

  The approved agenda for the webinar meeting was formally reviewed. The government Co-chair pointed out that voting would take place during the "Changes to the ILHPG Bylaws and Procedures" presentation and the "Prioritized Risk Group Definitions for 2017" presentation. She also explained to the group that the "Changes to Interventions and Services Guidance for 2017" presentation was not to be voted on during this meeting and the presentation served as an opportunity for members to see the guidance changes the I&S Committee is considering and a time for all members to ask questions, discuss, make recommendations regarding these changes.
- Webinar process; Attendance/Roll call; Announcements (15 minutes)
  - Webinar meeting, online meeting survey, and online discussion board instructions

    The facilitator reviewed instructions for the webinar, including where to access materials and presentations for the meeting. The ILHPG Website Administrator informed the group that the links on the webinar resource page had been changed. He stated that anyone who has saved these links for easy access to the website will need to replace them. He also stated that the evaluations and discussion boards for this meeting would be open until Friday, May 27th.
  - Announce logged in members and take roll call of other voting members to verify quorum

    Roll call was taken and announced. The facilitators verified there was a quorum of voting members present.
  - ILHPG Leadership

    The Co-chair acknowledged and introduced the leadership of the ILHPG.
  - Voting protocol

    The Co-chair reviewed the protocol for voting with members. She reminded them that two presentations on this webinar would be followed by voting.
  - Announcements

- » Member updates
  The Co-chair announced that two members, Rev. Doris Green (Region 8) and Fred Joiner (Region 3 RIG Rep), had both recently resigned from their ILHPG positions due to other obligations. The Co-chair also welcomed two new members, Ruth Ann Bertram (Region 3 RIG Rep) and James Reed (Centers for Minority Health Liaison) to the group.
- » 2016 Cumulative voting and non-voting member meeting attendance log
  The Co-chair reminded members to review the updated cumulative meeting and committee call attendance logs that had been sent to them by email earlier in the week. Members were also reminded that they were still able to view recorded webinars and get attendance credit for any meetings except for ones where there are scheduled votes taking place.
- » Reminder: Upcoming June 17, 2016 ILHPG webinar meeting
  The Co-chair reminded members of the upcoming June meeting and what the focus areas and content of the meeting will include. The Co-chair announced that Jeffery will be giving a presentation on HIV Prevention Intervention Services and High Impact Prevention.
- » Posted Reports/Updates:
  - Committee, Liaison and Regional Lead Agent, RIG Rep, and IDPH HIV Section reports
    The Co-chair reminded attendees that these documents are all located on the ILHPG webinar webpage. The full webinar presentation and full documents of items being presented or referenced during today's webinar were sent out to members for review in advance of the meeting.
- » Review meeting objectives and Concurrence checklist
  The Co-chair reviewed the objective for the meeting. The Co-chair reminded members that the concurrence checklist had recently been modified to meet the needs of the Integrated Plan. She said that members could review it on the ILHPG website and that there would be further explanation of the checklist at future meetings.
- » Other- Community Engagement
  The Co-chair announced that through May 13th, including people who have gone back to view recordings of previous webinars conducted this year, we have had 70 attendees/representatives from agencies, in addition to our voting members and regular non-voting members participate in our webinars. She also stated that over 20 new community stakeholder participated in the May Integrated Meeting webinar. She expressed that the webinar format has been a great tool to engage community members and stakeholders who otherwise could not attend face-to-face meetings. The Co-chair also announced that the summer newsletter was almost completed. She expressed her pride in how the newsletter has grown and thanked everyone who has contributed articles.
- » Other- Integrated Plan
  The Co-chair informed the group that a draft version of the Integrated Plan and several of its appendices would be e-mailed to members and stakeholders after the meeting. She strongly encouraged everyone to submit their comments either by email or on the newly created Integrated Plan discussion board (available through the ILHPG website).
- » Other- 2016 HIV/STD Conference
  The Co-Chair reminded the members that she is planning face-to-face ILHPG and Integrated meetings on October 25th morning in conjunction with the HIV/ STD Conference. She also encouraged anyone who was interested in joining the Conference Committee to contact Courtney Harris in the HIV Section Training Unit.

- Present, discuss, and vote on proposed changes to ILHPG bylaws and procedures (20 minutes)
  Chris Wade and Tremayne Coleman, ILHPG Membership Committee Co-chairs

- Input, Questions , Take-away (15 minutes)

  Tremayne provided an overview of the work that the Membership committee had done to change the ILHPG Bylaws and Procedures Manual so that it better reflected the new webinar meeting format and other needed changes. He reminded the members that although he was presenting the changes today, all members had previously received a copy of the Manual with revision so that they could review it before the meeting. First, Tremayne explained the recommended changes to the bylaws. These included omitting the word "quarterly" from the bylaws; adding the 2016 schedule into the bylaws; revising attendance requirements; and adding language to address meetings that might be face-to-face. He reminded members that a 2/3 majority vote was required for changes in by-laws.
  Questions and Comments:
  -Jill asked a question about attendance requirements. She wondered why the word "may" had been changed to "will" in regards to termination after 5 absences, especially because some unexpected circumstances may impede members from participating. The government Co-chair responded by first explaining that the number of allowed excused absences is based on the number of ½ day meetings that year. Compared to last year, there are less half day meetings, so the allowed absences decreased. She also explained that the termination procedure has always been that anyone who exceeds the maximum amount of absences "will" be terminated from the group and that the language needed to be updated. She also assured the group that anyone who is dealing with an unforeseen life event has the opportunity to ask for and be granted a temporary suspension of membership that will not affect their attendance record.
  - It was clarified that all webinar meetings count as one ½ day absence.
  After no further discussion of the bylaws, the Co-chair entertained a motion on the ILHPG Bylaws. A motion was made by Tremayne and seconded by Steven to adopt the recommended changes to the ILHPG Bylaws as presented by the Membership Committee. The motion carried with a final vote of 18 in favor, 0 opposed, and 5 members with no vote received (members present and not voting and members absent).

  After this vote, Tremayne continued with his review of the ILHPG Procedures. He explained the recommended changes to the procedures. These included adding the 2016 schedule into the procedures; revising voting procedures to better reflect OMA guidelines; clarifying information about meeting agendas; adding language to address meetings that might be face-to-face; and revising procedures about attendance requirements, public comment period, and concurrence voting (including the option of "concurrence with reservation" for concurrence letters). He reminded members that a quorum vote was required for changes to the procedures.
  There were no questions or comments at this time.
  After no further discussion of the procedures, the Co-chair entertained a motion on the ILHPG Procedures. A motion was made by Tremayne and seconded by Steven to adopt the recommended changes to the ILHPG Procedures as presented by the Membership Committee. The motion carried with a final vote of 18 in favor, 0 opposed, and 5 members with no vote received (members present and not voting and members absent).
  The government Co-chair thanked Tremayne, Marleigh, and the Membership Committee for their work.

- Vet Proposed Changes to Interventions and Services Guidance for 2017 with ILHPG (30 minutes)

  Jeffery Erdman and Serette King, Interventions and Services Committee Co-chairs

  - Input, Questions, Take-away (10 minutes)

    In this presentation, Jeffery gave an overview of the work that the I&S Committee had done to recommend changes for the 2017 Interventions and Services Guidance. He began by explaining that this guidance will be used by providers to initiate and practice effective HIV prevention interventions and strategies that are in line with the CDC's High Impact Prevention Model. The committee proposed four key changes to the guidance: incorporating biomedical components into the behavioral risk reduction activities,

incorporating medication adherence interventions for positives into the biomedical risk reduction intervention, incorporating new guidance into the HIV testing protocols via the CDC's Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers*, and preparing for the CDC rollout of prioritized Linkage-Retention-Reengagement in Care (LRC) interventions under the biomedical risk reduction interventions.*

Jeffery explained that the CDC is now incorporating biomedical components into multiple EBIs. The committee recommends adding language regarding biomedical components into each applicable EBI in the guidance. They also suggest that all service providers use the CDC's integrated curricula when delivering these integrated EBIs. Integrated curricula must be used by providers.

He continued by saying that the CDC has selected four evidence-based interventions to support HIV medication adherence. Three of these will be interventions are being prioritized by the I&S committee: HEART, Partnership for Health, and SMART. The committee recommends incorporating these interventions into the guidance and will require providers to utilize the appropriate e-learning curricula when delivering these interventions.

Jeffery then explained the new CDC guidance HIV testing. He informed them of important changes like separating prevention counseling from HIV testing events and further emphasis on linking high-risk HIV negative clients to nPEP and PrEP. The committee will attend upcoming CDC webinars about these changes and then work to incorporate them into the guidance and Fundamentals of HIV Testing.

Lastly, Jeffery spoke about new CDC LRC Interventions. He said that of the 11 LRCs that currently exist, the I&S Committee determined that only several of them are applicable for implementation in Illinois. Jeffery continued by saying that as of now, the only packaged LRC available is ARTAS. The next LRC, Stay Connected, should be available in approximately 18 months. The I&S Committee suggests that ARTAS should continue to be supported in Illinois and that the committee will work with IDPH to define the roles of Care and Prevention in LRC interventions. The committee will also monitor the rollout of other LRCs as the CDC makes them available.

Jeffery concluded his presentation by thanking Dr. Charles Collins, CDC, and the I&S Committee for their work on the guidance thus far.

-Debbie K., Andrea, and Karen commended Jeffery for a great presentation.

-There were no questions at this time

The government Co-chair thanked Jeffery and the I&S Committee for their work on the guidance and this presentation.

- *Brief break (5 minutes)*
- Present, discuss, and vote on analyses and recommended changes to the Prioritized Risk Group definitions for 2017 (30 minutes)

  Candi Crause and Tobi-Velicia Johnson, Epi/Needs Assessment Committee Co-chairs

  – Input, Questions, Take-away (15 minutes)

In this presentation, Tobi and Candi gave an overview of the work that the Epi/ Needs Assessment Committee had done to recommend changes for the 2017 Priority Population Risk Group Definitions. Tobi began by reminding the group of the 2017 Prioritized Populations: HIV+ and HIV- individuals of all races who report as MSM, HRH, PWID, MSM/WID, and any PWHIV who discloses "no known risk".

Candi continued by explaining how the risk factors for the Priority Populations were determined. She reported that IDPH had conducted an analysis of HIV testing risk assessment data in May 2016 and discussed this with the Epi/ NA Committee. The main findings were as follows:

- *The majority of newly diagnosed persons reported MSM behaviors.*
- *Nearly two-thirds of newly diagnosed persons with HRH risk (both male and female) report having sex with an HIV positive partner.*
- *Anal sex may present an increased risk for HIV infection, especially for transgender females.*

•*HRH persons with STI lab confirmed diagnosis was not prioritized for 2017.*

Tobi then explained the risk group definitions recommended by the Epi/NA Committee. They are as follows:

- *Men Who Have Sex with Men*
  - *Population Definition: HIV positive and HIV negative Men Who Have Sex with Men (MSM)*
  - *A high-risk MSM is defined as: any male (both cis and transgender males) aged 12 years or older who has ever had sex with a male.*
  - *Prioritized for Health Education/ Risk Reduction services only: SSAAM: An adolescent at high risk for future MSM HIV exposure is defined as any male (including cis and transgender male), age 13-19 years, who reports ever having had oral sex with a male or who states he is sexually attracted to males*
- *High Risk Heterosexual*
  - *Population Definition: HIV+ and HIV negative High Risk Heterosexuals*
  - *An HRH is defined as: Males not meeting MSM definitions and Females (both cis and transgender females) who do not meet the PWID definition and disclose ever having vaginal or anal sex with the other gender and also disclose meeting one of the following criteria: Males or Females living with HIV Disease; Males or Females who ever had vaginal or anal sex with an HIV positive partner of the other sex; or Females who ever had anal sex with a male.*
- *People Who Inject Drugs*
  - *Population Definition: HIV positive and HIV negative People Who Inject Drugs (PWID)*
  - *A high-risk PWID is defined as: a person of any gender who does not meet the MSM definition and discloses ever injecting drugs.*
- *MSM/WID*
  - *Population Definition: HIV positive and HIV negative MSM/WID is defined as any male who meets the definitions of both MSM and PWID.*
  - *A high-risk MSM/WID is defined as: a male who discloses ever having anal sex with a male and ever injecting drugs.*
- *People with HIV (PWHIV)- Other Risk*
  - *Population Definition: A person of any gender, race or ethnicity diagnosed with HIV Disease who discloses none of the following risks in their lifetime: ever having anal sex or vaginal sex and ever injecting drugs*
  - *Additionally, PWHIV with or without Prioritized Risks are prioritized for Surveillance-Based Services (SBS) if they have been reported to the IDPH HIV Surveillance as confirmed HIV positive and meets one of the following criteria: HIV-diagnosed within the past 12 months; No CD4 or VL reported within the past 12 months; or An STI Co-infection reported within the past 12 months.*

Candi concluded the presentation by explaining how ILHPG members and stakeholders could propose adding new populations to the priority list or other risk factors to the risk group definitions through the vetting process. Submissions for 2018 are due to the Epi/NA committee by March 31, 2017 and should include evidence in jurisdictions similar to Illinois of HIV-infection rates of 1.0+ to be consider for targeted prevention and HIV-infection rates at 0.1+% to be considered for routine testing. Other information included in the proposal should address whether or not the proposed risk is included in the Surveillance Case Report form; whether or not the sero-positivity of the risk can be assessed in isolation or in combination with another risk; whether or not a large sample size is available for analysis (n>= 200); existing research literature evidence; and whether or not the benefit of adding a group or definition is worth changing testing/ PROVIDE® procedures.

At the end of the presentation, the government Co-chair reminded members that the 2017 Risk Group Definitions had been sent to them by email prior to the meeting. The document showed members how the language had been changed in comparison to the 2016 definitions. She reminded members that they were asked to review this before the meeting.

- *Jeffery asked why "IDU" had been changed to "PWID" in the document. Candi explained that the group felt that the term "IDU" was not person-centered language. She also stated that the CDC has used "PWID" in several of their publications so the group thought the change was appropriate.*
- *Jeffery asked why the disclosure definition for PWID had changed from "ever sharing injection equipment or supplies" to "ever injecting drugs". Curt explained that the testing data analysis showed that the sero-positivity rate of PWID who did not disclose sharing equipment was higher than that of PWID who disclosed sharing. Candi explained that this may have occurred due to lack of disclosure or lack of knowledge. Curt also mentioned that the new recommended definition prioritizes all PWID for harm reduction.*
- *Jeffery asked why the risk of confirmed STI was eliminated for females but anal sex remains a risk definition despite its small sero-positivity rating in the analysis (.13%). Curt explained that although the sero-positivity rate for anal sex among all females was small, the risk of anal sex among transgender women was very evident. Candi and Tobi continued by saying that he committee wanted all definitions to be inclusive of both cis and transgender populations, so they decided to keep the definition.*
- *Jill asked if the PWID definition included people who inject hormones. Candi and Tobi responded with a "yes", particularly for transgender individuals with that risk. Candi also said the definition included steroids.*
- *Silas responded to the previous question by saying that hormones are not drugs. Tobi said that although hormones are not recreational drugs, the act of injecting hormones with a needle increases risk of HIV. Silas responded to Tobi by saying that was true, but by that logic, diabetics should be included in the PWID definition. He also said that categorizing transgender individuals who use hormones as "people who inject drugs" can be offensive. He suggested that the committee might want to review this as he did not feel that the definition was appropriate.*
- *The Parliamentarian explained that at this time, a motion could be made to accept the risk group definitions set forth by the Epi/NA Committee with the addition of language that would explain the difference between medical and non-medical drug use.*
- *Curt suggested that the words "non-prescribed" be added to the PWID definition when describing drug use.*
  At this time, Cynthia made a motion to accept the recommendations of the Epi/NA Committee for the risk group definitions with the addition of language about non-prescription drug use in the PWID definition.
- *After this motion, Curt wanted to clarify that one HIV+ transgender female was identified as a PWID in the analysis. He did not know the circumstances of use (i.e. non-prescription drug use v. hormone use) or if she had shared injection equipment.*

With no further discussion, Cynthia's motion to accept the definitions as presented by the Epi/NA committee with the addition of language about non-prescription drug use in the PWID definition was seconded by Scott. The motion carried with a final vote of 18 in favor, 0 opposed, and 5 members with no vote received (members present and not voting and members absent).

The government Co-chair thanked the Candi, Tobi, and the Epi/NA Committee for their work on the risk group definitions and presentation.

- Public Comment Period/Parking Lot (10 minutes)

  No public comment requests had been made and there was nothing on the Parking Lot.
- Adjourn

  The meeting was formally adjourned at 12:10 pm.