Illinois HIV Planning Group (ILHPG)/Ryan White Advisory Group Integrated Workshop – August 24, 2017, 11:00 am-4:00 pm

Minutes

Memorial Center for Learning and Innovation, 1A Auditorium

228 West Miller St., Springfield, IL 62702

Note: Boxed lunches will be available at the workshop meeting for Integrated Planning Group members and Community Stakeholders who confirmed their in-person attendance by August 14th.

11:00 am: Welcome; introduce co-chairs and facilitators, acknowledge moment of silence (5 minutes)

Everyone was welcomed to the meeting. The Integrated Planning Group Co-chairs introduced themselves and the IT/AV facilitator. Other presenters were then announced. The Co-chairs led the group in a moment of recognition for people past and present living with HIV and all the community partners representing small and large agencies, rural and urban settings, and from HIV care, prevention, treatment, and other related policy and supportive service areas.

11:05 am: Meeting process; Attendance; Announcements; Updates (15 minutes)

- Meeting process, meeting survey, online discussion board instructions *The facilitator noted that the meeting is being recorded and reviewed the online meeting instructions, meeting evaluation process, and discussion board instructions with everyone.*
- Roll call attendance of voting members, announcement of non-voting members and others, including those participating remotely
  The microphone was passed around the room and participants were asked to introduce themselves, state their region, agency affiliation and committee membership, if applicable. Since this is our first face-to-face meeting since last October, it will be nice to place faces with names.
- Review of agenda and meeting objectives; Announcements
  The co-chair reviewed the agenda and the objectives for today's meeting with the participants. The Co-chair reminded everyone the primary goal of the Integrated Planning Group and of the four National HIV/AIDS Strategy goals that are the primary driving force behind our planning activities and functions. A few reminders and announcements were made. The Co-chair showed a list of 52 community/agency representatives that was updated after the May meeting. This is a list of all people other than regular ILHPG, RW Advisory Group, and IDPH staff who have participated in ILHPG and Integrated Planning Group webinars so far this CY. That demonstrates a continued need to provide at least an option for people to participate in our meetings by webinar.

11:20 am: Overview of Concurrence Process and Checklist- (10 minutes)

Janet Nuss, IDPH ILHPG Coordinator, Integrated Planning Group Co-chair

- Questions & Answers, Discussion, Input – (5 minutes)

  : NHAS Goal 1 (Reduce New HIV Infections), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), Goal 3(Reduce HIV-Related Health Disparities); Goal 4(Achieve a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All

  The Co-chair provided an overview of CDC and HRSA's expectations for the concurrence process, the essential elements of concurrence, and recent clarification from CDC regarding concurrence. Concurrence is no longer associated with the State's Prevention application and budget. The PS18-1802 application and budget should be in alignment with CDC's grant guidance and the Integrated Plan submitted. The unanimous vote of concurrence and the resulting letter drafted and submitted by the Integrated Planning Group was associated with the state's Integrated Plan. If there have been no major changes or updates to the Integrated Plan since the concurrence letter was submitted last year, CDC has informed us that there is no need for another concurrence vote or letter. At the end of the meeting, after being informed on any updates that have been made to various components of the Integrated Plan, voting members of the group will make that decision.

11:35 am: Update on Illinois Getting to Zero Plan – (20 minutes)

Valerie Johansen, Lake County Health Department/Community Health Center

Cynthia Tucker, AIDS Foundation of Chicago, Getting to Zero Initiative

– Questions & Answers, Discussion, Input – (10 minutes)

: NHAS Goal 1 (Reduce New HIV Infections), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), Goal 3(Reduce HIV-Related Health Disparities); Goal 4(Achieve a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All

Valerie presented an overview of the Illinois Getting to Zero Framework. Throughout the presentation she solicited input and feedback from the group. The two main premises of the GTZ framework are that we will reach zero new infections and zero detectability. The aim of IL GTZ is to get ARV medications for treatment of HIV to everyone who needs them and to increase utilization of PrEP among vulnerable at risk populations. An increase in PrEP and AVR utilization by 20% from our current rates would result in fewer than 100 new cases of HIV by 2026 (functional zero).

Discussion:

Chris Wade and others stated that although we are optimistic about this happening, we realize that it would involve a lot of social and structural factors, such as policies, programs, social determinants, homelessness, housing issues, stigma, health system infrastructure, insurance providers. Changes would be needed in these to make these happen.

Valerie said that the GTZ group wants to make sure the community is on the same page so that we can all start to collectively and in partnership start to tackle these issues.

Lisa Roeder and others reiterated that the needs and barriers in downstate Illinois must be considered in this framework. GTZ may look different and be more of a challenge in small rural regions where resources are slim and people need to drive hundreds of miles to get tested or to see a provider.

Valerie said that the next step is that the GTZ Group asks Governor Rauner and Major Emanuel to appoint a task force to develop a blueprint for dramatically reducing new HIV infections and oversee implementation of the plan. Once the GTZ Group gathers all the input it has received from the community, it will synthesize that and return feedback to the community.

12:05 pm: Overview of Updated Illinois Unmet Need Analysis, HIV Continuum of Care and Presentation of Regional Continua of Care - (45 minutes)

Fangchao Ma, IDPH, HIV Section Epidemiologist

– Questions & Answers, Discussion, Input - (10 minutes)

: NHAS Goal 1 (Reduce New HIV Infections), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), Goal 3(Reduce HIV-Related Health Disparities); Goal 4(Achieve a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All

Dr. Ma provided an overview of Illinois's updated HIV Care Continuum, demonstrating how each of the bars of the statewide Cascade compared to regional estimates, and presented an updated Unmet Need analysis. For the Continuum of Care, we use eHARS data of cases diagnosed through 2015 and living as of 12/31/16, residing in Illinois at the time of diagnosis, ages 13 or older, and reported through 7/6/17. eHARS data was the only data used to estimate Continuum of Care elements. For the Unmet Need Analyses, eHARS data was supplemented with RW Part B and Medicaid data.

Dr. Ma described some limitations of the data. Region 2 and 3 lab data are incomplete. OSF Hospital Network transmits lab data in a version IDPH cannot process. IDPH is working with CDC to use Rhapsody software to resolve this issue. We have also discovered that OSF has only reported CD4s and not Viral Loads. In addition, if cases diagnosed in IL move out of state, we don't receive their lab reports, so they are still included in the denominator but not the numerator, making our rates of LTC, RC, and VS somewhat lower than they may actually be.

Illinois has seen a steady increase in LTC rates since 2012. We now have an overall rate of 80.72%. The LTC rate for the 13-24 year age group is low (74.86%) relative to the other age groups. The LTC rates for Blacks are lower (78.08%) than the overall rate. The LTC rate among IDU (71.43%) is the lowest among risk categories. The LTC rates for Regions 2 (64.53%), 3 (69.7%), and 5 (54.55%) are the lowest in the state.

Prevalence data is used to estimate rates of engaged in care (EC), retained in care (RC), and viral suppression (VS). Since 2014, Illinois has seen a slight decrease in these three rates. Viral suppression rates are higher than retained in care rates because some people don't meet HRSA's standard of 2 medical visits within a year. There are minimal gender differences for EC and RC. For VS, females have lower rates. Although youth have lower LTC rates, their EC rates are higher than the overall rate. The lowest rates for EC, RC, and VS are seen in the >= 65 age group.

By race/ethnicity, Blacks have the lowest RC and VS rates. By risk, IDU have the lowest EC, RC, and VS rates.

By region, Region 2 (25.67%) has the lowest EC rate. Region 5 (50%) has a lower than overall statewide LTC rate (56%) but a good EC rate. Region 2 also has the lowest RC rate (11.26%) compared to the statewide estimate (36%). The overall statewide VS rate is 44%. Region 2 has a rate of 15.98%. The situation with OSF reporting likely has something to do with these calculations. Other regions have about 95% of the laboratories reporting correctly.

Dr. Ma said that MMP now samples in care and out of care. We are waiting for CDC to provide us with weighted MMP data. We may be able to use that data to get a better estimate of EC, RC, and viral suppression.

For Unmet Need estimates, the lower the number the better. Unmet Need is people diagnosed and living with HIV with no evidence of being in care. Illinois' 2016 estimate for PLWH and PLWA combined is 39.4%. The Unmet Need analysis for Region2 actually shows Region 2 as having the lowest unmet need in Illinois and Region5 having the highest. Again, for the Unmet Need Analyses, eHARS data was supplemented with RW Part B and Medicaid data, providing a more accurate picture of those in care.

Discussion:

Paula – Region 5 data doesn't seem to correlate with what we are seeing. Dr. Ma stated that people in correctional facilities were included in the Unmet Need Analysis but not in the Continuum of Care estimates.

Bashirat – We have providers in Region 9 who only order labs once a year. That certainly impacts regional and statewide RC rates.

Jeff Maras and Cheryl Ward said that CDC and HRSA both require us to use the 2 lab visits in a 1 year period definition for the RC estimate for the Continuum of Care.

1:00 pm: Overview of NHAS Indicators and Illinois Progress in 2017 (25 minutes)

Livia Navon, IDPH, CDC Career Epidemiology Field Officer

Patricia Murphy, IDPH, HIV Evaluation Administrator

– Questions & Answers, Discussion, Input - (10 minutes)

: NHAS Goal 1 (Reduce New HIV Infections), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), Goal 3(Reduce HIV-Related Health Disparities); Goal 4(Achieve a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All

Livia Navon presented a summary of the progress Illinois has made in achieving the 2020 NHAS indicators. The full report with details on how each indicator is measured can be accessed at the following link: http://ilhpg.org/docs_082417

The White House Office on National HIV/AIDS Policy provides the states with Guidance on specifically how to measure each of the indicators. Baseline measures were calculated for Illinois and were used to set annual targets (except for Indicator 3 which is measured every 2 years) to accomplish the goals by 2020.

Indicator 1: Increase the percentage of PLWH who know their status- 86.4% Illinois made some improvement in this indicator in 2016 but was slightly below reaching the target (86.5%) we had set.

Indicator 2: Decrease the number of new HIV diagnoses by ≥ 25%. Our target for 2016 was 1,495 new diagnoses. The actual number was 1,433 so Illinois met this target.

Indicator 3: Reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by ≥ 10%. Not measured this year. This indicator relies on YRBS survey data that is released every 2 years.

Indicator 4: Increase percentage of newly diagnosed persons linked to HIV medical care within 1 month of diagnosis to ≥85%. Illinois met this target. In 2016, our Linkage to Care (LC) rate was 81.3%. Our target for 2016 was 80%.

Indicator 5: Increase percentage of persons diagnosed with HIV that are retained in HIV care to ≥ 90%. Illinois did not achieve our Retention in Care (RC) target. Our target for 2016 was 53.4% and the actual percentage achieved was 40.9%. This percentage actually decreased from 2015 to 2016.

Indicator 6: Increase percentage of persons with diagnosed HIV who are virally suppressed to ≥ 80%. Illinois did not achieve our Viral Suppression target. Our target for 2016 was 53.1% and the actual percentage achieved was 45.7%.

Indicator 7: Reduce percentage of persons in HIV medical care who are homeless to ≤ 5%. This measure has not been updated for 2016. We are waiting for the CDC to issue reweighted 2015 Medical Monitoring Project data, which is to be used for this measure.

Indicator 8: Reduce death rate among persons with diagnosed HIV by ≥ 33%. Illinois did not see improvement or meet this 2016 target. Our 2016 target was 14.0 per 1,000 persons. The actual rate was 15.4 per 1,000 persons.

Indicator 9: Reduce disparities in rate of new diagnoses by ≥ 15% for gay and bisexual men, young Black gay and bisexual men, and Black females.

Gay and bisexual men: Illinois met and exceeded the target disparity ratio (21.0) with an actual ratio of 19.7.

Young Black gay and bisexual men: Illinois met and exceeded the target disparity ratio (132.3) with an actual ratio of 123.

Black females: Illinois met and exceeded the target disparity ratio (0.81) with an actual ratio of 0.68.

Indicator 10: Increase percentage of youth and persons who inject drugs (PWID) with diagnosed HIV who are virally suppressed to ≥ 80%.

Youth: Illinois did not meet its 2016 target of 49.2%, but did show some improvement with the actual number of 44.4%.

PWID: Illinois did not meet its target of 48.3%. Instead the actual percentage (39.6%) was worse than the 2015 baseline.

Indicator 11: Increase percentage of transgender women in HIV medical care who are virally suppressed to ≥ 90%. This is a new indicator. The baseline is 77.1%. The 2017 target will be 80.3%.

Indicator 12: Increase number of persons prescribed PrEP by ≥ 500% from baseline of 1,234 in 2014 to ≥ 7,404 by 2020. Illinois did not meet its 2016 target of 2,777 people prescribed PrEP, but we made significant improvement with the actual number achieved (2,712).

Indicator 13: Decrease stigma among persons diagnosed with HIV by ≥ 25%. We are also not able to measure this indicator at this time. We are to use MMP data to do so and CDC will be issuing reweighted 2015 data.

Discussion:

There was discussion about the data collected for Indicator 11 for transgender women. Livia said that for standardization, CDC dictates the data sets that are to be used for each indicator and how the measurements should be conducted.

Jeff Maras commented that since the guidance requires that we use RW Program data to measure this indicator, we are working with not a large number (estimated to be about 185) transgender women in that data set. He said that the data being collected by the RW Program now is more comprehensive than historically. There may be additional opportunities to collect data. Case managers assess clients' gender identity at assessment and reassessment.

Marissa Miller commented that the client risk assessment asks people if they self-identify as a transgender male or female and she believes some transgender individuals have historically identified themselves as MSM. She suggested that we train case managers on how to have conversations with clients who may be transitioning and how to use that information once collected. She also suggested that we conduct a needs assessment specifically of transgender persons and that this assessment of their identity and discussions with their case managers during those visits be part of that assessment.

Curt stated that he thinks CDC used RW data for this measurement because not all states collect transgender data on their case report forms. IDPH has been doing this since 2009.

There were comments made that the actual number of people prescribed PrEP is likely higher since we were limited in the data sources used to determine prescriptions. Jeff Maras suggested we consider adding data from the state's PrEP program next year since we are increasing our enrollment.

Jill Dispenza questioned why only people ≥ 18 years of age were used to measure the Homeless indicator when she knows there are a large number of homeless youth. She was told that the MMP, from which we are to measure this indicator, is only administered to people ≥ 18 years of age.

Mike said that there is a national fact sheet on Internalized Stigma that shows that 80% of people experience internalized stigma. CDC also just released am article that shows that the national rates of testing for transgender individuals has decreased.

1:40 pm: Break (15 minutes)

1:55 pm: Brief Overview of Updates to Integrated Plan: Prioritized Populations for Prevention; Risk Group Definitions; Guidance for Approved Prevention Interventions and Strategies; 2017 Illinois HIV Resource Inventory - (20 minutes)
Janet Nuss, IDPH ILHPG Coordinator, Integrated Planning Group Co-chair

– Questions & Answers, Discussion, Input - (10 minutes)

: NHAS Goal 1 (Reduce New HIV Infections), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), Goal 3(Reduce HIV-Related Health Disparities); Goal 4(Achieve a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All

Prior to determination on whether a concurrence vote/letter is needed, the Co-chair provided an overview of all the updates to various components of the Integrated Plan that had been made in 2017. The ILHPG committees and the Integrated Planning Steering Committee had provided input and involved in those updates and the Integrated Planning Group had been informed of these changes at past meetings this year. Additional updates had been and are still to be presented today. These updates include:

Illinois and Regional Unmet Need Analysis
Illinois and Regional Continuum of Care Update
Progress on Illinois' NHAS 2020 Indicators
2017 IDPH HIV Resources Inventory Assessment
Demonstration of Prevention and Care Grants/Budgets alignment with the Integrated Plan
Demonstration that prevention and care services were delivered according to priorities identified in Integrated Plan.
Prioritized populations for Targeted Prevention Services for 2018
Risk definitions for the 2018 Prioritized Populations for Prevention Services
Guidance for 2018 Approved Prevention Strategies and Interventions

Janet said that these updates reflect minor changes and updates to components of the Integrated Plan.

Discussion:

Chris Wade said that he is concerned that we are not prioritizing black females as well as people with a recent history of incarceration or partners of those who were recently incarcerated. Men who had sex with men while incarcerated often do not disclose having those risk behaviors and would not be captured in one of the prioritized risk groups.

Lexie Arjona stated that she was concerned that young MSM particularly those who have oral sex or are questioning their sexual identity are not disclosing their risk behaviors.

Curt stated that our analysis of the data did not show a strong association between HIV seropositivity and recent incarceration therefore that was removed from the definition several years ago.

The Co-chair reminded people that the risk definitions for the 2018 Prioritized Populations for Prevention Services have been approved by the ILHPG. The Epi/Needs Assessment solicits suggestions for factors to include or remove from the risk group definitions each year so there will always be opportunities to explore other factors, look at research findings, and conduct our own data analyses to make modifications in the definitions. She also said that the risk group definitions enable us to identify those at highest risk for HIV with our targeted testing services.

Curt said that there are also additional testing scopes available in each region for people that do not fall within the Prioritized Populations.

2:20 pm: Summary of 2018 Prevention Grant Application/Budget and Their Linkage to/Alignment with Integrated Plan Priorities – (40 minutes)

Curt Hicks, IDPH HIV Prevention Administrator

: *NHAS Goal 1 (Reduce New HIV Infections), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), Goal 3(Reduce HIV-Related Health Disparities); Goal 4(Achieve a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All*

– Questions & Answers, Discussion, Input - (10 minutes)

Curt provided a summary of the Illinois 2018 Prevention and Surveillance Application and Budget to CDC and how they align with the Integrated Plan. We are expecting slightly over $4 million in Prevention funding and ~$850,000 in Surveillance funding. We cannot use Prevention funds for medical services, including PrEP. We also cannot use our federal funds for Syringe Services, but we can use GRF for these services. We anticipate increasing our regional grant funding from $4.4 million in 2017 to $5 million in 2018. Curt provided an in-depth overview of the 11 strategies and the 136 activities that we will be mandated to implement with the grant. Curt showed a few graphs to illustrate where Illinois is in terms of new diagnoses. Among females, every prioritized population is seeing a sharply decreasing trend. Among men, most of our prioritized populations have seen a decreasing trend. Only Black and Hispanic MSM have shown increases from 2006-2012. Clearly, we have to prioritize these two populations as Illinois' most critical HIV incidence disparities. The need to build capacity to serve Black and Hispanic MSM is underscored by our 2016 HIV prevention service delivery data which shows that these two populations each received less than their incidence share of the services. We have come a long way in the past 6 years to close these gaps. Basing the regional grant scopes on the regional gap analysis and using incidence-proportioned scopes have helped to narrow these gaps. Curt hen summarized some minor changes in the regional HIV prevention grants and summarized how the grant activities would contribute to meeting the three primary goals of the NHAS.

Discussion:

Valerie said that she is surprised to see such a small amount of funding allocated for Prevention for Negatives when those services could be used to enhance PrEP uptake. Curt and Eduardo said that IDPH plans to present plans at the meeting tomorrow to promote PrEP uptake by providing 19 LHD sites with GRF awards.

Valerie commented that any changes in the criteria for Surveillance Based Services need to be on Provide. Curt said that he was aware of that but at this time we are limited in terms of Provide Enterprise ® development.

There was discussion about molecular surveillance. Peter McLoyd expressed that there is a lot of community concern about how this will be rolled out in terms of outreach and privacy. He also asked if we would be involving the community in the policy development. Curt said that we have not begun policy development yet. He believes CDC has issued some guidance on this.

Eduardo said that at a recent NASTAD meeting, Houston had presented on the recent work it had done with cluster analysis. There was a fear that it would be used by law enforcement to target undocumented clients. Eduardo said that we will be vigilant about data sharing and the concerns about cluster analysis.

Livia said that cluster analysis data has been collected for awhile, but it just has not been used. There are discussions happening now at the CDC on local usage of this data.

There was a comment commending the proposal to add Social Networking Strategy and Community Promise. These can be very useful for harm reduction activities.

Candi Crause said that she appreciates funding for structural interventions such as condoms. She would like us to consider allocating funding for harm reduction supplies outside the fee-for service scopes. We know harm reduction materials are provided to the regions but there is still cost associated with marketing, staff time, and education.

Chris Wade commented that in his travels across the state, he has noted that peer counselors in correctional settings need more support for the great work they are doing.

Jenny Epstein asked if we would be doing any policy initiatives in terms of condom access in correctional settings. There is a pilot project going on in California. Michael Gaines said that he has proffered this with IDOC and they do not want to discuss it at this time. IDOC is allowing peer educators to talk to clients about PrEP prior to their release, however.

3:30 pm: Concurrence Discussion **and Vote if Needed** – (15 mins)

The Co-chair stated that this is the time allocated on the agenda for Concurrence Discussion and vote if the group feels needed. IDPH feels that all the updates to the Integrated Plan made this year are minor and do not feel they constitute a need for a new concurrence vote/letter. She asked if there was any discussion and there was none. She then said that we would entertain a motion from the group regarding a new concurrence vote/letter.

3:32 PM: Steven St. Julian made the motion to forgo a new concurrence vote and letter in light of the minor changes made to the Integrated Plan. Scott Fletcher seconded that motion. The motion carried with 34 votes in favor, 9 members absent or who did not cast a vote, 0 abstentions, and 0 opposed.

3:35 pm: **Discussion/Vote** on Draft IHIPC Bylaws, Procedures Which Have Been Vetted and Gone through Public Comment Process – (15 minutes)

The Co-chair asked if members needed a recap summarizing the bylaws and procedures or if they were prepared for the vote. Previous drafts had been sent to members for public comment. The Integrated Planning Steering Committee met in July and considered all the recommendations and comments made and made final updates to the draft document. The final draft document was then sent to voting members and community stakeholders on August 1st and voting members were instructed to review the document and come prepared for discussion and vote today. Members expressed they did not feel the presentation was needed and there were no questions. Janet said we would entertain a motion to approve the bylaws & procedures.

3:40 pm: Scott Fletcher made a motion to accept the approved bylaws and procedures. 3:41pm: Louis Hobson seconded the motion.

Discussion:

Mike said that he is concerned about the composition of voting membership. There are only 4 PLWH on the membership with an optional 4 persons representing those at high risk who also may be HIV+. He also expressed concern about the other 10 appointed voting members (Note: actually it is 8) who represent areas like the St. Louis TGA that don't know about HIV and aren't familiar with our HIV planning process.

Chris reiterated these concerns. He stated that this minimizes PLWH in the HIV planning process.

Janet said that in the Membership Plan that will be presented next, there is a matrix used to score applications. Applicants who are HIV positive receive the highest amount of points in a specific category. People self-identified as being in one of the high risk populations also receive a higher score in one of the categories. This makes it much more likely for PLWH who apply for membership to be selected. In addition, PLWH can also be selected for membership because they meet other areas of expertise or demographic characteristics that are needed on the group. The "4 PLWH" is including but not limited to that number. Other applicants representing other areas of the targeted composition (i.e., service providers, etc.) can also be PLWH. From her experience on the ILHPG, Janet said that that often happens. The ILHPG has typically had 6-8 PLWHA on the group because they meet multiple demographics. Janet also noted that the IHIPC Membership plans, including the proposed composition of members, have been presented and discussed at meetings several times over the last 9 months, with this group, with community stakeholders, and with input solicited from and provided by consumers multiple times.

Chris said he understands that but is concerned with cooptation, disclosure and meaningful involvement of PLWH. It seems a lot of this has been turned over to government with not a lot of community engagement and a lesser voice for PLWH at the table.

The Co-chair asked if there was other discussion. There was none offered. She then asked the Parliamentarian how to proceed? Scott said to proceed with the vote.

Lexie – Can we address Mike and Chris' concerns at this point? The Parliamentarian said that there is a motion on the floor. That motion has to pass or fail before we can entertain another motion.

Candi said that as an Integrated Planning Group the care side has done a good job at having peers and community representation on its group. I hear Chris' concerns, but on the prevention side I echo the concerns that we have struggled always have had consumers of prevention services at the table. I think the Steering Committee did a good job of considering care and prevention and organizing the priorities of both planning groups and determining the composition of voting membership for this new group.

The Co-chair reiterated that the Integrated Planning Steering Committee has summarized and worked in collaboration with the full group and other community stakeholders to solicit input multiple times over the last 8-9 months.

Valerie said she feels that the Co-chair's comments minimize Chris' comments and the discussion on this.

Lisa Roeder – Don't we have to vote on this motion before we can entertain an amendment? Lisa asked that we call the question and take a vote as is.

Marissa stated that she feels that whether we change the bylaws or not, our responses to Chris are dismissive to community input.

Scott apologized but commented that his responses were in regard to proper Parliamentarian procedure.

Chris stated that he does not take this process personal.

The Co-chair said she was not being dismissive of Chris but speaking on behalf of the Integrated Planning Steering Committee and all the hard work that committee has put into this and the process it has followed over the last 8-9 months.

Chris stated that Lisa shut this process down with calling the question. He asked her to comment.
Lisa said that this became personal when Chris asked the person to make the motion to be friendly enough to amend the motion. Lisa said she is calling the question.
Scott said we needed to vote and have a 2/3 majority approve calling the question.
3:50 pm: The vote to call the question was defeated with a vote of 14 in favor, 7 opposed, 12 abstentions, and 9 members absent or not casting a vote.
The original motion was back on the floor. A motion to amend the original motion can be added to the motion (the section re: targeted composition of the voting IHIPC removed from the bylaws). Scott, who made the original motion, accepted the friendly amendment. The motion was made to accept the bylaws and procedures as presenting, removing the targeted composition of IHIPC voting membership until that can be further addressed. Jill seconded the motion.
Discussion:
Scott will support whatever structure the group comes up with but wants to recognize all the work done by the committee and does not want to committee to feel there work has been discredited. PLWH have always been represented on the group but are also represented in a lot of other venues.
Steven heard Chris' comments and agrees that the planning group should reflect the disease as close as possible. It may be as simple as putting wording in the bylaws to reflect that the makeup of the group reflect the Illinois epidemic and "including but not limited to…." be added. There is nothing to say that the other 23 elected voting members cannot be HIV+. I provide care services and I'm HIV+. There is a lot of overlap here and a lot of room for HIV+ to be members representing other needed areas on the group. It was not the intent of the people to say there should only be 4 HIV+ on the group. It was that at minimum, there need to be at least 4.
Jeffery agrees it is good to hearing from community members. CAHISC requires 1/3 of its membership being PLWH. I'm not saying we follow that but I'm saying
Peter said this in accordance with Part A statute, 1/3 of its membership must be non-aligned HIV+ consumers.
Nicole said that if the ILHPG has historically had 7-8 PLWH on its group, without specifying that in its bylaws, we may already be there.
4:05 pm: Scott made a motion which was seconded by Jill Dispenza to adopt the proposed bylaws and procedures as presented except for the targeted composition of IHIPC voting members. The motion carried with a vote of 30 in favor, 4 opposed, 1 abstention, and 8 members absent or not casting a vote.
The Co-chair said she will send that section of the bylaws back to the committee for reconsideration.
The Co-chair presented images of the two logos, initially created by Janet's intern and approved by the Integrated Planning Steering Committee that had been sent to the IDPH Communications for review, approval, and modification, if needed. These are the two approved and modified images they have returned. We now need to select one as our logo for the IHIPC. The image with the state of Illinois on the left side of the screen facing the audience is Logo 1 and the image with the people on the right side of the screen facing the audience is logo 2.
4:10 PM: Logo 1 was approved with a vote of 23 in favor of selecting Logo 1 and 12 in favor of selecting Logo 2. 9 members either were absent or did not cast a vote.
The Co-chair stated that we will need to hold off on the next presentation because it has to do with presenting Membership and Recruitment Plans and since a part of this has to go back to the committee for reconsideration, the presentation may need to be modified. We had expected to open up new membership applications after this meeting, but that timeline will definitely need to be modified. It may also delay our IHIPC startup plans. We will need to set up a group discussion forum or plan another webinar after the Integrated Planning Steering Committee meets sometime in September to present the new Membership Composition recommendations and to provide the below presentation that has been put on hold.

~~3:40 pm: Overview of Membership Plans for 2018 and Formal Opening of New Member Recruitment – (10 minutes)~~
~~Janet Nuss, IDPH ILHPG Coordinator, Integrated Planning Group Co-chair~~
~~Jeffrey Maras, IDPH HIV RW Part B Administrator, Integrated Planning Group Co-chair~~

4:15 pm: Public Comment Period/Parking Lot/Announcements - (10 minutes)
There were no public comments. The Co-chair reminded participants to hand in their evaluations and of the location (same building in Theater 2A) of tomorrow's meeting (8:45 am – 1pm) for those attending.

4:20 pm: Adjourn
The meeting was formally adjourned.

: *Planning Group presentations/ discussions are designed to be centered on Planning Group functions/processes and the goals/ indicators of the National HIV/AIDS Strategy (NHAS) and/or the steps of the HIV Care Continuum. This symbol, followed by its description, indicates the focus of the presentation in relation to NHAS or the HIV Care Continuum.*