

Illinois HIV Integrated Planning Council (IHIPC) Meeting Minutes-DRAFT

June 29, 2018, 8:30 am – 1:30 pm

8:30 am: Welcome; Introductions, Moment of silence

*The Co-Chair Janet Nuss welcomed all members and guests to the meeting. She introduced herself, the website/ webinar coordinator Scott Fletcher, this meeting's presenters (most of which are the co-chairs of IHIPC committees). Janet then led a moment of silence recognizing all people living with HIV past and present and all those working to end the epidemic in Illinois. Janet encouraged members to request to lead the moment of silence at future meetings. Members should inform Janet if they would like to do this.*

8:35 am: Meeting process and instructions; Roll call; Announcements

- Roll call attendance of voting members, announcement of non-voting members/others, including remote participants
  - » *Janet reminded everyone that the meeting was being recorded, announced that some members and guests were joining the meeting via webinar, and reviewed webinar participation instructions. Remote participant will be added to the roster/ meeting attendance list and have the opportunity to participate in meeting discussion by phone.*
  - » *Janet mentioned that meeting documents are available on the website: [ihipc.org](http://ihipc.org). The recorded webinar of this meeting will be posted by next week. Previously recorded meetings and materials are also available on the website.*
  - » *Hard copy meeting surveys are available at the meeting and online for remote participants. The survey is to be filled out as combined evaluation for both the June 28<sup>th</sup> and 29<sup>th</sup> meetings. Participants were asked to submit surveys at the conclusion of this meeting.*
  - » *Janet reminded everyone there would be a period of public comment at the end of this meeting. Public comment cards were still being accepted and could be submitted online or by paper at the meeting. One public comment card had been submitted thus far and would be addressed during the public comment period.*
  - » *The microphone was passed around and all members and guests were asked to introduce themselves by name, agency, committee, and preferred pronoun (if desired).*
- Review of agenda, Concurrence checklist, Meeting objectives; Announcements-
  - » *Janet reviewed the objectives of the meeting and the related agenda topics/ discussions. Printed copies of the agenda were made available. She reviewed the goals of the IHIPC, including integration of National HIV/AIDS Strategy (NHAS) goals into IHIPC's purpose and work.*
  - » *The IHIPC Concurrence Checklist was reviewed and made available in meeting packet. Janet encourage members to review the Elements of Concurrence at every meeting, to ensure that all elements were being met through IHIPC meetings/ objectives and that planning group members are being informed and providing input into updates to the Integrated Plan.*
  - » *An announcement was made for all voting IHIPC members to please submit travel vouchers for reimbursement if desired. Since this is the end of the state fiscal year, it is important that vouchers be submitted ASAP, preferably today, so they can be processed promptly.*

8:55 am: Overview of IHIPC Membership Gap Analysis, Opening of New Member Recruitment

Janet Nuss, IDPH IHIPC Coordinator, Integrated Planning Group Co-chair  
IHIPC Membership Committee Co-chairs

Janet explained the membership gap analysis process the IHIPC uses to mirror its members' demographics with the HIV epidemiology in Illinois. At this time, the group is at full capacity of elected voting membership (27 members) as all members have been assigned to two or three year terms through December 2019 or 2020. There is a need, however, to fill at-large seats as previous at-large members have filled the roles of unexpected vacancies in membership (there are 0 at large members at this time).

Demographic data self-reported by members at the beginning year was used to complete the compilation of the current membership's make-up. The survey is designed to collect information about the primary risk group each members most represent on the planning group, either personally or professionally. In order to match membership to the epidemiologic data, prevalence data (as of 2016- including Chicago) and incidence data (from 2012-2016 – excluding Chicago) were combined in a 50/ 50 weighted analysis. This weighted average allows both Care (prevalence data) and Prevention (Incidence data) to be equally integrated into IHIPC's membership.

Janet reviewed the results of the analysis. In regards to risk, the current membership reflected the epidemiology fairly well. In regards to race, the current membership over-represents the white population, which has caused gaps in minority (black, Hispanic, & "other") representation. When risk and race are combined, it is evident that specific membership gaps appear in the MSM of color population (HRH and PWID were generally reflective of the epidemiology by race). Beyond the race/ risk assessment, it is also important to consider the targeted composition of the IHIPC membership as written in the bylaws when recruiting new members. At this time, the group is missing representation from the transgender community. Some regions are also severely underrepresented (Regions 1 & 2) or somewhat underrepresented (Regions 5, 6, and 7). Based on this information, Janet encourage everyone to help recruit members to fill the following gaps: (people of color (Black, Hispanic, or "other" race), Black and Hispanic MSM, people representing the transgender community, and people from Regions 1 and 2, in particular).

Janet noted that the group benefitted by adopting the at-large member policy as it has filled mid-year gaps very well. At this time, the by-laws state that there should be 3 at-large members. The Membership Committee is proposing that the by-laws be modified to allow for 6 at-large member. A vote regarding this took place after question/ discussion.

#### Questions & Answers, Discussion, Input -

*Q: Sara asked: How do we account for unaffiliated members (not affiliated with any funded agency).*

*A: Janet responded by saying that there is no requirement in our Bylaws for members re: members being unaffiliated vs affiliated. She knows this is different for Part A planning groups.*

*Addendum to this comment: Part A planning groups are responsible for priority setting and resource allocation of care funds in the jurisdiction, which is not a requirement of Part B planning groups, and which may be a factor in why Part A planning groups are required to have some unaffiliated members.*

*Q: Chad asked: Why would we not prioritize people who are not getting services from funded agencies?*

*A: Janet responded by stating that it really is not a matter of prioritizing people based on agency affiliation as membership is open to all people with association to the HIV community. .*

*C: Steven stated that Janet is correct in that there are no requirements of affiliation at this time. He suggested that it may be something for the Membership Committee to further discuss.*

*C: Chad stated that it is his personal thought that the group should designate spots for unaffiliated members so that more voices from different places are heard in planning efforts.*

*C: Janet said that this topic will go back to the Membership Committee for further discussion. The committee should first explore the definitions of "unaffiliated" for both Prevention and Care designated spots.*

*C: Members from both Chicago and St Louis Planning Councils said their planning groups do take affiliation into consideration for membership.*

*C: Lyyti suggested that this affiliated v. unaffiliated membership issue could possibly be resolved on the scoring matrix instead of as a designated position.*

*C: Janet stated that this could be true. It is also important to mention that members can fill more than one category. For example, some people living with HIV filled gaps in professional experience with certain population groups.*

*C: James C. mentioned that he was a client representative that was not employed by any agency. He is happy to bring his perspectives about this to the group.*

*C: Jenny stated that the group should think about the implications of adding unaffiliated members to the group. If they are employed, could they come to daytime meetings? Adjustments like this would need to be made for insightful participation. Candi agreed with Jenny's point about accessibility of daytime meetings.*

C: Janet stated that this also relates back to having meetings accessible by webinar. That has helped to get other people participating in our meetings. Meeting expectations are made clear to applicants so that people are able to determine if they can commit to the group and seek permission to membership responsibilities, including meeting attendance, from their agency supervisors, if needed.

Q: Jill asked: What is the current count of elected voting members that are living with HIV?

A: Janet stated that the IHIPC is currently above the by-law requirement of having at least 4 elected voting member who are living with HIV. She believes that the current count is 7 HIV+ voting members.

Q: Curtis asked: How can someone apply- is it only online?

A: Janet stated that the application will be posted online after this meeting. Paper applications were also available at the meeting.

C: Candi stated that the group should remember that some consumers that are HIV- (i.e.- PrEP). Their representation is important in our effort of getting to zero.

Q: Lisa agreed that PrEP clients should be considered in the recruitment process. Transgender/ hormone therapy recipients should also be considered in this process.

A: Janet agreed that these suggestions were good. People of special populations are considered and will continue to be in this year's recruiting process. We just need to educate these people and encourage them to apply. That is why recruiting by members in their communities is so important.

Q: Mildred asked: Has there ever been priority to formerly incarcerated individuals for membership? What about care givers and families of people living with HIV?

A: Janet stated that there is no priority given to formerly incarcerated individuals at this time, but representation from the correctional community is important. Michael Gaines and another member currently represent the correctional community on the group. Loved ones of people living with HIV are considered on the membership applicant scoring matrix.

With no more questions, Janet concluded the discussion by reviewing the sections of the application and criteria of the scoring matrix with the group. She stated that interviews may or may not be conducted based on the number of applicants. Janet formally announced that active recruitment was now open with applications being accepted now through September 15, 2018. Applications were available at the meeting and will be available on the website in the coming days. Janet encouraged all members to recruit within their communities so that membership gaps can be filled.

#### **Vote**

At 9:25am, Janet entertained the following motion: To change the number of at-large members that the IHIPC selects from "up to 3" to "up to 6". The motion was made by Steven and seconded by Cynthia. There was no discussion about the motion at this time. A consensus vote was taken by raise of hands. The motion carried unanimously with 32 members in favor, none opposed, none abstaining, and 2 members absent from the vote.

#### 9:25 am: Overview of IHIPC Leadership Roles and Selection of 2018-2019 IHIPC Leadership –

Janet Nuss and Jeffrey Maras, IHIPC Integrated Planning Steering Committee Co-chairs

IHIPC Membership Committee Co-chairs

Janet stated that it was now time for the group to nominate and elect the new IHIPC leadership. She reviewed the following leadership positions: community co-chair (1 year commitment), co-chair elect (1 year commitment followed by one year as community co-chair), parliamentarian (2 year commitment), and secretary (2 year commitment). Since we are electing the first positions in mid-year instead of at the end of the year as we would normally do, the 1 year terms will go through 2019 and the 2 year terms will go through 2020. The committee co-chair leadership positions have already been selected. Combined, these leadership roles will form the new Integrated Steering Committee. Janet stated that each person elected to these vacant positions must be able to commit to an extra committee meeting each month and to their position's specific responsibilities (which she reviewed in-depth).

The nomination process was reviewed. Any member could nominate themselves or others, and nominees could accept or decline. After the nomination process closed, each nominee would be asked to address the group with interest, ability, etc. The election would then follow addresses by nominees. Nominations were as follows:

- Community Co-Chair:
  - Candi nominated Mike Benner. Mike accepted the nomination.
  - Mike Maginn nominated Susan Rebrig. Susan respectfully declined.

- *Community Co-chair elect:*
  - *Scott nominated Chad Hendry. Chad respectfully declined. Chad stated that he would like to see a person of color in the position.*
  - *Mike Maginn nominated Don Hunt. Don respectfully declined.*
  - *Jill nominated Nicole Holmes. Nicole accepted the nomination.*
- *Parliamentarian:*
  - *Jill nominated Scott Fletcher. Scott agreed to accept if there was no one else interested.*
- *Secretary:*
  - *Lesli nominated Cynthia Tucker. Cynthia accepted the nomination.*

*All members were given a chance to nominate for any position after initial nominations were completed by category. With no other nomination, the process closed. The address of nominees then began: Mike stated that the role of Community Co-Chair will be a good challenge that he believes that he is equipped to fulfill. He looks forward to being mentored by experienced leaders in the group so that he can do the same in the future. Mike comes into the role with an open mind and looks forward to the opportunity. • Nicole stated that she was incredibly grateful for the nomination of Community Co-Chair Elect. She states that she is a newer professional in the field, so she looks forward to being trained amongst experienced members. • Cynthia stated that it will be a pleasure to continue to serve the IHIPC through the Secretary role as well as continuing to be the liaison between the IHIPC and CAHISC. • Scott thanked the group for the nomination of Parliamentarian. He states that he is experienced in the procedures of the role and will do all that he can to serve the position well.*

*Nominees were published on the presentation projector for all to see. Election ballots were handed out to voting members, filled out, and then collected. Members participating via webinar were also able to vote. Lyyti (member of the current Integrated Steering Committee) was appointed as ballot counter. The results of the voting were unanimous in approving these members for the following positions:*

*Mike Benner- Community Co-Chair; Nicole Holmes- Community Co-Chair Elect;  
Scott Fletcher- Parliamentarian; and Cynthia Tucker- Secretary.*

*Janet will be coordinating with the elected individuals in the coming days to further acclimate them to their roles and to schedule a meeting of the new IHIPC Steering Committee.*

## 10:00 am: Present, Discuss, Vet, and Vote on Updates to Recommended Priority Populations for Targeted Prevention Services for 2019

Janet Nuss, IDPH HIV Community Planning Administrator

*Janet presented on behalf of the Epi/ Needs Assessment Committee, explaining the purpose of prioritization for prevention services. The process is not only a requirement of Prevention's federal funders, but it is also important to ensure that risk-target services are reaching populations that bear the greatest burden of HIV and are disproportionately affected by it. The priority population groups are categorized by transmission risk and race.*

*Janet explained the process by which the prioritization analysis occurred. The Epi/ Needs Assessment Committee weighted incidence and late diagnosis data (2012-2016-excluding Chicago) with prevalence data (As of December 2016 at current residence-excluding Chicago) in order to determine prioritization. In 2017, the former ILHPG Epi/ Needs Assessment Committee considered several weighted calculations of incidence, prevalence, and late diagnosis (90/5/5, 60/35/5, and 66.7/33.3/0, respectively). Ultimately, the 2017 Committee decided that the weight of 90% incidence, 5% prevalence, and 5% late diagnosis would be best for this prevention activity. After discussion, the current 2018 IHIPC Committee also agreed to use this weighting again in for 2019 recommendations. The Committee plans to consider new weights and data sets for 2020 recommendations.*

*After this preface, the 2019 recommendations were reviewed, comparing them to the 2018 recommendations. By risk, MSM prioritization slightly increased (70.8 percent), and HRH and PWID slightly declined (22.0 and 3.9 respectfully). MSM/WID prioritization stayed consistent at 3.3 percent. Prioritizations were also reviewed by race and risk (see slides for variation between 2018 and 2019). The most significant increases in prioritization in relation to risk and race appeared among MSM of color. For almost every risk group (excluding MSM/WID), NH Black populations were prioritized the highest, followed by NH white, Hispanic, and "other" populations. Social determinates*

*of health considerations/ recommendations for each prioritized population were included in the narrative portion of the prioritization document. Other points of consideration were made regarding late testing, geographic barriers, youth/ age, prevention for HIV+ individuals, income, unemployment, etc. Please see the document for specific information.*

*Questions & Answers, Discussion, Input, and Vote - (15 minutes)*

*Q: Rocio asked: How does the transgender community fit into priority populations?*

*A: Janet responded that there is still very limited data in the transgender community. For the sake of prioritization, transgender individuals are categorized based on their behavioral risk, most of which identify as HRH. Janet asked Curt to explain in more detail.*

*A: Curt stated that transgender and cis-gender people are categorized in risk groups in the same way, by their risk behaviors. In order to ensure that transgender individuals are being tested, performance guidelines/ standards are written into grants so that at least 1% of testing is performed with transgender people. There are different testing positivity rates among transgender v. cis-gender individuals, but gender is not always reported correctly by providers. The most currently evaluated Illinois data shows that of people who tested and identified as transgender, African American transwomen had a 4.9% sero-positivity rate, Latina transwomen had 1.9% sero-positivity rate, and white transwomen as well as transmen of all races had a 0% sero-positivity rates. These sample sizes, however were very small. In Illinois, it is estimated that approximately 1% of all new infections are attributed to transgender individuals.*

*Q: Steven asked Curt to clarify how data for transgender individuals might be captured? For example, how would a transgender female having anal sex with HIV- partner be categorized in Provide™?*

*A: Curt responded that according to the 2019 Risk Group Definitions (which were later presented in the meeting), this person would be prioritized as an HRH.*

*C: Cynthia recommended that the group look at national research on the impact of HIV on the transgender community and continue to be inclusive of them in service categories.*

*A: Curt responded that providers are and will continue to be inclusive of the population through performance standards.*

*C: Chad stated that he feels that transwomen are unique and should possibly not be “lumped” into MSM or HRH groups. This is something that should be considered, possibly with more national data as Cynthia suggested.*

*A: Mike responded by saying that when doing a prevention assessment, most transgender individuals identify as heterosexual. This is the reason that they are included in this way.*

*A: Curt agreed with Mike and also mentioned that feedback from transgender individuals on this group indicated that transgender people want to be considered as heterosexual just as their cis-gender counterparts are. It is similar to the difference between gay and bisexual men: there are understood differences that are respected, but both groups are categorized as MSM. It should be considered that terms for planning group purposes v. direct work with a client may mean different thing. At this time, the current system for capturing transgender individuals in prioritization groups is working and is respectful to transwomen. Additionally, if two more gender categories were added to this prioritization, the analysis would go from 16 risk & race groups to 64 groups. This would not be efficient for its purpose.*

*C: Rocio thanked everyone for their comments and recognition of this special population.*

*C: Curt clarified that transwomen are prioritized as HRH if they have ever had vaginal or anal sex with any (cis or transgender) male (HIV- or HIV+).*

*C: Jeffery stated that he thinks that sometimes providers miss that transgender individuals are prioritized through performance goals (1% of testing), which are often exceeded by prevention providers. Lead agents and grant monitors should always accompany the Prioritization document with the Risk Group Definition document to ensure their provider agencies understand how this population is prioritized and can be served. In general, it is a good idea to keep this Prioritization document handy for providers to reiterate why we are targeting these specific groups. For example, the document states young MSM need to be prioritized, and that it reflected in project scopes. The document shows that we are trying to target populations based on data/ disproportionate HIV rates in Illinois. Last year, Curt did a presentation where we saw that progress was being made in serving risk-targeted populations in need which was very interesting and showed how far we have truly come. Again, please keep these documents handy and share at your RIG meetings.*

*C: Jenny commented on the importance of including the narrative portion with the prioritization chart as a way to identify social determinants of health and how they affect individuals. For example, the correlations between housing and unemployment data are very important to consider. The planning body and agencies should continue to look at this and see if connections to resources can be made in communities.*

## **Vote:**

*At 10:35 am, Janet entertained the following motion: To accept the 2019 Prioritized Populations for Targeted Prevention Services as recommended and presented on behalf of the Epi/ Needs Assessment Committee. The motion was made by Scott and seconded by Steven. There was no discussion about the motion at this time. A roll call vote was taken: the motion carried with 29 in favor, 2 opposed, and 3 members absent from the vote. None abstained.*

10:40 am: Present, Discuss, Vet, and Vote on Recommended Changes to the Prioritized Risk Group definitions for 2019

Nicole Holmes and Mike Maginn, IHIPC Epi/Needs Assessment Committee Co-chairs

*Nicole Homes and Mike Maginn presented on the Prioritized Risk Group Definitions for 2019. Mike began by stating that defining the prioritized populations is important as it allows for narrow targeting of services to people most at-risk for HIV, which is in line with National HIV/AIDS Strategy (NHAS) and High Impact Prevention (HIP) goals. Mike stated that a 2013 analysis of 19,000 Illinois tests categorized by participant answers to questions in prevention risk assessments allowed the Department to see which behavioral factors correlate to significant risk for HIV. This data has since been used to shape the Risk Group Definitions. Mike explained that revisions or additions can be made to the Risk Group Definitions annually through a vetting process, which allows any person who wishes to recommend revisions to the definitions to submit a proposal with supporting data to the Epi/Needs Assessment for review. This opportunity for the 2019 Risk Group definitions closed on March 31<sup>st</sup>, 2018 with no recommendations. A similar process will be in place next year for the 2020 definition.*

*Nicole presented the proposed Prioritized Risk Group Definitions by transmission risk factor, which included HIV+ and HIV- MSM, HRH, PWID, and MSM/WTD. HIV+ people can also be categorized as “other risk” if they do not fall into the prioritized populations because they do not identify a behavioral risk. They therefore are recommended for biomedical interventions only. Definitions for targeting HIV+ individuals for Surveillance- Based Services were also reviewed. Please see presentation for detailed definitions of prioritized populations.*

## Questions & Answers, Discussion, Input, and Vote

*Q: Jill stated: I see the inclusiveness in the definitions, but should we prioritize people of color in a specifically different way in this document in order to get to 0?*

*A: Curt responded by stating that people of color may not be specifically included in the definitions, but they are accounted for in the Prioritized Populations document as well as in service scopes. Risk definitions are based only on identified risk behaviors- not on race or social determinants. These definitions and the Prioritized Populations document work hand in hand to guide work/ scopes and have been successful.*

*Q: Mildred asked: Can there be a preamble or paragraph that explains this (Curt's comment above)? This will help any viewer not related to this group see how these documents are related.*

*A: Curt responded by saying that there are some prefaces and narrative in each document explaining this, but they can most likely be added to.*

*A: Janet also noted that a preface was added to the Risk Group definitions to help with this, but it can always be enhanced.*

*C: Jeffery also agreed that both documents should be used together to show how risk is related to targeting by race. For example, Black MSM account for 30 percent of the Prioritized Population calculation.*

*C: Mildred stated that in terms of framing the preface, one relatively new factor in HIV is that the epidemic is decreasing overall, but is disproportionately increasing in populations like people of color and transgender individuals. She encourages that the preface include verbiage that emphasizes the urgency in health disparities around these communities.*

*A: Janet stated that preface language should be taken back to the Epi/ Need Assessment Committee for further discussion. .*

*Q: Candi asked if the group should consider adding language to the Priority Populations document that clarifies how transwomen are included in the calculation of HRH targeting/ scopes.*

*C: Steven said: To me, I do not believe that it would be difficult to pull transwomen out of the female/ HRH risk group as gender is reported in Provide™.*

*A: M. Maginn stated that pulling this data is possible in Provide™ and is done in the regions for reporting.*

A: Curt stated that there is a presentation that took place at a previous meeting last year that reviewed HIV data for transwomen v female women. This presentation could be made available.

A: Janet stated that there should be an update on data for transgender individuals presented at the upcoming meeting in October.

**Vote:**

At 11:11, Janet entertained the following motion: to accept the recommended 2019 Risk Group Definitions as presented by the Epi/ Needs Assessment Committee. Mike made the motion, and Nicole seconded it. Discussion regarding this vote was as follows:

C: Cynthia recommended that an amendment be made to the Risk Group Definitions to include special language regarding transgender populations and MSM of color as a special point of consideration.

C: Mildred agreed with this.

A: Janet and others asked Cynthia and Mildred to recommend an amendment with specific language so that that all members understand what is being proposed to be added.

C: Steven recommended that a breakdown of the HRH category to include distinction between cisgender women and transwomen be included in the Priority Populations document.

A: Janet reminded the group that the vote is regarding the recommended Risk Group Definitions only. The Priority Populations document has already been voted on and approved.

A: Curt stated that doing this may be a disservice to transwomen in regards to resource allocation. At this time, transgender women are getting higher proportions of testing by being included in the HRH category. Comparative to other populations, HIV incidence of transgender individuals is very low. If the Priority Populations are broken down to reflect this, it would result in significantly less scopes for service for transgender individuals.

A: Steven thanked Curt for this explanation and no longer wanted to include his recommendation in the amendment.

C: Mildred stated that she understands how the scopes are inclusive, but there is a need for language in the document that allows for a better understanding of the need for services among disproportionately affected populations.

A: Curt noted that language about transgender individuals as a special point of consideration is included in the Risk Group Definitions documents (bottom of page 2 of the document). If it needs to be worded differently or placed in the preface, it certainly can be.

A: Cynthia stated that the amendment should denote that there is a special urgency in these groups because of inequities, especially for the transgender population as there is too little data to support them as a stand-alone prioritized group. The recommendation is to add narrative that deliberately shows this, but does not change scopes.

Following discussion, the following amendment was presented to the group on the projector: To amend the 2019 Risk Group definitions by adding language emphasizing that special consideration should be given to the transgender and Black and Latino MSM populations reflective of the urgency of the disproportionate impact and inequities of HIV in those population groups. The motion for acceptance of the amendment was made by Jill at 11:37am and seconded by Lisa. A roll call vote was taken: 27 members voted in favor, 4 members opposed, and 3 members were absent. No members abstained from voting.

After the amendment passed, a new motion was made and was as follows: To accept the 2019 Risk Group definitions for the Prioritized Populations as recommended and presented by the Epi/ Needs Assessment Committee and amended by this group. The motion for acceptance of this amendment was made by Steven at 11:41am and seconded by M. Maginn. A roll call vote was taken: 27 members voted in favor, 2 members opposed, 2 members abstained from voting, and 3 members were absent.

11:45 am – 12:30 pm: Lunch Break

12:30 pm: Present, Discuss, Vet, and Vote on Current and Proposed Changes to HIV Prevention Interventions and Services Guidance for 2019

Jeffery Erdman and Sara Zamor, IHIPC LTC, RRC, ART, and VS Committee Co-chairs

Jill Dispenza and Candi Crause, IHIPC Primary Prevention Committee Co-chairs

Jeffery Erdman present information on the current and proposed changes to the HIV Prevention Interventions and Services Guidance for 2019. He stated that this document derives from the ILHPG Interventions and Services Committee and is a manual for best practice of prevention interventions and is in line with CDC's HIP, which emphasizes cost-effectiveness, practicality, the potential for large outreach, the potential for combination of strategies, and effectiveness of preventing HIV in prevention activities.

The main sections of the document includes interventions by service categories (strategies, recruitment, behavioral interventions, and biomedical risk reduction), interventions by risk group, grantee requirements, and performance standards. The following were approved interventions for 2018:

- Recruitment: Social networking/ social media recruitment/ outreach services at gather sites/ incentives for testing (recruitment services reach populations but do not prevent HIV alone: they should be combined with other interventions to be effective).
- Strategies: Harm reduction, Comprehensive Risk Counseling Services (CRCS), Risk-based testing and referral, specific vaccinations (see presentation), Partner Services, SBS, Targeted screening for Hepatitis C and STIs. Some strategies are inclusive/ exclusive of specific populations (please see presentation).
- Behavioral Interventions: Please see presentation for an extensive list of approved behavioral interventions. It is important to note that the committee is only recommending CDC –supported behavioral interventions, which are proven to be both cost-effective and evidence based.
- Biomedical Risk Reduction: Linkage-Retention-Reengagement in Care (LRC) Interventions: Stay Connected, ARTAS; Medication Adherence: HEART, SMART couples, Partnership for Health; Risk Reduction for Negatives: PrEP and NPEP.

Jeffery mentioned that there will be an upcoming additional training for members that takes an in-depth look at each intervention listed above. That training will be recorded soon, and members will be notified by Janet when it is available.

After this information was reviewed, Jeffery presented the recommended changes to this information for the 2019 Guidance:

- Remove CRCS as Strategy as it no longer supported by CDC: The Head of CDC behavioral interventions, Dr. Collins, stated to the Committees that CRCS will no longer be trained on or supported at this time.
- Add HIV Navigation Services for positive and negative clients: This strategy, which is designed to connect clients to both Prevention and Care services, can be used in place of CRCS for PrEP. The Committees are working with CDC and the Denver training center to bring HIV Navigation Services to IL. An online pre-course is now available through CDC. Language added to the Guidance will ensure that HIV Navigation Service roles and responsibility for both prevention and care providers will be carefully and clearly documented.
- Add PrEP guidance to service requirements and performance standards: As more PrEP sites and providers are upcoming and being identified, the committee has recommended the IDPH add this information to the Guidance for grantees.

#### Questions:

*Q: Joan asked: Now that there won't be CRCS to compliment HIV testing, is an HIV Navigation Service scope appropriate if PrEP is discussed with client?*

*A: Jeffery responded that as long as there are work scopes for HIV Navigation in the work plan and PrEP is discussed, that should be acceptable.*

*Q: Scott asked: For HIV Navigation services, do you always need a lab result to initiate the intervention so that you know if you should go down the PrEP or ART route? Asking for test results sometimes makes a client uncomfortable.*

*A: Jeffery stated that a test result is not needed in order to complete the HIV Navigation Services. The procedure is similar to that of adherence counseling- a lab result is technically not needed if the intervention is being performed based on a referral.*

*Q: Joan asked: In regards to SBS, if contact is made with a positive person, which results in contact with a negative partner, which when then results in a PrEP referral, is this a scope for SBS services or HIV Navigation?*

*A: Jeffery stated that this PrEP referral would most likely fall under an HIV Navigation scope apart from SBS services.*

*Q- Joan asked: When will the PrEP guidance be available?*

*A: Jeffery stated that the recommendation is for IDPH to complete the guidance. The LTC, RRC, ART, VS and Primary Prevention Committees will be helping with this. IDPH will propose a draft, and the Committee will review and make recommended modifications, as needed.*

*Q: Lisa stated that it seems that HIV Navigation Services can take place on both the Prevention and Care sides. How should Care case managers document and record this, especially if used with HIV- partners?*

*A: Jeffrey stated that more guidance and clarification is needed on the difference between Care and Prevention implementing this intervention. Once guidance for this intervention is compiled and shared, it should help address some of those recording issues. In the big picture, it is a possibility that there may someday be a need for Prevention funding to be funneled to Care for negative partners. This might also call for more cross training of providers. The integrated process and guidance is yet to be discussed and determined by the Committees.*

*C: With no further questions or discussion proffered, Janet thanked both committees for their work.*

**Vote:**

*At 1:10, Janet entertained the following motion: To accept the changes to the HIV Prevention and Interventions Services Guidance for 2019 as recommended by the IHIPC LTC, RRC, ART, VS and Primary Prevention Committees. Tina made the motion, and Joe seconded it. The motion carried unanimously by consensus vote: 31 members voted yes, none opposed, none abstained, and 3 members were absent.*

1:10-1:15 pm: Public Comment Period/Parking Lot

*The Co-chair reminded members of the rules for Public Comment. The IHIPC is under no obligation to discuss the issue during this meeting unless the Chair calls for discussion. It may be something that needs to be taken back and referred to a committee or to an HIV Section Program.*

*Karen Lewis said she has seen issues with linking clients to prevention and care services, especially in rural areas. She states that she works with clients from all over state and has difficulties identifying resources and providers. She proposed that a Resource List of Prevention and Care resources and providers be compiled and kept updated.*

*C: Janet said that the HIV/STD Hotline/website and the HIV Care Connect website maintain updated information and lists of HIV prevention and care services in Illinois.*

*C: Karen stated that she has been trying to use a list on an IDPH website and it is outdated. This should be looked into.*

*C: Janet said that she will follow up with Curt and Jeff about this issue. Until then, please refer to HIV Care Connect and the HIV/STD Hotline websites for information.*

**Follow-up Response:**

Thanks for the issue brought to light and discussion during the Public Comment Period about the testing site information on the IDPH website needing to be update. That information was passed onto Curt Hicks and Jeffrey Maras. Here is a synopsis of their responses:

“Thanks, Janet, I’ll touch base with Carolyn about getting the HIV Testing Agencies’ info updated. There’s no point in posting a list of Test Counselors. People who need a test should call a testing agency, not an individual counselor (who might be on vacation, change jobs, retired, etc.) when the client called. We have so many test counselors coming and going on a monthly basis we couldn’t possibly keep such a list up to date. We will update the Testing Agency list though.

Under the Regional Grant, each grantee is responsible for maintaining their own effective up-to-date referral list that works for their immediate geographic area. Some Lead Agents help out by providing a more general list that covers the region as a whole. But it’s really the local lists of resources nearest to the subgrantee’s service site that the provider needs to keep updated.

The Hotline number (1-800-AID-AIDS) and website <http://www.centeronhalsted.org/hot/admin/survey.cfm> are generally the best single statewide information source for Prevention referrals. Hotline staff can individually assess with a client such factors as client’s location, client’s

access to transportation, client's risk, race, ethnicity and gender and the goodness of fit to programs they can access. Even if we published "The Book of Scopes" for all grants and subgrants online, most clients wouldn't understand it anyway. A client wanting clean syringes would learn nothing at all looking at a list of lead agencies, grantees and subgrantees. They very likely wouldn't even know what "harm reduction" was and would skim right past that. That's why the Hotline is the best single source for helping a client find a program that is both accessible and best suited to meet their indeed needs. A grantee or subgrantee like Karen can talk directly to their Prevention and Care Regional Lead Agency or Grant Monitor for help in updating their own local referral lists for finding effective contacts to ensure linkages to care."

In regard to your question about needing more information on HIV Care referral agencies on the IDPH website, Jeffrey Maras noted that "People who access the IDPH website looking for information about care resources are linked to the HIV Care Connect website for those connections. The RW program uses the HIV Care Connect website to maintain its list of lead agents for each region in the state. The lead agents are the first line of contact to connect clients to care. Their contact information is maintained on the HIV Care Connect website.

<https://hivcareconnect.com/refer/> Names of the subgrantee providers other than the lead agents aren't currently listed on the website. Those referrals are made directly through the lead agents and case managers.

1:15-1:20 pm: Recap of Today's Presentations; How Information Presented Impacts the IHIPC; Next HIV Planning Steps; Facilitated Discussion

*Janet took the opportunity to recognize and thank the current Integrated Planning Steering Committee for their service over the last year and a half before the new leadership takes over. She then continued by reviewing committee tasks from the meeting: the Membership Committee will discuss affiliation of membership, the Epi/ Need Assessment committee will work on the preface and emphasis of disparities for the Risk Group definition document, and the LTC, RRC, ART, VS and Primary Prevention Committees will continue to work on updating the Guidance for 2019.*

*Next Janet asked if anyone had any questions or concerns. She encouraged members to think about how the meeting has aligned with NHLAS. The following comments/questions were proposed:*

*Q: Rocio asked if there is consideration for including a case manager that only works with Spanish-Speaking clients to the group.*

*A: Janet said that they are free to apply for membership but there was no special stipulation for such a member in the Bylaws. .*

*C: Deborah proposed that an ad-hoc housing advisory group be created. Integration of Prevention and Care is important for housing as well.*

*C: Jill stated that it is great to meet in-person and that it makes a big difference in the work of the group. If there ever is a choice to have in-person meetings only, please do this. Some good discussion and decisions were made at this meeting that may not have been possible on a webinar.*

*C: Steven agreed and stated that seeing everyone's body language helps in the meeting process. He also would like us to have as many in-person meetings as possible.*

1:22 pm: Adjourn- *The meeting was formally adjourned.*