

Pink highlighted activities: HIV Integrated Planning Program

Orange highlighted activities: HIV Prevention Program (including Testing Program)

Aqua highlighted activities: HIV Training Program

Purple highlighted activities: HIV Care Program (including HIV Corrections, HIV Housing, and Minority AIDS Initiative Programs)

Green highlighted activities: Perinatal HIV Prevention Program

Blue highlighted activities: HIV Surveillance Program

ILLINOIS INTEGRATED PLAN UPDATES

GOAL 1: Reduce new HIV infections.

Objective 1.1 By 2021, lower the annual number of new infections in Illinois by 10 percent, from approximately 1,800 to 1,620.

Strategy 1.1.1 Intensify HIV prevention and care efforts in the hardest hit areas and for special populations and populations disproportionately impacted.

Activity Number	Responsible Parties	Activity Description	Metric	September 2016 - August 2017 Update	July 2017-June 2018 Update	July 2018-June 2019 Update
1.1.1.1	Integrated Planning Group Epi/Needs Assessment Committee; IDPH HIV Surveillance Program, IDPH STD Program	Provide updated IL HIV epidemiologic profile annually and STD profile, as needed, to the Integrated Planning Group, facilitate discussion, and receive input and recommendations on: (1) hardest hit and prioritized areas and populations, and (2) HIV-related health disparities/inequities in new HIV diagnoses in Illinois.	<ul style="list-style-type: none"> HIV incidence, prevalence, late diagnosis data, and identified health disparities cross tabulated by region, race/ethnicity, risk, age, and gender STD co-infection rates among diagnosed PLWH, cross tabulated by race/ethnicity, risk, age, and gender 	<ul style="list-style-type: none"> Updated Illinois HIV and STD epi profile data were analyzed and presented to the Integrated Planning Group for discussion and input at the February and Aug 2017 meetings, identifying areas and populations with disparities and hardest hit by the epidemic. April 2017 IDPH HIV Surveillance data analysis showed there were 1,433 new HIV diagnoses in Illinois in 2016, which was a decrease of 8.8% from 2015. 	<ul style="list-style-type: none"> Updated Illinois HIV and STD epi profile data were analyzed and presented to the Integrated Planning Group for discussion and input at the February 2018 meeting, identifying areas and populations with disparities and hardest hit by the epidemic. IDPH HIV Surveillance data as of December 2017 showed: There were 1,433 new HIV diagnoses in Illinois in 2016 (8.8% decrease from 2015). Rates of new infections among Blacks (women and men) were higher than other racial/ethnic groups. 	<ul style="list-style-type: none"> Updated Illinois HIV and STD epi profile data were analyzed and presented to the Integrated Planning Group for discussion and input at its Feb 2019 meeting, identifying areas and populations with disparities and hardest hit by the epidemic. IDPH HIV Surveillance data as of December 2018 continues to show that rates of new infections among Blacks (women and men) were higher than other racial/ethnic groups.
1.1.1.2	HIV Integrated Planning and Prevention Programs; IHIPC Epi/Needs Assessment Committee	Upon review of risk disclosure and seroconversion of recent HIV testing data and other analyses, propose recommended changes to the risk group definitions for the prioritized populations that maintain or improve the seropositivity rates of clients newly-diagnosed through risk-based testing.	<ul style="list-style-type: none"> Analysis of recent testing data reviewed Annually reviewed/updated prioritized risk group definitions 	<ul style="list-style-type: none"> ILHPC Epi Committee reviewed analysis of HIV testing data and solicited/reviewed recommendations for changes to the risk group definitions for the prioritized populations for 2018 HIV prevention services. These were presented to the ILHPC for discussion at May 2017 meeting and approved. 	<ul style="list-style-type: none"> The IHIPC Epi/NA Committee solicited suggestions on recommended changes to the risk group definitions for prioritized populations for 2019 HIV prevention services. Receiving none, the committee recommended there be no changes to the risk group definitions, which was approved by the IHIPC at its June 2018 meeting. The IHIPC Epi/NA Committee plans to review analyses of more recent HIV testing data in December 2018 for use in the 2019 risk group vetting process. 	<ul style="list-style-type: none"> The IHIPC Epi/NA Committee solicited suggestions for further analyses of factors to consider for inclusion in the risk group definitions for prioritized populations for 2020 targeted HIV prevention services. The Committee reviewed analyses of more recent HIV testing data for possible use in the risk group definition vetting process. Receiving no recommendations from these actions, the committee recommended no changes to the risk group definitions, which was approved by the IHIPC at its June 2018 meeting.

1.1.1.3	HIV Integrated Planning Program; IDPH HIV Section Chief; HIV Section Programs; GTZ Steering Committee/ Implementation Council; Community stakeholders	Develop, launch, and monitor implementation of the “Getting to Zero Illinois Plan”, engaging/soliciting input from City/State HIV leadership/planning bodies/stakeholders, and community.	Completed: <ul style="list-style-type: none"> • Town halls conducted • Focus groups completed • Surveys completed • Needs assessment analyses • GTZ Plan developed GTZ Plan Indicators: <ul style="list-style-type: none"> • GTZ Committee meetings held • GTZ Implementation Council meetings held • PrEP utilization numbers/rates • Viral Suppression for PLWH • PrEP4Illinois enrollment 	<ul style="list-style-type: none"> • Monthly Steering Committee Meetings held and GTZ Framework have been developed. • The GTZ workgroup engaged the HIV community, including the Integrated HPG at its August 2017 meeting, in presentation and solicitation of input on the framework. 	<ul style="list-style-type: none"> • Nov. 13 – launch of online survey, both English and Spanish • December 2017: Two GTZ town hall meetings conducted in Chicago • January – February 2018: Series of eight GTZ town hall meetings conducted in downstate Illinois. • Please see the Year 1 PrEP data included in the HIV Section Training Unit Update. 	<ul style="list-style-type: none"> • Summer 2018 - Five committees were formed to review the results of all the needs assessment activities conducted. • December 2018 -The draft GTZ-IL Plan was released for input • May 2019 -The final GTZ-IL Plan was released • June 2019 - The IHIPC voted its support of the GTZ IL Plan • IHIPC Community Co-chair was selected to represent the IHIPC on the GTZ-IL Implementation Steering Council.
1.1.1.4	HIV Training Program; MATEC IDPH Prevention Unit	Increase capacity for delivering PrEP and nPEP in each region through funding of local health department PrEP demonstration grants. <ul style="list-style-type: none"> • Each LHD site funded through PrEP Project will increase the number of licensed prescribers by at least 3%. • All clients seeking STD services in funded PrEP Demonstration Project sites will be educated/offered PrEP. 	By region: <ul style="list-style-type: none"> • Number of prevention counselors and case managers trained in nPEP/PrEP decision counseling • Number of licensed prescribers trained in nPEP/PrEP decision counseling • Number of licensed prescribers actively accepting PrEP referrals • Number of sites actively providing PrEP/ nPEP 	<ul style="list-style-type: none"> • 19 STD LHD sites given \$20,000 for SFY17 as partners of a PrEP Demonstration Project funded through the Local Health Protection grant. 	<ul style="list-style-type: none"> • 16 STD LHS sites given between \$20,000 and \$35,000 for SFY18 for Year 2 of the IDPH PrEP Demonstration Project. Five sites have started internal PrEP clinics at their locations. Sites are continuing to work with providers in their communities to build a PrEP network of providers. • PrEP Project Data Collection: <ul style="list-style-type: none"> • 5991 clients rcvd PrEP ed. • 428 PrEP referrals given • 270 new clients enrolled • ~25 providers educated • 98 LHD staff trained • 17 sites with printed advertising • 7 sites produced 18 billboards 	16 STD LHD Sites given between \$20,000 and \$35,000 for SFY19 Year 3 of the PrEP Project. All sites excelled in building provider linkages and partnerships and are continuing to build their network of PrEP providers. All sites have clinicians prescribing PrEP at their facility as well as provide referrals. Two sites started new, internal PrEP clinics at their locations. PrEP Project Data Collection: <ul style="list-style-type: none"> • >7000 clients receiving PrEP education through LHD STD/PrEP clinics • 624 PrEP referrals given (Includes pt. referrals given where PrEP enrollment was not stated as ‘Yes’ or ‘No’) • 330 new clients enrolled • ~50 providers educated • 150 LHD staff trained • 12 sites with printed advertising • 8 sites utilizing billboards, 3 others utilizing bus wraps and ads.
1.1.1.5	HIV Training Program; MATEC	Develop/conduct PrEP and nPEP educational webinars and trainings for grantees and program partners at least twice a year.	<ul style="list-style-type: none"> • Course completion records 	<ul style="list-style-type: none"> • MATEC is currently developing PrEP 101 and PrEP 102 online courses as part of their agreement with IDPH. 	<ul style="list-style-type: none"> • MATEC is currently developing PrEP 101 and PrEP 102 online courses as part of their agreement with IDPH. 	MATEC conducted two trainings PrEP 101 and 102 to clients as part of their agreement with IDPH.
1.1.1.6	HIV Training Program; MATEC	Conduct PrEP prescriber/provider training/updates to health care providers twice a year.	<ul style="list-style-type: none"> • Course completion records 	<ul style="list-style-type: none"> • In partnership with MATEC and the Denver Prevention Training Center, two PrEP Implementation Summits were held in Illinois in June 2017 for local health departments and community-based organizations. • MATEC is planning to provide two prescriber trainings per their agreement. 	<ul style="list-style-type: none"> • MATEC has provided two prescriber trainings as per their agreement. 	MATEC conducted four trainings to Ryan White case managers and providers in four areas of the state as part of their agreement.

1.1.1.7	<p>Prevention RRA Program, regional grant monitors, grantees</p> <p>Evaluation: RRA Coordinator</p>	<p>Deliver at least 1.0% of regional prevention grant services to transgender persons, especially Black and Latino/a transgender individuals.</p>	<ul style="list-style-type: none"> Percentage of person-sessions of risk targeted prevention services delivered to transgender persons Query RIG Risk-based Testing & RRA Sessions: (# Sessions to MTF+ FTM) / (Total # Sessions) 	<ul style="list-style-type: none"> 2.5 % of person-sessions of Risk Targeted Prevention services were delivered to transgender individuals in this period compared to 4.4% in the preceding year. $(94+230)/(7,123+5,628) = 2.5 \%$ 	<ul style="list-style-type: none"> 1.7 % of person-sessions of Regional Grant Risk Targeted Prevention services were delivered to transgender persons in this period compared to 2.5% in the previous year. $(159+80)/(8,876+5,356) = 1.7 \%$ 	<ul style="list-style-type: none"> 2.17 % of person-sessions of Regional Grant Risk Targeted Prevention services were delivered to transgender persons in this period compared to 1.7% in the previous year. $(187+65)/(7,588+4,007) = 2.17 \%$
1.1.1.8	<p>Prevention RRA Program, regional grant monitors, grantees</p> <p>Evaluation: RRA Coordinator</p>	<p>Ensure that HIV Prevention services in each region are prioritizing young MSM.</p>	<ul style="list-style-type: none"> Number of programs serving Young MSM funded per region List of Provider Agencies for AAARA, Direct, QoL & RIG with scopes for MSM or MSM/IDU including Young MSM and Young MSM/IDU. 	<ul style="list-style-type: none"> R1 – Lee CHD: HIV/STI Testing; Open Door HC: O/R HIV/STI Testing & PCC; TPQC: O/R HIV/ STI Testing, CLEAR, PCC & Pfh; Winnebago CHD: HIV/STI Testing, CRCS & PCC R2- McLean CHD - gay bar and college campus outreach HIV/STI testing with PCC; Central Illinois Friends does gay bar outreach HIV/ STI testing, VOICES/VOCES; FCAN: CLEAR & CRCS R3 – Phoenix – O/R HIV/STI Testing, HEART & CRCS; Adams: HIV Testing & Pfh; Fifth Street Renaissance: O/R HIV Testing & CRCS; Logan CDPH: HIV Testing; Macon CDPH: HIV Testing; Phoenix Center: O/R HIV/STI Testing, Heart, CRCS R4 – WPT - HIV testing, Mpowerment & CRCS for YBMSM; Bethany Place - HIV testing & PCC; ESHD- HIV/STI testing with PCC, CRCS; Madison County HD conducts HIV/STI testing & CRCS; CYHS conducts HIV testing; SIHF (HIV/STI testing, gay bar outreach R5- Jackson CHD: O/R HIV/STI testing to Rainbow Café, jail, gay bar & park, Pfh & CRCS; Jefferson CHD: HIV Testing; Pfh; Community Action Place: O/R HIV Testing; CRCS R6 – CUPHD-PrEP-promotion and Mpowerment R7 – FCAN - CLEAR, CRCS for HIV+ YMSM; Renz - Bar outreach HIV/STI testing; Lake County HD- HIV/STI testing, CRCS; Open Door (HIV/STI testing, VOICES/VOCES); Will County HD - HIV/STI testing, PCC, CRCS); DuPage HD (HIV/STI testing, CRCS); Regional Care (HIV testing, gay bar outreach). R8 –AMYS conducts YMSM groups, FCAN serves HIV+ YMSM; Renz conducts bar outreach; HBHC conducts bar outreach; PRCC conducts bar outreach 	<ul style="list-style-type: none"> R1: CRA, Lee County HD, open Door Clinic, The project of the quad cities, Winnebago county HD, R2: Central Illinois Friends of PWA, JOLT, McLean County HD, Sisters and Brothers Helping Each Other. R3: Adams County HD, Fifth Street Renaissance, Logan County Department of Public Health, Macon County HD, Phoenix Center, Sangamon County HD R4: Bethany Place, Coordinated Youth and Human Services, East Side HD, Macoupin County HD, Madison County HD, Southern Illinois Healthcare Foundation, St. Clair County HD, Writers, Planners, Trainers, R5: Jackson County HD, Jefferson County HD, Perry County HD, The Community Action Place. R6: Champaign-Urbana Public Health District, Coles County HD, Sisters and Brothers Helping Each Other R7: Chicago Recovery Alliance, DuPage County HD, Children’s Home and Aid, Lake County HD, Open Door Clinic, Regional Care Association, Renz Addition Treatment Center, Sisters and Brothers Helping Each Other, Will County HD R8: Aunt Martha’s Health and Wellness, Chicago Recovery Alliance, Corazon Community Services, Howard Brown Health Center, Making A Daily Effort, Proactive Community Services, Project Vida, Puerto Rican Cultural Center, Renz Addition Treatment Center, Sisters and Brothers Helping Each Other, South Suburban HIV/AIDS Regional Clinics. R9: Center on Halsted, Men & Women in Prison Ministries, FOLA Community Services, Brothers Health Collective, Asian Human Services, Puerto Rican Cultural Center, South Side Help Center, UIC COIP 	<ul style="list-style-type: none"> R1: CRA, Lee County HD, Open Door Clinic, Project of the Quad Cities, Winnebago CHD R2: Central Illinois Friends, JOLT, McLean CHD, Sisters and Brothers Helping Each Other. R3: Adams CHD, Fifth Street Renaissance, Logan County Department of Public Health, Macon CHD, Phoenix Center, Sangamon CHD R4: Bethany Place, East Side HD, St. Clair CHD, Macoupin CHD, Coordinated Youth & Human Services, Madison CHD, Writers, Planners, Trainers, Southern IL Healthcare Foundation R5: Jackson CHD, Jefferson CHD, Perry CHD, The Community Action Place. R6: CUPHD, Coles CHD, Sisters and Brothers Helping Each Other R7: Chicago Recovery Alliance, DuPage CHD, Children’s Home and Aid, Lake CHD, Open Door Clinic, Regional Care Association, Renz Addition Treatment Center, Sisters and Brothers Helping Each Other, Will CHD R8: Aunt Martha’s Health and Wellness, Chicago Recovery Alliance, Corazon Community Services, Howard Brown Health Center, Making A Daily Effort, Proactive Community Services, Project Vida, Puerto Rican Cultural Center, Renz Addition Treatment Center, Sisters and Brothers Helping Each Other, South Suburban HIV/AIDS Regional Clinics. R9: Center on Halsted, Men & Women in Prison Ministries, FOLA Community Services, Brothers Health Collective, Asian Human Services, Puerto Rican Cultural Center, South Side Help Center, UIC COIP

1.1.1.9	HIV Prevention Testing Program Evaluation: Data Team	Intensify the delivery of HIV testing and linkage/referral to medical care, to young MSM.	Provider Type = AAARA, Direct, QOL, RIG <ul style="list-style-type: none"> Number of HIV tests performed with young MSM, aged 12-24 New HIV positivity rate Number New Dxd YMSM engaged in medical care Number Prior Dxd YMSM engaged in medical care 	<ul style="list-style-type: none"> 634 tests performed for Young MSM 7/634 = 1.1041% positive Young MSM 7 positive Young MSM linked to medical care 	<ul style="list-style-type: none"> 2,925 testing events performed for Young MSM 17 / 2,925 = 0.58% newly diagnosed positive rate for Young MSM 14 new Dx'd YMSM engaged in medical care 8 Prior Dx'd YMSM engaged in medical care 	<ul style="list-style-type: none"> 2,568 testing events performed for Young MSM 17 / 2,568 = 0.66% newly diagnosed positive rate for Young MSM 10 new Dx'd YMSM engaged in medical care 3 Prior Dx'd YMSM engaged in medical care
1.1.1.10	HIV Prevention Testing Program , grant monitors, grantees Evaluation: Testing Coordinator	Deliver risk-targeted HIV testing, with partner services and linkage to HIV care for identified positives, to prioritized risk populations in proportion to that population's regional incidence.	Use 2 Reports: <ul style="list-style-type: none"> Prevention-Performance Assessment –Testing-HIV & HCT Positives Report RHS= AAARA, Direct, QOL, RIG Number of HIV tests performed New Positives = No prior Surv Case Report in eHARS OR Confirmed positive result date on or before eHARS First Diagnosis Date Seropositivity rate for newly diagnosed HIV-positive individuals = # New Dx / Total Testing Events % linked to medical care in 30 days = Medical Appointment, VL or CD4 result within 30 days after First Reactive Test results % linked to medical care after 30 days = Medical Appointment, VL or CD4 result dated after 30 days after First Reactive Test results Percentage interviewed for partner services = For confirmed positives only: # asked about at-risk partners / total confirmed positives 	Statistics per Provide Enterprise reports as of 11/22/2017 may be subject to change as further positive outcomes are reported. <ul style="list-style-type: none"> 11,920 HIV tests were completed in the reporting period 0.43% (51/11,920) positivity rate for newly diagnosed, confirmed HIV-positive individuals. 65% (33/51) of newly diagnosed, confirmed HIV linked to medical care in 30 days 18% (9/51) of newly diagnosed, confirmed linked to medical care after 30 days 100% (51/51) of newly diagnosed, confirmed interviewed for partner services 	<ul style="list-style-type: none"> 16,114 HIV screens (Risk targeted) 61 New confirmed positives 0.38% (61/16,114) positivity rate for newly diagnosed, confirmed HIV positives 56% (34/61) of newly diagnosed, confirmed HIV linked to medical care in 30 days 20% (12/61) of newly diagnosed, confirmed linked to medical care after 30 days 98% (60/61) of newly diagnosed, confirmed interviewed for partner services 	<ul style="list-style-type: none"> 16,526 HIV screens (Risk targeted) New confirmed positives: 55 0.33% (55/16,526) positivity rate for newly diagnosed, confirmed HIV positives 56% (31/55) of newly diagnosed, confirmed HIV linked to medical care in 30 days 13% (7/55) of newly diagnosed, confirmed HIV linked to medical care after 30 days 96% (53/55) of newly diagnosed, confirmed HIV interviewed for partner services

1.1.1.11	<p>HIV Prevention Testing Program; grant monitors, grantees</p> <p>Evaluation: Data Team</p>	<p>Deliver routine HIV screening, with linkage to partner services and HIV medical care, in health care sites in the highest incidence areas in each region.</p>	<p>Prevention-Performance Assessment –Testing-HIV & HCT Positives Report</p> <ul style="list-style-type: none"> • RHS = Cat B, CAPUS, RT • Number of HIV screens performed • New Positives = No prior. Case Report in eHARS OR Confirmed positive result date on or before eHARS First Diagnosis Date • Seropositivity rate for newly diagnosed HIV-positive individuals = # New Dx / Total Testing Events • Percentage linked to medical care in 30 days = Medical Appointment, VL or CD4 result dated within 30 days after First Reactive Test results • Percentage linked to medical care after 30 days = Medical Appointment, VL or CD4 result dated after 30 days after First Reactive Test results • Percentage linked to partner services = For confirmed positives only: # asked about at-risk partners / total confirmed positives 	<p>Statistics per Provide Enterprise reports as of 11/6/2017 are subject to change as further positive outcomes are reported.</p> <ul style="list-style-type: none"> • 15,528 tests • New confirmed positives: 22 • 0.14% (22 positives / 15,528 total tests) • 41% (9 linked to Care within 30 days / 22 total number of positive cases) • 5% (1 linked to Care after 30 days / 22 total number of positive cases) • 100% (22 linked to Partner Services/22 total number of positive cases) 	<ul style="list-style-type: none"> • 17,013 HIV screens performed • New confirmed positives: 36 • 0.22% (36 positives/17,013 screens) • 47% (17 linked to Care within 30 days/36 total number of positive cases) • 2.7% (1 linked to Care after 30 days/36 total number of positive cases) • 100% (36 linked to Partner Services/36 total number of positive cases) 	<ul style="list-style-type: none"> • 26,240 HIV screens performed • New confirmed positives: 14 • 0.05% (26 positives/26,240 screens) • 64.3% (9 linked to Care within 30 days/14 total number of positive cases) • 7.1% (1 linked to Care after 30 days/14 total number of positive cases) • 50% (7 linked to Partner Services/14 total number of positive cases)
1.1.1.12	<p>Perinatal HIV Prevention Program; grantees; Statewide Perinatal Network</p>	<p>Deliver routine HIV screening to pregnant women in Illinois in their first and third trimester, with linkage to HIV medical care and partner services for those testing positive.</p>	<ul style="list-style-type: none"> • Number of HIV tests performed on pregnant women • Number of infants born to untested mothers • Percentage of postnatally tested infants born to untested mothers 	<ul style="list-style-type: none"> • During this period, there were 143,427 deliveries reported through the monthly reporting. • 109 known positives and 7,093 women were eligible for HIV testing at the time of presentation. • Of those 7,093 a total of 7,065 were tested. (18 were missed for testing and 10 declined) • There were 24 infants born to untested mothers. 1 mother was tested postpartum, 16 were missed and 2 refused. A total of 6 or 25% of infants were tested postnatally. 	<ul style="list-style-type: none"> • During this period, there were 141,710 deliveries reported. • 119 known positives and 7,438 women were eligible for HIV testing at the time of presentation. • Of those 7,438 a total of 7,392 (99.4%) were tested. (36 were missed for testing and 10 declined) • 37 infants were born to untested mothers. 3 mothers were tested postpartum, 26 were missed and 2 refused. A total of 9 or 24.3% of infants were tested postnatally. • Captured third trimester testing data since beginning of year and updated the reporting forms. 	<ul style="list-style-type: none"> • During this period, there were 135,410 deliveries reported. • 118 known positives • 14,726 women presented with a negative test result prior to the third trimester and were eligible for third trimester HIV testing at the time of presentation. Of these 14,726 a total of 14,476 (98.3%) were rapid tested. • 4,490 women presented without any HIV screening test. Of those 4,490 a total of 4,292 (95.6%) were tested. • 29 infants were born to untested mothers. 3 mothers were tested postpartum, 19 were missed and 1 refused. A total of 6 or 20.7% of infants were tested postnatally.

1.1.1.13	<p>HIV Prevention RRA Program, regional grant monitors, grantees</p> <p>Evaluation: RRA Coordinator</p>	<p>Deliver effective behavioral and biomedical interventions for HIV-negatives at highest risk, in proportion to that population’s regional incidence.</p>	<p>For AAARA, Direct, QOL, RIG delivered to prioritized risk HIV-negative Persons</p> <ul style="list-style-type: none"> • Person-sessions of EBIs • # nPEP referrals accessed* • # PrEP referrals accessed* <p>*Accessed from Testing or RRA</p> <p>Com. Promise-Group, Connect, d-UP-Group, Harm Reduction Counseling, MMMV, MPowerment-MGroups, POL-Group, Safe In the City, Sister to Sister, Voices/Voces</p>	<p>1,582 person-sessions of effective behavioral and biomedical interventions were delivered to prioritized risk negatives.</p> <table border="0"> <tr> <td>Risk</td> <td>EBI</td> </tr> <tr> <td>MSM</td> <td>101</td> </tr> <tr> <td>HRH</td> <td>18</td> </tr> <tr> <td>IDU</td> <td>1,283</td> </tr> <tr> <td>MSM/IDU</td> <td>180</td> </tr> <tr> <td>Total</td> <td>1,582</td> </tr> </table> <table border="0"> <tr> <td>Risk from</td> <td>PrEP Access from</td> <td>nPEP Access</td> </tr> <tr> <td></td> <td>RRA & Testing</td> <td>RRA &</td> </tr> <tr> <td>Testing</td> <td></td> <td></td> </tr> <tr> <td>MSM</td> <td>1,168</td> <td></td> </tr> <tr> <td>28</td> <td></td> <td></td> </tr> </table>	Risk	EBI	MSM	101	HRH	18	IDU	1,283	MSM/IDU	180	Total	1,582	Risk from	PrEP Access from	nPEP Access		RRA & Testing	RRA &	Testing			MSM	1,168		28			<p>2,309 person-sessions of effective behavioral and biomedical interventions were delivered to prioritized risk negatives.</p> <table border="0"> <tr> <td>Risk</td> <td>EBI</td> </tr> <tr> <td>MSM</td> <td>359</td> </tr> <tr> <td>HRH</td> <td>74</td> </tr> <tr> <td>IDU</td> <td>1,453</td> </tr> <tr> <td>MSM/IDU</td> <td>504</td> </tr> <tr> <td>Total</td> <td>2,309</td> </tr> </table> <table border="0"> <tr> <td>Risk from</td> <td>PrEP Access from</td> <td>nPEP Access</td> </tr> <tr> <td></td> <td>RRA & Testing</td> <td>RRA &</td> </tr> <tr> <td>Testing</td> <td></td> <td></td> </tr> <tr> <td>MSM</td> <td>1,066</td> <td></td> </tr> </table>	Risk	EBI	MSM	359	HRH	74	IDU	1,453	MSM/IDU	504	Total	2,309	Risk from	PrEP Access from	nPEP Access		RRA & Testing	RRA &	Testing			MSM	1,066		<p>1828 person-sessions of effective behavioral and biomedical interventions were delivered to prioritized risk negatives.</p> <table border="0"> <tr> <td>Risk</td> <td>EBI</td> </tr> <tr> <td>MSM</td> <td>720</td> </tr> <tr> <td>HRH</td> <td>101</td> </tr> <tr> <td>IDU</td> <td>856</td> </tr> <tr> <td>MSM/IDU</td> <td>151</td> </tr> <tr> <td>Total</td> <td>1828</td> </tr> </table> <table border="0"> <tr> <td>Risk</td> <td>PrEP Access from</td> <td>nPEP Access from</td> </tr> <tr> <td></td> <td>RRA & Testing</td> <td>RRA & Testing</td> </tr> <tr> <td>MSM</td> <td>3447</td> <td>10</td> </tr> <tr> <td>HRH</td> <td>1368</td> <td>7</td> </tr> <tr> <td>IDU</td> <td>26</td> <td>1</td> </tr> <tr> <td>MSM/IDU</td> <td>11</td> <td>8</td> </tr> <tr> <td>Total</td> <td>4852</td> <td>26</td> </tr> </table>	Risk	EBI	MSM	720	HRH	101	IDU	856	MSM/IDU	151	Total	1828	Risk	PrEP Access from	nPEP Access from		RRA & Testing	RRA & Testing	MSM	3447	10	HRH	1368	7	IDU	26	1	MSM/IDU	11	8	Total	4852	26
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Total	4852	26																																																																																								
1.1.1.14	<p>HIV Prevention RRA Program, regional grant monitors, grantees</p> <p>Evaluation: RRA Coordinator</p>	<p>Deliver effective behavioral and biomedical risk-reduction interventions for PLWH.</p>	<ul style="list-style-type: none"> • Report: HERR Service Demographics – both Prevention & Surveillance • Providers=AAARA, QOL, RIG • Person-sessions of Effective Behavioral Interventions delivered to PLWH (CLEAR, Connect, d-UP-Group, Harm Reduction Counseling, Healthy Relationship, MMMV, MPowerment-MGroups, Promise-Group, POL-Group, Safe In the City, Sister to Sister, START, Voices/Voces, Willow) • Person-sessions of Effective Biomedical Interventions delivered to PLWH- (CDC-supported EBIs4Pos = HEART, Partnership For Health, SmartCOUPLES) 	<ul style="list-style-type: none"> • 2325 person-sessions of Effective Behavioral Interventions were delivered to PLWH • 2219 person-sessions of effective biomedical interventions were delivered to PLWH. 	<ul style="list-style-type: none"> • 2030 person-sessions of Effective Behavioral Interventions were delivered to PLWH • 929 person-sessions of effective biomedical interventions were delivered to PLWH. 	<ul style="list-style-type: none"> • 1220 person-sessions of Effective Behavioral Interventions were delivered to PLWH • 1200 person-sessions of effective biomedical interventions were delivered to PLWH. 																																																																																				

1.1.1.15	Perinatal HIV Prevention Program , grant monitors, grantees, Statewide Perinatal Network Evaluation: Perinatal HIV Prevention Coordinator	Provide enhanced perinatal case management (ECM) and expert medical technical assistance via the Perinatal HIV Hotline, supporting the delivery of effective biomedical risk-reduction interventions for HIV-positive women and their infants during and after pregnancy, labor, and delivery.	<ul style="list-style-type: none"> • # of HIV-positive pregnant women who delivered during the reporting interval • # of HIV-positive pregnant women who delivered during the reporting interval who received Enhanced Perinatal Case Management (ECM) • Of HIV-positive women delivering who received ECM: <ul style="list-style-type: none"> • % engaged in HIV care prior to labor and delivery • % not engaged in HIV care prior to labor & delivery who received HIV meds prior to • % of infants born to HIV+ pregnant women who received HIV medication postnatally • # of HIV+ pregnant women who received directly observed therapy prenatally during period • # of HIV-positive pregnant women who received directly observed therapy postnatally during the period 	<ul style="list-style-type: none"> • # of HIV-positive pregnant women who delivered during interval -109 • # of HIV-positive pregnant women who delivered during the interval who received Enhanced Perinatal Case Management (ECM) -84 • Of HIV-positive women delivering during period who received ECM: <ul style="list-style-type: none"> • % engaged in HIV care prior to labor and delivery - 82% (66/84) • % not engaged in HIV care prior to labor and delivery who received HIV medication prior to delivery - 0% (0/84) • % of infants born to HIV+ pregnant women who received HIV med postnatally -100% • # of HIV-positive pregnant women who received directly observed therapy prenatally during the period - 2 • # of HIV+ pregnant women who received directly observed therapy postnatally during the period - 0 	<ul style="list-style-type: none"> • # of HIV-positive pregnant women who delivered during interval -119 • # of HIV-positive pregnant women who delivered during the interval who received Enhanced Perinatal Case Management (ECM) - 45 • Of HIV-positive women delivering during period who received ECM: <ul style="list-style-type: none"> • % engaged in HIV care prior to labor and delivery - 78% (35/45) • % receiving AZT prophylaxis during labor and delivery – 89% (40/45) • % of infants born to HIV+ pregnant women who received HIV med postnatally -100% • # of HIV-positive pregnant women who received outpatient directly observed therapy (DOT) prenatally during the reporting period – 2 • # of infants who received directly observed therapy (DOT) during the reporting period - 4 	<ul style="list-style-type: none"> • # of HIV-positive pregnant women who delivered during interval -123 • # of HIV-positive pregnant women who delivered during the interval who received Enhanced Perinatal Case Management (ECM) - 32 • Of HIV-positive women delivering during period who received ECM: <ul style="list-style-type: none"> • % engaged in HIV care prior to labor and delivery - 91% (29/32) • % receiving AZT prophylaxis during labor and delivery – 87% (28/32) • % of infants born to HIV+ pregnant women who received HIV med postnatally -100% • # of HIV-positive pregnant women who received outpatient directly observed therapy (DOT) prenatally during the reporting period – 0 • # of infants who received directly observed therapy (DOT) during the reporting period - 2
1.1.1.16	HIV Prevention Testing Program , grant monitors, grantees Evaluation: Data Team	Intensify the delivery of expanded partner services and HIV testing for sex and/or needle sharing partners of positives.	Query Partner services from all sources: HIV Testing + RWCM + SBS + OOJ <ul style="list-style-type: none"> • # of notifiable partners named • Percentage of named notifiable partners already positive • Percentage of named notifiable partners not known to be positive contacted • Percentage of contacted partners tested • Percentage of tested partners preliminary positive • Percentage of tested partners linked to care within 30 days • Percentage of tested partners linked to care after 30 days 	Statistics per Provide Enterprise reports as of 11/6/2017 may be subject to change as further partner of positive outcomes are reported. <ul style="list-style-type: none"> • # of notifiable partners named 32 • Percentage of named notifiable partners already positive 16% • Percentage of named notifiable partners not known to be positive contacted 97% • Percentage of contacted partners tested 40% • Percentage of tested partners preliminary positive 0% • Percentage of tested partners linked to care within 30 days - N/A • Percentage of tested partners linked to care after 30 days - N/A 	<ul style="list-style-type: none"> • # of notifiable partners named 132 • Percentage of named notifiable partners already positive 22% (29/132) • Percentage of named notifiable partners not known to be positive contacted 20% (21/103) • Percentage of contacted partners tested 71% (15/21) • Percentage of tested partners preliminary positive 33% (5/15) • Percentage of tested partners linked to care within 30 days - N/A (0/0) • Percentage of tested partners linked to care after 30 days - N/A (0/0) 	<ul style="list-style-type: none"> • # of notifiable partners named = 86 • % of named notifiable partners already positive = 17.4% (15/86) • % of named notifiable partners not known to be positive contacted = 23.9% (17/71) • % of contacted partners tested 52.9% (9/17) • % of contacted partners tested preliminary positive = 22.2% (2/9) • % of tested partners linked to care within 30 days - N/A (0/0) • % of tested partners linked to care after 30 days - N/A (0/0)
1.1.1.17	HIV Care Program , RWPB case managers	Deliver partner services to RWPB clients engaging in risky behaviors.	<ul style="list-style-type: none"> • Number of clients engaging in risky behaviors • Number of partners identified • Number of partners located • Number of partners tested and informed of their status 	<ul style="list-style-type: none"> • 640 clients identified with risky behaviors • 6 partners identified • 0 partners located • 0 partners tested 	<ul style="list-style-type: none"> • 1,059 clients identified with risky behaviors • 12 partners identified • 0 partners located • 0 partners tested 	<ul style="list-style-type: none"> • 749 clients identified with risky behaviors • 2 partners identified • 0 partners located • 0 partners tested

1.1.1.18	HIV Care Corrections Program, IDOC	Conduct HIV and HCV testing at Summits of Hope throughout the state in partnership with the Department of Corrections.	<ul style="list-style-type: none"> • Number of Summits held • Number of recently released participants • Number of HIV, HCV, and STI tests performed • Number of risk assessments conducted • Number of service referrals provided to high-risk individuals 	<ul style="list-style-type: none"> • 9 Summits held • 2,807 recently released participants • 1,970 HIV, HCV, STI tests performed • 2,764 risk assessments conducted • 89 service referrals provided to high-risk individuals 	<ul style="list-style-type: none"> • 9 Summits held • 3,460 recently released participants • 1,901 HIV, HCV, STI tests performed • 2,822 risk assessments conducted • 91 service referrals provided to high-risk individuals 	<ul style="list-style-type: none"> • 8 Summits held • 2,972 recently released participants • 1,270 HIV, HCV, STI tests performed • 2,540 risk assessments conducted • 82 service referrals provided to high-risk individuals
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Strategy 1.1.2 Expand efforts to prevent new HIV infections by using a combination of effective, evidence-based approaches.

1.1.2.1	HIV Prevention Program, grant monitors, lead agencies, grantees Evaluation: HIV Prevention Administrator	Using High-Impact Prevention (HIP) approach, provide a combination of HIV testing, partner services, linkage to care, STI/VH testing, surveillance-based services, and cost-effective behavioral and biomedical interventions for HIV-negative individuals in each region statewide, as funding permits.	<ul style="list-style-type: none"> • Grant scopes of services documenting each service category within each region • Regional Service Plan spreadsheet 	<ul style="list-style-type: none"> • Accomplished in Regions 1-8 through the Regional Prevention Grants 	<ul style="list-style-type: none"> • Accomplished in Regions 1-8 through the Regional Prevention Grants augmented by AAARA, Direct, and QOL grants. 	<ul style="list-style-type: none"> • Accomplished in Regions 1-8 through the Regional Prevention Grants augmented by AAARA, Direct, and QOL grants.
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1.1.2.2	Perinatal HIV Prevention Program, DSU, Women’s Health Evaluation: Perinatal HIV Prevention Coordinator	Provide perinatal HIV prevention training for RW case managers and Women’s Health family case managers.	<ul style="list-style-type: none"> • Number of RW family case managers trained by the Perinatal HIV Program 	<ul style="list-style-type: none"> • No Perinatal HIV Case Management Trainings were conducted during this reporting period. 	<ul style="list-style-type: none"> • No Perinatal HIV Case Management Trainings were conducted during this reporting period. 	<ul style="list-style-type: none"> • No Perinatal HIV Case Management Trainings were conducted during this reporting period.
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1.1.2.3	HIV Training Program	Annually conduct a training needs assessment of HIV Care and Prevention Program grantees and providers.	<ul style="list-style-type: none"> • Survey results 	<ul style="list-style-type: none"> • An assessment of the training needs of providers was completed in February 2017. 	<ul style="list-style-type: none"> • An assessment of the training needs of providers is in progress. 	<ul style="list-style-type: none"> • An assessment of the training needs of providers was completed in January 2019.
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Strategy 1.1.3 Educate and increase public knowledge about HIV through use of social media and evidence-based strategies and campaigns.

1.1.3.1	HIV Prevention Program, Director’s Office, Communications, Evaluation: HIV RRA Coordinator	Publicize current, accurate information about HIV transmission, national and statewide statistics, disease progression, prevention, screening, and treatment on the IDPH website.	<ul style="list-style-type: none"> • Number of HIV prevention materials/updates posted on website 	IDPH Website Topics include: <ul style="list-style-type: none"> • HIV Testing • Routine HIV Testing in Pregnancy • HIV Prevention Services • Reducing HIV Risk • Safer Injection • HIV Vaccines • HIV Microbicides • Pre-Exposure Prophylaxis (PrEP) • Getting to Zero 	IDPH Website Topics include: <ul style="list-style-type: none"> • HIV Testing – (Sites Updated) • Routine HIV Testing in Pregnancy • HIV Prevention Services • Reducing HIV Risk • Safer Injection • HIV Vaccines • HIV Microbicides • Pre-Exposure Prophylaxis (PrEP) • Getting to Zero 	IDPH Website Topics include: <ul style="list-style-type: none"> • HIV Testing – (Sites Updated) • Routine HIV Testing in Pregnancy • HIV Prevention Services • Reducing HIV Risk • Safer Injection • HIV Vaccines • HIV Microbicides • Pre-Exposure Prophylaxis (PrEP) • Getting to Zero
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1.1.3.2	HIV Training Program, HIV Section Integrated Planning Program, IDPH Communications	Publicize current, accurate information about HIV transmission, national and statewide statistics, disease progression, prevention, screening, and treatment through messaging via IDPH social media.	<ul style="list-style-type: none"> • Number of people reached by IDPH via HIV-related Facebook posts or HIV-Facebook page, Post clicks, Post reactions, and followers of Facebook page 	<ul style="list-style-type: none"> • We will be working with IDPH Communications in 2018 to determine how to generate a report to obtain these measures from the IDPH website and Facebook page and to discuss the possibility of setting up an HIV Facebook page. • Visits to HPG website: 9,700 • HPG Facebook: <ul style="list-style-type: none"> ♦ People reached: 790 ♦ Post clicks: 44 ♦ Post reactions: 81 ♦ Followers: 84 	<ul style="list-style-type: none"> • We will be working with IDPH Communications in 2019 to determine how to generate a report to obtain these measures from the IDPH website and Facebook page and to discuss the possibility of setting up an HIV Facebook page. 	No progress has been made in this area. Plans to further utilize HIV Section Training page are in the works.
1.1.3.3	HIV Training Program	Prepare awareness messages and infographics for distribution through social media outlets for each HIV/AIDS Awareness Day.	<ul style="list-style-type: none"> • Views and responses on social media outlets 	<ul style="list-style-type: none"> • The Training Unit presented awareness messages, including infographics, for the 2017 National Black HIV/AIDS Awareness Day. 	<ul style="list-style-type: none"> • The Training Unit presented awareness messages, including infographics, for the 2018 National Black HIV/AIDS Awareness Day. 	The Training Unit presented awareness messages, including infographics, for the 2019 National Black HIV/AIDS Awareness Day.
1.1.3.4	HIV Prevention Program, grant monitors, grantees	Publicize current, accurate information about HIV transmission, national and statewide statistics, disease progression, prevention, screening, and treatment through the Illinois AIDS/HIV & STD Hotline.	<ul style="list-style-type: none"> • Number of information-providing calls completed by the Hotline 	<ul style="list-style-type: none"> • 8,556 calls were received by the IL HIV/STD Hotline in FY17 	<ul style="list-style-type: none"> • 6,897 calls were received by the IL HIV/STD Hotline in FY18 	3,890 calls were received by the IL HIV/STD Hotline in SFY19
1.1.3.5 NEW	HIV Prevention Program, grant monitors, grantees	Engage Prioritized Populations, especially those who are youth & young adults into HIV Prevention services via Social Networking Strategies, Social Media, and CDC Social Marketing.	<ul style="list-style-type: none"> • Number of funded providers that implemented Social Networking Strategies or Social Media or CDC Social Marketing materials targeted to Prioritized Populations. 	Objective added after this reporting period.	Objective added after this reporting period.	RIG LAs: 31 funded providers implemented SNS or Social Media/Marketing CDC campaigns QOL: 9/11, 81% AAARA & Hotline: 1 Direct: 5 / 11

Objective 1.2 By 2021, increase program coordination and service integration to facilitate a seamless transition between testing, treatment, care, and secondary prevention services.

Strategy 1.2.1 Streamline prevention, care, and treatment by increasing integration/coordination within and across programs (e.g., HIV prevention & care; HIV prevention, surveillance, & care; HIV & STI).

1.2.1.1	HIV Care Program, HIV Prevention Program, Groupware Technology, Inc.	Build a new, electronic Care-to-Prevention transferrable referral within the Provide Enterprise client record and documentation system.	<ul style="list-style-type: none"> • Number of referrals electronically transferred from Care to Prevention • Number of prevention services for PLWH accessed by care-referred 	Not Accomplished. GTI Provide Development contract expired 7/1/2017.	Not Accomplished. GTI Provide Development contract expired 7/1/2017.	Not Accomplished. GTI Provide Development contract was just executed 7/1/2019.
1.2.1.2	Integrated HIV Planning Program	Conduct statewide integrated prevention and care planning meetings annually to discuss and evaluate Integrated Plan progress, needed modifications, and ways to enhance service integration.	<ul style="list-style-type: none"> • Number of statewide meetings • Number of meeting participants • Meeting agendas and minutes • Ratings/responsiveness of meeting evaluations 	<ul style="list-style-type: none"> • In this period, 6 meetings of the Integrated Planning Group and 4 meetings of the ILHPG were conducted. Attendee sheets and evaluations were compiled and are posted on www.ilhpg.org website. 	<ul style="list-style-type: none"> • In this period, 8 meetings of the Integrated Planning Group were conducted. Minutes, attendee sheets, and evaluations were posted on the www.ihpc.org and http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg-websites. 	<ul style="list-style-type: none"> • In this period, 8 meetings of the IHPC were conducted. • Minutes, attendee sheets, and evaluations of all meetings were posted on the http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg-websites.

1.2.1.3	HIV Prevention Program , HIV Surveillance Unit, STI Program	In coordination with the STI Program, conduct a cross-match of PLWH with cases of recent STIs, to ensure that PLWH with STI co-infection are assigned for surveillance-based services (SBS) and receive STI treatment, partner services, behavioral and biomedical risk-reduction, and linkage to medical care, as needed.	Of SBS cases with Referral Type = STI co-infection <i>closed</i> during the reporting period: <ul style="list-style-type: none"> • Number of cases assigned • Number located • Number agreed to service • Number linked to medical care • Number elicited for partners • Number of notifiable partners named • Number received risk reduction counseling 	STI-Co-infected SBS Referrals: <ul style="list-style-type: none"> • 75 cases assigned • 35 located • 27 accepted service • 3 linked to care • 22 asked about partners • 4 potentially notifiable partners named • 3 accessed risk reduction counseling 	<ul style="list-style-type: none"> • 190 cases assigned • 112 located • 85 accepted service • 47 already in care • 35 engaged into care • 76 asked about partners • 0 potentially notifiable partners named • 15 accessed a risk reduction intervention 	STI-Co-infected SBS Referrals: <ul style="list-style-type: none"> • 150 cases assigned • 85 located • 66 accepted service • 58 already in care • 5 engaged into care • 56 asked about partners • 5 potentially notifiable partners named • 35 accessed a risk reduction intervention
1.2.1.4	HIV Prevention Program , grant monitors, prevention grantees, DSU, regional care lead agents, case managers, care health care providers Evaluation: HIV Data Team	Increase the percentage of HIV-positive clients referred to RWPB case management (CM) by an IDPH-funded prevention or SBS provider following HIV testing or receipt of surveillance-based services, who attend an HIV medical visit within 30 days of the test result or the referral to RWCM.	Of Part B HIV case management referrals from any HIV Testing or SBS source: <ul style="list-style-type: none"> • Percentage of referred positives who attend an HIV medical appointment within 30 days • Percentage of referred positives who attend an HIV medical appointment after 30 days • Percentage of referred positives who decline case management enrollment • Percentage of referred positives who decline HIV medical care 	Statistics per Provide Enterprise reports as of 11/6/2017 may be subject to change as further positive outcomes are reported. Of Part B HIV case management referrals from any HIV Testing or SBS source: <ul style="list-style-type: none"> • 57% of referred positives attended medical appointment within 30 days • 24% attended medical appointment after 30 days • 9% of referred positives (with a linkage to care record) declined case management • None of the CM referred positives declined referral to medical care 	Of Part B HIV case management referrals from any HIV Testing or SBS source: <ul style="list-style-type: none"> • 12% (11/95) of referred positives (with a linkage to care record) declined case management • 4% (4/95) of referred positives (with a linkage to care record) were not able to be reached. • 24% (23/95) of referred positives (with a linkage to care record) were currently enrolled when referred and had already attended a medical apt. in the past 12 months • 9% (9/95) of referred positives attended medical appointment within 30 days • 17% (16/95) attended medical appointment after 30 days. • 0% (32/95) did not attend a medical appointment. 	<ul style="list-style-type: none"> •% of referred positives attended medical appointment within 30 days = 50.7% (70/138) •% of referred positives attended medical appointment after 30 days = 10.9% (15/138) •%of referred positives (with a linkage to care record) declined case management = 0.0% (0/138) •% of referred positives (with a linkage to care record) were not able to be reached = 30.4% (42/138) •% of referred positives (with a linkage to care record) were currently enrolled when referred and had already attended a medical apt. in the past 12 months = 3.6% (5/138) •% of referred positives that did not attend a medical appointment = 38.4% (53/138)

Strategy 1.2.2 Foster continuity of high-quality comprehensive health care coverage for PLWH with seamless transitions between RWHP programs/services and ACA coverage/services.

1.2.2.1	HIV Care Program	Conduct quality assurance site visits to ensure that the core and supportive services authorized under RWPB and HOPWA are provided to clients via our medical case management model.	<ul style="list-style-type: none"> • Tracking of enrollment and service utilization • Ongoing quality assurance review of clients enrolled in these services/number of site visits • Number of clients reviewed at site visits 	<ul style="list-style-type: none"> • 10 site visits conducted • 66 client files reviewed • Improvements, concerns and projects going forward are discussed/agreed upon as required by the National Monitoring Standards (NMS). The provider/sub-grantee will continue to participate in/provide all material necessary to carry out monitoring activities, monitor service contractors for compliance with federal and programmatic requirements, and improve/establish policies and procedures to ensure compliance with requirements. 	<ul style="list-style-type: none"> • 10 site visits conducted • 92 client files reviewed • Improvements, concerns and projects going forward are discussed and agreed upon as required by the National Monitoring Standards (NMS). The provider/sub-grantee will continue to participate in and provide all material necessary to carry out monitoring activities, monitor any service contractors for compliance with federal and programmatic requirements, and improve and establish policies and procedures to ensure compliance with federal and programmatic requirements. 	<ul style="list-style-type: none"> • 9 site visits conducted • 173 client files reviewed • Improvements, concerns and projects going forward are discussed and agreed upon as required by the National Monitoring Standards (NMS). The provider/sub-grantee will continue to participate in and provide all material necessary to carry out monitoring activities, monitor any service contractors for compliance with federal and programmatic requirements, and improve and establish policies and procedures to ensure compliance with federal and programmatic requirements.
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1.2.2.2	AIDS Drug Assistance Program/ Medication Assistance Program, Continuation of Health Insurance Coverage/ Premium Assistance Program	Provide ADAP formulary medications for eligible uninsured, underinsured, and insured clients; and Premium assistance to ensure continuity of health care coverage for approved insurance plans.	<ul style="list-style-type: none"> Tracking of: <ul style="list-style-type: none"> MAP/PAP enrollment Service utilization of medication and insurance premiums Ongoing quality assurance review of clients enrolled in healthcare coverage 	<ul style="list-style-type: none"> MAP enrollment: 12,086 6,639 clients received medication 87,889 medications dispensed PAP enrollment: 3,129 3,091 clients with premiums paid 45,276 premiums paid 19 regimen alerts during period MAP concluded HCV medication pilot program which served its first 100 dually infected clients. The MAP program has extended its HEPC program past the pilot and has now served 125 clients. MAP is piloting a 12-month open formulary that started on 4/1/2017. The exclusionary list is posted on IDPH website, GTI Enrollment Website, and the HIV Care Connect Website. 	<ul style="list-style-type: none"> MAP enrollment: 12,928 8,088 clients received medication 125,976 medications dispensed PAP enrollment: 3,345 3,292 clients with premiums paid 47,661 premiums paid 64 regimen alerts during period MAP is continuing its HCV medication program which served 111 dually infected clients during this timeframe. MAP is continuing its open formulary that started on 4/1/2017. The exclusionary list is posted on IDPH website, GTI Enrollment Website, and the HIV Care Connect Website. 	<ul style="list-style-type: none"> MAP enrollment: 13,757 7,936 clients received medication 122,265 medications dispensed PAP enrollment: 3,185 3,166 clients with premiums paid 44,745 premiums paid 26 regimen alerts during period MAP is continuing its HCV medication program which served 86 dually infected clients during this timeframe. MAP is continuing its open formulary that started on 4/1/2017. The exclusionary list is posted on IDPH website, GTI Enrollment Website, and the HIV Care Connect Website.
1.2.2.3	HIV Care Corrections Program, IDOC	Prior to discharge, coordinate the transition of HIV-positive clients into RWPB case management and to an HIV medical provider post-incarceration.	<ul style="list-style-type: none"> Number of PLWH enrolled in post-incarceration case management Number of recently released PLWH with at least one medical appointment 	<ul style="list-style-type: none"> 126 enrolled in Corrections CM 117 enrolled in Corrections CM with at least one medical appointment 	<ul style="list-style-type: none"> 61 clients enrolled in Corrections CM 59 clients enrolled in Corrections CM with at least one medical appointment 	<ul style="list-style-type: none"> 94 clients enrolled in Corrections CM 92 clients enrolled in Corrections CM with at least one medical appointment

Strategy 1.2.3 Intensify efforts to engage the Department of Corrections (DOC) and community-based providers serving corrections and reentry population.

1.2.3.1	Integrated Planning Group Membership Committee; Steering Committee; IDPH HIV Section staff	Increase the number of newly-engaged community stakeholders, including representatives from faith-based communities, corrections, and reentry populations, who participate/provide input at HIV Planning Group meetings/activities	<ul style="list-style-type: none"> Integrated Planning Group meeting attendance logs 	<ul style="list-style-type: none"> During this period, over 100 new community stakeholders, including representatives from these identified areas participated in ILHPG and Integrated Planning Group meetings 	<ul style="list-style-type: none"> During this period, over 100 new community stakeholders, including representatives from these identified targeted areas participated in Integrated Planning Group webinar or in-person meetings. 	<ul style="list-style-type: none"> During this period, over 100 new community stakeholders, including representatives from these identified targeted areas participated in Integrated Planning Group webinar or in-person meetings. Over 60 youth and young adults participated in a series of HIV/STD focus groups and surveys targeted for high-risk youth.
1.2.3.2	HIV Care Corrections Program, IDOC	Renew Inter-Governmental Agreement (IGA) with IDOC for the following: Summits of Hope, Peer Education Program, Reentry Program, discharge planning, HIV/HCV testing, and educational activities.	<ul style="list-style-type: none"> Documentation showing renewal and full execution of the IGA 	<ul style="list-style-type: none"> Two executed IGA's were completed in this reporting time. The first was for July 2016 – June 2017, and the second is for July 2017 – March 2018. 	<ul style="list-style-type: none"> Two IGA's were completed in this reporting time. July 2017 – March 2018, finished April 2018 – March 2019, continuing 	<ul style="list-style-type: none"> Two IGA's were completed in this reporting time. April 2018 – March 2019, finished April 2019 – March 2022, continuing
1.2.3.3	HIV Care Corrections Program, IDOC	Provide peer to peer HIV, STI, and HCV education and training within correctional facilities statewide.	<ul style="list-style-type: none"> Number of peer educators certified for training Number of education sessions they conducted Number of participants they engaged in educational activities 	<ul style="list-style-type: none"> 124 certified correctional peer educators 27 peer to peer educational sessions conducted in correctional facilities 112 participants 	<ul style="list-style-type: none"> 152 certified correctional peer educators 25 peer to peer educational sessions conducted in correctional facilities 97 participants 	<ul style="list-style-type: none"> 119 certified correctional peer educators 26 peer to peer educational sessions conducted in correctional facilities 752 participants

1.2.3.4	HIV Care Corrections Program, IDOC, PHIMC	Provide HIV 101 training for correctional medical staff and provide IDOC correctional facilities with HIV/HCV test kits.	<ul style="list-style-type: none"> • Number of HIV reentry and discharge planning trainings provided; • Number of medical providers who completed training and received CMEs/CEUs 	<ul style="list-style-type: none"> • 29 medical providers • PHIMC conducted two discharge planning trainings in Springfield and East St. Louis. Overall, attendees reported that overall HIV-related skills improved a great deal and that they would share information gained at trainings with colleagues and patients/clients. • Statewide re-entry conference held in Chicago. 	<ul style="list-style-type: none"> • 80 medical providers • PHIMC conducted four discharge planning trainings in Chicago, East St. Louis, Springfield and Peoria. • Statewide re-entry conference held in Chicago. 109 individuals attended. • 6, 023 test kits provided to correctional facilities. 	<ul style="list-style-type: none"> • 173 medical providers • PHIMC conducted four discharge planning trainings in Chicago and Springfield. • Statewide re-entry conference held in Chicago 107 attendees, 91 in Springfield • 6,300 test kits provided to correctional facilities.
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GOAL 2: Increase Access to Care and Improve Health Outcomes for PLWH.

Objective 2.1 By 2021, ensure that all PLWH in Illinois have access to HIV care and related support services.

Strategy 2.1.1 Facilitate linkage to and engagement in HIV medical care, focusing on the most disproportionately affected, hardest hit and hard-to-reach populations.

Activity Number	Responsible Parties	Activity Description	Metric	September 2016 - August 2017 Update	July 2017-June 2018 Update	July 2018-June 2019 Update
2.1.1.1	HIV Training Program	Provide Fundamentals of HIV Risk-Targeted Testing Course at least five times per year to facilitate transition into HIV care for individuals testing positive through targeted testing programs.	<ul style="list-style-type: none"> • Number of trainings provided • Number of providers completing the trainings 	<ul style="list-style-type: none"> • Risk Targeted Testing (formerly Foundations) was presented five times (Belleville, Wheaton, Springfield, Peoria, Collinsville) • An additional course is scheduled for Dec 5 – 8, 2017 (Wheaton) 	<ul style="list-style-type: none"> • Risk Targeted Testing (formerly Foundations) was presented five times (Belleville, Wheaton, Springfield, Peoria, Collinsville) during this period. • _____ Providers completed the trainings. 	Risk Targeted Testing was presented six times (Chicago, Springfield, Elgin, Peoria, and 2 in Belleville) during this period. 81 Providers completed the trainings.
2.1.1.2	HIV Prevention Program , Routine testing providers Evaluation: HIV Rte. Screening Coordinator	Increase the number and percentage of people newly diagnosed as HIV-positive through IDPH-funded routine HIV testing linked to medical care within 30 days of a preliminary positive result.	<ul style="list-style-type: none"> • Number of people newly-diagnosed as HIV-positive identified through routine HIV screening; • Of those, the number and percentage linked to medical care within 30 days 	Statistics per Provide Enterprise reports as of 11/6/2017 (may be subject to change as further positive outcomes are reported): Of Routine Screening-identified Preliminary or Confirmed positives: <ul style="list-style-type: none"> • # of new positives identified - 193 • # linked to medical care within 30 days - 61 • # linked to medical care after 30 days -21 	Of Routine Screening- identified Preliminary or Confirmed positives: <ul style="list-style-type: none"> • Number of new positives identified- 30 • Number of linked to medical care within 30 days- 12 • Number linked to medical care after 30 days- 1 	Of Routine Screening- identified Preliminary or Confirmed positives: <ul style="list-style-type: none"> • Number of new positives identified - 9 • Number of linked to medical care within 30 days - 5 • Number linked to medical care after 30 days - 1
2.1.1.3	HIV Prevention Program , Risk-based testing providers Evaluation: HIV Testing Coordinator	Increase the number and percentage of people newly diagnosed as HIV-positive through IDPH-funded risk-targeted testing linked to medical care within 30 days of a preliminary positive result.	Of Risk-Based HIV Testing Preliminary & Confirmed positives for RIG, QOL, AAARA, Direct: <ul style="list-style-type: none"> • Number and seropositivity rate of people newly-diagnosed as HIV-positive, identified through RIG, QoL, AAARA, and Direct-testing grants; • Of those, the number and percentage linked to medical care within 30 days (Note): The IDPH Positives Only report may be used to assess new HIV diagnoses after recently queried StateNos for all positive tests have been entered.	Statistics per Provide Enterprise reports as of 11/22/2017 may be subject to change as further positive outcomes are reported. <ul style="list-style-type: none"> • 11,920 HIV tests were completed in the reporting period • 0.43% (51/11,920) positivity rate for newly diagnosed, confirmed HIV-positive individuals. • 65% (33/51) of newly diagnosed, confirmed HIV linked to medical care in 30 days • 18% (9/51) of newly diagnosed, confirmed linked to medical care after 30 days • 100% (51/51) of newly diagnosed, confirmed interviewed for partner services 	<ul style="list-style-type: none"> • 16,114 HIV screens (Risk targeted) • 61 New confirmed positives • 0.38% (61/16,114) positivity rate for newly diagnosed, confirmed HIV positives • 56% (34/61) of newly diagnosed, confirmed HIV linked to medical care in 30 days • 20% (12/61) of newly diagnosed, confirmed linked to medical care after 30 days • 98% (60/61) of newly diagnosed, confirmed interviewed for partner services 	<ul style="list-style-type: none"> • 16,526 HIV screens (Risk targeted) • 55 New confirmed positives • 0.33% (55/16,526) positivity rate for newly diagnosed, confirmed HIV positives • 56% (31/55) of newly diagnosed, confirmed HIV linked to medical care in 30 days • 13% (7/55) of newly diagnosed, confirmed HIV linked to medical care after 30 days • 96% (53/55) of newly diagnosed, confirmed HIV interviewed for partner services

2.1.1.4	HIV Prevention Program , perinatal prevention providers and grantees	Link newly HIV-diagnosed infants, identified through perinatal HIV testing and reported to the perinatal HIV hotline, to medical care within 30 days of a preliminary positive result.	<ul style="list-style-type: none"> Number of new positive infants identified; Number linked to medical care within 30 days 	<ul style="list-style-type: none"> One new positive infant identified during this time and was linked to care immediately. 	<ul style="list-style-type: none"> Four (4) new positive infants identified during this time and was linked to care immediately. All four infants received directly observed therapy (DOT). 	No positive infants were identified during this time.
2.1.1.5	HIV Prevention Program , regional care and prevention lead agencies, surveillance-based service providers Evaluation: HIV Data Team	Link individuals newly HIV-diagnosed within the past 12 months and identified for surveillance-based services (SBS) to HIV medical care.	SBS Newly HIV-diagnosed Individuals: <ul style="list-style-type: none"> Number assigned to agencies Number located Number who agree to services Number already in care Number linked to medical care Number elicited for partners Number of notifiable partners named Number who received risk reduction counseling 	SBS Newly HIV-diagnosed Individuals: <ul style="list-style-type: none"> 163 cases assigned 100 located 80 accepted 7 linked to care 58 asked about partners 9 potentially notifiable partners 15 accessed risk reduction counseling 	SBS Newly HIV-diagnosed Individuals: <ul style="list-style-type: none"> 354 cases assigned 207 cases located 152 cases accepted service 114 cases already in care 34 cases linked to care 133 asked about partners 23 potentially notifiable partners 40 accessed risk reduction counseling 	SBS Newly HIV-diagnosed Individuals: <ul style="list-style-type: none"> # of cases assigned: 256 # of cases located: 124 # of cases accepted service: 94 # of cases already in care: 73 # of cases engaged into care: 17 # of cases asked about partners: 74 # of potentially notifiable partners named: 11 # of cases accessed a risk reduction intervention: 36
Strategy 2.1.2 Maintain and reengage PLWH in medical care and increase adherence to antiretroviral therapy and viral suppression rates.						
2.1.2.1	HIV Prevention Program , Regional prevention lead agents, SBS providers Evaluation: HIV Data Team	Conduct surveillance-based services (SBS) for PLWH who lack evidence of HIV medical care within eHARS, RW case management, ADAP, and CHIC to engage them into a system of HIV care.	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> Number of cases assigned Number located Number who accepted services Number linked to medical care Number elicited for partners Number of notifiable partners named Number who receive risk reduction counseling 	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> 908 SBS cases were assigned 337 were located 230 accepted services 20 were linked to medical care 204 partners were elicited 42 notifiable partners were named 129 received risk reduction counseling 	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> 2230 SBS NIC cases were assigned 515 were located 273 accepted services 211 were already in medical care 50 were engaged in medical care 88 received medication adherence intervention 	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> # of cases assigned: 1227 # of cases located: 351 # of cases accepted service: 242 # of cases already in care: 216 # of cases engaged into care: 18 # of cases accessed a medication adherence intervention: 86
2.1.2.2	HIV Care Program , Care lead agencies and their hired retention specialist employees	Create/support retention specialist positions to conduct outreach to PLWH who have fallen out of care to reengage them in care and to work with medical case managers to reduce barriers to medical care and help clients adhere with HIV medications and treatment.	<ul style="list-style-type: none"> Number or retention specialists funded; Number of HIV-positive clients re-engaged in medical care 	<ul style="list-style-type: none"> 849 clients re-engaged in Care Planning to hire regional retention specialists to conduct outreach activities for clients identified as lost to care or in need of re-engagement. These retention specialists will work with medical case managers to ensure that clients receive medical care, HIV treatment, treatment adherence counseling, and other services as needed. 	<ul style="list-style-type: none"> 1,059 clients re-engaged in Care Regional retention specialists were hired to conduct outreach activities for clients who have been identified as lost to care or in need of re-engagement. These retention specialists are working with medical case managers to ensure that clients receive medical care, HIV treatment, treatment adherence counseling, and other services as needed. 	<ul style="list-style-type: none"> 1,100 clients re-engaged in Care Regional retention specialists were hired to conduct outreach activities for clients who have been identified as lost to care or in need of re-engagement. These retention specialists are working with medical case managers to ensure that clients receive medical care, HIV treatment, treatment adherence counseling, and other services as needed.
2.1.2.3	HIV Care Program , contracted dispensing pharmacy	Provide medication counseling prior to every new medication dispensed from the Medication Assistance Program (MAP).	<ul style="list-style-type: none"> Number of clients who received medication dispenses 	<ul style="list-style-type: none"> 6,839 clients received medication 	<ul style="list-style-type: none"> 8,088 clients received medication 	7,936 clients received medication
2.1.2.4	HIV Care Program , Care lead agents and providers	Conduct treatment adherence counseling at critical benchmark visits with enrolled/enrolling clients.	<ul style="list-style-type: none"> Number of clients who received treatment adherence counseling 	<ul style="list-style-type: none"> 422 clients received treatment adherence counseling 	<ul style="list-style-type: none"> 6,364 clients received treatment adherence counseling 	<ul style="list-style-type: none"> 6,772 clients received treatment adherence counseling

2.1.2.5	HIV Care Program, medical case managers	Monitor medical appointment attendance for open enrolled RWPB clients.	<ul style="list-style-type: none"> • Number of open clients enrolled in RWPB • Number of medical appointments attended 	<ul style="list-style-type: none"> • 12,689 enrolled • 39,795 medical appointments attended 	<ul style="list-style-type: none"> • 12,403 enrolled • 52,910 medical appointments attended 	<ul style="list-style-type: none"> • 13,758 enrolled • 57,022 medical appointments attended
2.1.2.6	HIV Care Program	Mail enrollment recertification letters to all actively enrolled clients 30 days prior to Part B eligibility expiration; notify clients with web user accounts via text or email.	<ul style="list-style-type: none"> • Number of letters disseminated • Number of active web user accounts 	<ul style="list-style-type: none"> • RWPB monthly reapplication mailings went out each month in both English and Spanish, as well as three 2017 Open Enrollment letters in both English and Spanish. • 839 active web user accounts 	<ul style="list-style-type: none"> • RWPB monthly reapplication mailings went out each month in both English and Spanish. • 847 active web user accounts 	<ul style="list-style-type: none"> • RWPB monthly reapplication mailings went out each month in both English and Spanish. • 846 active web user accounts
2.1.2.7	HIV Care Program, Care lead agents	Evaluate client eligibility expirations and ART prescriptions during client file reviews.	<ul style="list-style-type: none"> • Number of ongoing lead agency quality assurance reviews • Number of client files reviewed by region and results disseminated/discussed with regional lead agents 	<ul style="list-style-type: none"> • 7 regional lead agency site visits completed • 151 client files reviewed with regional lead agents • Site visits gave IDPH reviewers insight into the work performed by providing input and feedback from staff, MCMs, and clients. During site visit, areas where regions excel and areas for improvement to meet HRSA, IDPH, or Best Practice Standards were discussed as well as changes/projects moving forward. Discussion from the site visit, site monitoring recommendations, findings, information from the medical case management (MCM) meeting and the client meeting, feedback on questions or technical assistance (TA) requested during the site monitoring visit were discussed, and clarification of TA questions and results of visit were disseminated at exit. Other areas, such as training staff and administration, are noted if they exceed the expectations of site monitoring staff. 	<ul style="list-style-type: none"> • 10 site visits conducted • 192 client files reviewed • Improvements, concerns and projects going forward were discussed and agreed upon as required by the National Monitoring Standards (NMS). The provider/sub-grantee will continue to participate in and provide all material necessary to carry out monitoring activities, monitor any service contractors for compliance with federal and programmatic requirements, and improve and establish policies and procedures to ensure compliance with federal and programmatic requirements. 	<ul style="list-style-type: none"> • 9 site visits conducted • 173 client files reviewed • Improvements, concerns and projects going forward are discussed and agreed upon as required by the National Monitoring Standards (NMS). The provider/sub-grantee will continue to participate in and provide all material necessary to carry out monitoring activities, monitor any service contractors for compliance with federal and programmatic requirements, and improve and establish policies and procedures to ensure compliance with federal and programmatic requirements.
2.1.2.8 NEW	HIV Care Program, Care lead agents	Promote telemedicine as an option for Outpatient/Ambulatory Health Services for HIV+ clients, focusing on those regional jurisdictions that have a larger rural coverage area, and incorporate telemedicine into the Ryan White Part B (RWPB) portfolio of approved outpatient ambulatory services.	The RWPB Program will add a required field in the Provide Enterprise® data system to be able to track the type of medical visit, including telemedicine encounter, to determine utilization of telemedicine services. Metric: # telemedicine encounters	• No update – New activity added in 2019.	• No update – New activity added in 2019.	• No update – New activity added in 2019.

2.1.2.9 NEW	HIV Care Program	Implement 1) a Linkage to Care protocol to enroll former clients into ADAP/Care who have been lost to care and are virally unsuppressed and 2) new strategies to increase viral suppression rates for those individuals enrolled into ADAP, but not enrolled in case management who are virally unsuppressed.	<ul style="list-style-type: none"> Number of former clients who are virally unsuppressed and meet specified criteria referred to Minority AIDS Initiative (MAI) grantees for follow-up; of those, the number who successfully enroll in ADAP and Care services. Number of former clients who do not meet MAI criteria referred to Linkage to Care Coordinator; of those, the number who successfully enroll into ADAP and Care services. 	• No update – New activity added in 2019.	• No update – New activity added in 2019.	• No update – New activity added in 2019.
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Strategy 2.1.3 Facilitate continued engagement in HIV medical care for corrections and reentry populations.

2.1.3.1	HIV Care Corrections Program, IDOC	Schedule medical appointments for DOC inmates known HIV-positive 120 days before release and track their attendance.	<ul style="list-style-type: none"> Number of DOC inmates known HIV-positive released; Of those, the number of appointments to medical providers made by DOC; Of those, the number who kept their appointment post-release 	• 140 appointments to medical providers made by DOC	• 164 appointments to medical providers made by DOC	• 169 appointments to medical providers made by DOC
2.1.3.2	HIV Care Corrections Program, IDOC	Transition HIV-positive inmates to a medical provider and a RWPB post-incarceration medical case manager prior to discharge to coordinate medical care upon reentry.	<ul style="list-style-type: none"> Number enrolled in post-incarceration case management Number of recently released positives with at least one medical appointment 	<ul style="list-style-type: none"> 126 enrolled in Corrections CM 117 enrolled in Corrections CM with at least one medical appointment 	<ul style="list-style-type: none"> 61 clients enrolled in Corrections CM 59 clients enrolled in Corrections CM with at least one medical appointment 	<ul style="list-style-type: none"> 197 enrolled in Corrections CM 178 enrolled in Corrections CM with at least one medical appointment

Objective 2.2 By 2021, increase coordination and access to health care and supportive services and programs for PLWH.

Strategy 2.2.1 Increase the use of data to improve HIV health outcomes by expanding data tracking and sharing across programs.

2.2.1.1	HIV Surveillance Program	Conduct monthly queries cross-referencing eHARS cases against recent STI diagnoses to identify SBS case referrals.	<ul style="list-style-type: none"> Number of months in which queries occur Number of HIV-STI co-infected cases identified for SBS 	<ul style="list-style-type: none"> Monthly queries for SBS case referrals were performed for 9 months. 2,015 (non-unique) co-infected cases were identified. 	<ul style="list-style-type: none"> 9 monthly queries for SBS case referrals were performed. 855 unique co-infected cases were identified. 	<ul style="list-style-type: none"> 8 queries for SBS case referrals were performed. 1,575 unique cases for gonorrhea, chlamydia, or syphilis were identified
2.2.1.2	HIV Surveillance Program; HIV Care and STD Programs; RWPB case managers	In coordination with the STD Programs, conduct a monthly cross-match of living eHARS cases with new STI cases and active RWPB clients and refer active RWPB clients with STD co-infection(s) for case management follow-up.	<ul style="list-style-type: none"> Number of HIV/STI cases cross-matched/referred for RWPB case manager follow-up 	<ul style="list-style-type: none"> Anticipated rule change will allow the STD and HIV Programs to routinely match data to determine co-infections. The plan is to update the Provide Enterprise system so that when there are matches of new STI infection with RWPB clients, a referral for follow-up can be sent to case managers. 	<ul style="list-style-type: none"> Rule change allows the STD and HIV Programs to routinely match data to determine co-infections. The plan is to update the Provide Enterprise system so that when there are matches of new STI infection with RWPB clients, a referral for follow-up can be sent to case managers. 	<ul style="list-style-type: none"> Rule change allows the STD and HIV Programs to routinely match data to determine co-infections. Now that there is an updated contract with GTI, the Provide Enterprise system will be updated so that when there are matches of new STI infection with RWPB clients, a referral for follow-up can be sent to case managers.
2.2.1.3	HIV Surveillance Program	In a timely manner, provide lists of HIV-positive individuals identified as belonging to a transmission cluster, to the appropriate HIV Prevention and Care programs.	<ul style="list-style-type: none"> Number of HIV-diagnosed individuals identified as belonging to an emerging transmission cluster who are referred to the appropriate LHD/CBO for network services 	• No report – newly added this year	<ul style="list-style-type: none"> From June 2017 to May 2018, no new HIV transmission clusters met the CDC criteria for recent and rapid transmission of HIV during this period (i.e., cases diagnosed in most recent 3-year period, 0.5% genetic distance, and at least 5 new cases diagnosed in past 12 months). 	No new HIV transmission clusters met the CDC criteria for recent and rapid transmission of HIV during this period (i.e., cases diagnosed in most recent 3-year period, 0.5% genetic distance, and at least 5 new cases diagnosed in past 12 months).

2.2.1.4	HIV Surveillance Program, HIV Prevention Program, IDPH-funded SBS and DIS (disease investigation specialist) providers	Using partner services programs, facilitate cluster investigation and intervention (for persons with newly diagnosed infection and those with previously diagnosed infection) and support HIV care continuum activities.	<ul style="list-style-type: none"> • # clusters identified • # cluster investigations initiated • # cases located • # cluster cases referred • # cases agreed to services • # were already in HIV care • # were engaged into Care • # received a Risk Reduction Intervention • # notifiable partners elicited 	• No report – newly added this year	<ul style="list-style-type: none"> • 1 previously identified cluster • 3 cluster cases referred • 0 cases located 	No new HIV transmission clusters met the CDC criteria for recent and rapid transmission of HIV during this period (i.e., cases diagnosed in most recent 3-year period, 0.5% genetic distance, and at least 5 new cases diagnosed in past 12 months).
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2.2.1.5	HIV Prevention Program, HIV Surveillance Programs, IDPH-funded SBS and DIS (disease investigation specialist) providers Evaluation: Regional HIV Prevention Grant Manager	Improve rates of engagement in medical care for newly diagnosed positives and previously diagnosed positives not in care.	<ul style="list-style-type: none"> • Number of cases assigned • Of cases assigned, % located • Of cases located, % who agree to services • Of cases agreeing to services, % linked to medical care • Of cases agreeing to services, % documented as already in medical care 	<ul style="list-style-type: none"> • 908 SBS cases were assigned compared to 618 assigned in the preceding year. • 37.1% of assigned cases were located compared to 21.2% in the preceding year • 68.2% of located cases agreed to services compared to 52.7% in the preceding year • Of those who agreed to services, 8.7% were successfully linked to medical care with 85.7% identified as already in care. In the preceding year, of those who agreed to services, 8.7% were successfully linked to medical care with 85.5% identified as already in care. 	<ul style="list-style-type: none"> • 1,813 SBS cases were assigned compared to 908 assigned in the preceding year. • 39.1% of assigned cases were located compared to 37.1% in the preceding year • 56.4% of located cases agreed to services compared to 68.2% in the preceding year • Of the number who agreed to services, 22.8% were successfully linked to medical care with 71.2% identified as already in care. In the preceding year, of those who agreed to services, 8.7% were successfully linked to medical care with 85.7% identified as already in care. 	SBS Cases: # of cases assigned: 1,749 # of cases located: 608 (34.7%) # of located cases accepted service: 444 (73.0%) # of cases who accepted service and already in care: 382 (86.0%) # of cases who accepted service and engaged into care: 47 (10.6%)
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Strategy 2.2.2 Increase coordination among public and private providers and organizations providing clinical and supportive services to PLWH.

2.2.2.1	HIV Care Program	Participate in community engagement and HIV planning meetings with entities that foster the goals of coordination, facilitate interagency relationships, and solve regional coordination problems.	<ul style="list-style-type: none"> • Number of community engagement and HIV planning meetings with other entities attended by State HIV Care Program staff 	<p>Numbers of regional meetings and attendees by region:</p> <ul style="list-style-type: none"> • Region 4: 11 QM meetings with ~ 12 attendees; Qtrly advisory board meetings with 10-20 attendees. • Region 5: 11 staff meetings with PD, MCMs, and peer rep; Qtrly advisory board mtgs. With ~ 14 attendees. • Region 6: Qtrly advisory board meetings; Weekly multidisciplinary team meeting with 8-10 MCM • Region 7&8: <ul style="list-style-type: none"> • 3 Collar Counties Advisory Board meetings: 9 -10 attendees • 4 Contract Administrator Meetings: 40-60 attendees • 3 Consumer Advisory Board Meetings: 3-5 attendees • 4 Case Management leadership meetings: 8-15 attendees 	<p>The State participated in meetings of three planning groups this past year:</p> <ul style="list-style-type: none"> • St. Louis Planning Council, part of the Transactional Grant Area (TGA): the RWPB Admin. Attended 10/12 mtgs. in 2017-2018. • CAHISC Planning Council meeting: The RWPB Admin. attended 7/11 council meetings during the 2017-2018 period. The Admin. Participated on the Health Access Subcommittee of this planning body and attended 5 meetings during this reporting period. • The IHIPC quarterly meeting and biannual face-to-face meetings has been fully attended by the RWPB team and administration. • Quarterly ALL Ryan White Cross Parts Meetings. • Statewide Housing Consolidated Planning meeting with the Illinois Housing Development Authority. 	<p>The State participated in meetings of three planning groups this past year:</p> <ul style="list-style-type: none"> • St. Louis Planning Council, part of the Transactional Grant Area (TGA): the RWPB Admin. Attended 10/12 mtgs. in 2018-2019. • CAHISC Planning Council meeting: The RWPB Admin. attended 7/11 council meetings during the 2018-2019 period. The Admin. Participated on the Health Access Subcommittee of this planning body and attended 5 meetings during this reporting period. • The IHIPC quarterly meeting and biannual face-to-face meetings has been fully attended by the RWPB team and administration. • Quarterly ALL Ryan White Cross Parts Meetings. • Statewide Housing Consolidated Planning meeting with the Illinois Housing Development Authority.
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Strategy 2.2.3 Increase the number and diversity of providers of clinical and support services for PLWH in each region throughout the state.

2.2.3.1	HIV Care Program, Care lead agents	Contract with HIV service providers as determined by regional needs assessments.	<ul style="list-style-type: none"> • Number of current contractors • Consolidated list of contractors 	<ul style="list-style-type: none"> • 153 contractors • Please see Attachment 2 for consolidated list of contractors. 	• 104 contractors	• 96 contractors
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Strategy 2.2.4 Increase housing options and other supports for PLWH who have co-occurring conditions and/or difficulty meeting basic needs.

2.2.4.1	HIV Care Housing Program	Provide short-term mortgage, rent, and emergency financial assistance (EFA) to individuals meeting the eligibility threshold.	<ul style="list-style-type: none"> • Number of clients receiving housing and EFA services 	<ul style="list-style-type: none"> • Reported in service utilization table. 	<ul style="list-style-type: none"> • 463 clients receiving housing or EFA 	<ul style="list-style-type: none"> • 456 clients receiving housing or EFA
2.2.4.2	HIV Care Corrections Program , post-incarceration case managers	Assist in locating housing for individuals with limited housing options who are recently released from correctional facilities.	<ul style="list-style-type: none"> • Number of recently released clients receiving assistance in locating housing 	<ul style="list-style-type: none"> • 143 recently released clients received assistance in locating housing 	<ul style="list-style-type: none"> • 139 recently released clients received assistance in locating housing 	<ul style="list-style-type: none"> • 179 recently released clients received assistance in locating housing

GOAL 3: Reduce HIV-Related Disparities and Health Inequities.

Objective 3.1 By 2021, reduce HIV-related disparities in the hardest hit areas and populations.

Strategy 3.1.1 Enhance and expand services to the State's hardest hit and priority populations.

Activity Number	Responsible Parties	Activity Description	Metric	September 2016 - August 2017 Update	July 2017-June 2018 Update	July 2018-June 2019 Update
3.1.1.1	HIV Surveillance Program	Explore community viral load as a comparative measure to target HIV prevention services and reduce HIV-related disparities and compile community viral load data for hardest hit groups within each region.	<ul style="list-style-type: none"> • Community viral load measures by race, transmission category, region 	<p>This is a new measure; the best method to measure community viral load (CVL) has been assessed.</p> <ul style="list-style-type: none"> • Assessment: A limitation of CVL calculated from Surveillance records is that only Diagnosed, In Care Cases can be accurately assessed. Thus eHARS-based CVL predominately measures the efficacy of statewide HIV Treatment management. The Viral Loads of PWH Not in Care will be over 12 months old and those of Undiagnosed PWH cases are unknown. An eHARS-based CVL thus largely excludes the undiagnosed and NIC PWH that Prevention seeks to diagnose/engage. eHARS-based CVL can only measure disparities in the efficacy of HIV Treatment management of currently In-Care HIV Patients. 	<p>The HIV Surveillance program is working with several laboratories that have been non-compliant with reporting requirements to improve the reporting of HIV viral load data.</p> <ul style="list-style-type: none"> • As of February 2018, Individual Unsuppressed Viral Load was added as a criterion for SBS referral. Most of these cases had already been referred based on Newly Diagnosed or Not-in-Care or STI-co-infected status. However, a few new cases were generated by this new query 	<ul style="list-style-type: none"> • The laboratory reporting compliance issues referenced during the previous reporting cycle were resolved in March 2019. • 8 SBS queries were performed to identify virally unsuppressed cases <ul style="list-style-type: none"> - 100% of cases were referred for linkage to care services • Statewide and regional HIV Care Continuums by sex, age, race/ethnicity and risk were developed to identify disparities
3.1.1.2	HIV Integrated Planning Program , Illinois HIV Integrated Planning Council (IHIPC)	Analyzing the linkage between the priority populations and Integrated Plan HIV prevention resources, priorities, & strategies, provide input to the HIV Section to ensure that prevention resources/services are appropriately allocated to the jurisdiction's hardest hit and prioritized populations.	<ul style="list-style-type: none"> • Annual analysis of HIV prevention service delivery data and regional distribution of prevention funding/service scopes. 	<ul style="list-style-type: none"> • At the May 2017 Integrated Planning Group meeting, an analysis of CY2016 Prevention services data and its linkage to the priorities identified in the Integrated Plan was presented. 	<ul style="list-style-type: none"> • At the June 2018 Integrated Planning Group meeting, analyses of FFY 2017 HIV Prevention and Care resource allocation, services data, and their linkage to the priorities identified in the Integrated Plan were presented. 	<ul style="list-style-type: none"> • At the June 2019 Integrated Planning Group meeting, analyses of FFY 2018 HIV Prevention and Care resource allocation, services data, and were presented to the IHIPC for review and discussion to demonstrate their linkage to the priorities identified in the Integrated Plan.

3.1.1.3	Illinois HIV Integrated Planning Group , HIV Integrated Planning Program	Reviewing risk disclosure and seroconversion of recent HIV testing data and other data, make recommendations to IDPH on risk group definitions for the prioritized target populations that maintain or improve the seropositivity rates of clients newly-diagnosed through risk-based testing.	<ul style="list-style-type: none"> Annual analysis of HIV testing data for factors related to increased seropositivity 	<ul style="list-style-type: none"> At the May 2017 Integrated Planning Group meeting, an analysis of CY2015 Prevention testing data and seropositivity of relevant factors was presented prior to the approval of the risk group definitions for 2018. 	<ul style="list-style-type: none"> At the June 2018 Integrated Planning Group meeting, a review of the analysis of CY2015 Prevention testing data, other data sources, and seropositivity of relevant factors was presented prior to approval of the risk group definitions for 2019. No new data analysis was presented. 	<ul style="list-style-type: none"> At the Dec. 2018 Integrated Planning Group meeting, a review of the analysis of HIV Prevention testing data from Jan2016-Oct2018 and seropositivity of relevant factors was presented. This analysis was used by the IHIPC Epi/Needs Assessment Committee to make recommendations on the risk group definitions for 2020, which were approved at the June 2019 IHIPC meeting.
3.1.1.4	HIV Prevention Program ; IDPH-funded prevention lead agencies and regional providers	Fund risk-targeted HIV testing to the highest incidence populations within each region in proportion to their regional incidence, emphasizing populations regionally underserved relative to incidence proportions by other grants.	<ul style="list-style-type: none"> Estimated incidence rates of prioritized populations in final year vs. baseline (dropping toward general population incidence rate) Variance between estimated incidence rates among prioritized populations in final year vs. baseline (disparities among prioritized populations reduced) 	<ul style="list-style-type: none"> In CY16-17, Regional Grants funded risk-targeted HIV testing to the prioritized populations within each region in proportion to their regional HIV incidence using gap analysis to emphasize populations regionally underserved relative to incidence proportions by other grants. 	<ul style="list-style-type: none"> In SFY18, Regional Grants funded risk-targeted HIV testing to the prioritized populations within each region in proportion to their regional HIV incidence using gap analysis to emphasize populations regionally underserved relative to incidence proportions by other grants. 	<ul style="list-style-type: none"> In SFY19, Regional Grants funded risk-targeted HIV testing to the prioritized populations within each region in proportion to their regional HIV incidence using gap analysis to emphasize populations regionally underserved relative to incidence proportions by other grants.
3.1.1.5	HIV Prevention Program , HIV Surveillance Program; IDPH-funded SBS and DIS providers	Conduct surveillance-based services to engage in care PLWH who lack evidence of care within eHARS, Ryan White care management, ADAP, and CHIC.	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> Number of cases assigned Number located Number who agree to services Number already in Care Number linked to medical care 	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> 908 SBS cases were assigned 337 were located 230 accepted services 20 were linked to medical care 	2230 SBS NIC cases were assigned <ul style="list-style-type: none"> 515 were located 273 agreed to services 211 were already in medical care 50 were linked to medical care 88 received medication adherence intervention 	SBS Cases with Not-In-Care Referral Type assigned to an agency <ul style="list-style-type: none"> # of cases assigned: 1227 # of cases located: 351 # of cases accepted service: 242 # of cases already in care: 216 # of cases engaged into care: 18 # of cases accessed a medication adherence intervention: 86
3.1.1.6	Minority AIDS Initiative Program	Increase enrollment in MAP through targeted outreach to identify HIV-positive minority populations.	<ul style="list-style-type: none"> Number of individuals enrolled in MAP through the Minority AIDS Initiative Program 	<ul style="list-style-type: none"> 238 enrolled in MAP by MAI provider 	<ul style="list-style-type: none"> 237 clients enrolled in MAP by MAI provider 	<ul style="list-style-type: none"> 172 clients enrolled in MAP by MAI provider
3.1.1.7	Minority AIDS Initiative Program	Conduct education and outreach to identify high risk HIV minority individuals not enrolled in MAP.	<ul style="list-style-type: none"> Number of outreach sessions conducted for minority populations 	<ul style="list-style-type: none"> 548 outreach events conducted 23,683 total participants. Participants include duplication among outreach events. 	<ul style="list-style-type: none"> 101 outreach events conducted 31,178 participants. Participants include duplication among outreach events. 	<ul style="list-style-type: none"> 232 outreach events conducted 26,569 participants. Participants include duplication amount outreach events.

Strategy 3.1.2 Enhance retention in care initiatives for the groups in the state with the lowest rates of viral suppression.

3.1.2.1	HIV Care Program , contracted providers	Develop, initiate, and follow up with RW Part B Program quality improvement initiatives to improve the rate of viral suppression in the state.	<ul style="list-style-type: none"> • Viral Load Summary Reports for clients actively enrolled in RW case management, documenting undetectable viral loads, broken down by case manager • Quality Improvement Reports following viral load suppression QI initiatives 	<ul style="list-style-type: none"> • Reports were made available for case managers to generate lists of clients/history of viral load results. These are then discussed at 6-month eligibility assessment during completion of Care Plan. • Client mental health report for 6/30/16 to 3/31/17 was run, then at the end of each month for each of the 8 Illinois service regions. Involvement by all grantees, aided by guidance/tools developed by the IDPH RWPB program was exemplary. The Illinois QMC plans to continue many processes in this initiative to positively impact client care, incl. use of modern education methods, technology and social media to increase awareness of viral suppression among PLWH in Illinois. Overall awareness of the importance of medical compliance to the point of clients becoming virally undetectable has clearly improved the level of follow-up and communication and will likely improve the health of Illinois RWHAB clients. 	<ul style="list-style-type: none"> • Reports were made available for case managers to generate lists of clients/history of viral load results. These are then discussed at 6-month eligibility assessment during completion of Care Plan. • Client mental health report for 6/30/17 to 3/31/18 was run, then at the end of each month for each of the 8 Illinois service regions. Involvement by all grantees, aided by guidance/tools developed by the IDPH RWPB program was exemplary. The Illinois QMC plans to continue many processes in this initiative to positively impact client care, incl. use of modern education methods, technology and social media to increase awareness of viral suppression among PLWH in Illinois. Overall awareness of the importance of medical compliance to the point of clients becoming virally undetectable has clearly improved the level of follow-up and communication and will likely improve the health of Illinois RWHAB clients. 	<ul style="list-style-type: none"> • Reports were made available for case managers to generate lists of clients/history of viral load results. These are then discussed at 6-month eligibility assessment during completion of Care Plan. • Service standards and program manuals were updated to focus on viral suppression as ultimate goal. • Performance measures were developed based on HRSA recommendations and are reviewed on a quarterly basis to analyze state and regional progress and improvement. Each service category contains a goal for viral suppression that will be closely monitored.
3.1.2.2	HIV Care Program , contracted providers	Review and address client viral load results at each eligibility assessment.	<ul style="list-style-type: none"> • Number of individuals with a completed Care Plan 	<ul style="list-style-type: none"> • 6,263 individuals with a completed Care Plan during this time frame • A Care Plan is required at each 6-month eligibility assessment, where case managers review and address lab results, including client viral load and suppression. If client is not virally suppressed, case manager provides narrative in the Care Plan with steps to take to address detectable viral load. 	<ul style="list-style-type: none"> • 6,505 individuals with a completed Care Plan during this time frame. • A Care Plan is required at each 6-month eligibility assessment, where case managers review and address lab results, including client viral load and suppression. If client is not virally suppressed, case manager provides narrative in the Care Plan with steps to be taken to address the detectable viral load. 	<ul style="list-style-type: none"> • 6,799 individuals with a completed Care Plan during this time frame. • A Care Plan is required at each 6-month eligibility assessment, where case managers review and address lab results, including client viral load and suppression. If client is not virally suppressed, case manager provides narrative in the Care Plan with steps to be taken to address the detectable viral load.
3.1.2.3	HIV Prevention Program , HIV Surveillance Program; IDPH-funded SBS and DIS providers	Conduct surveillance-based services (SBS) to engage PLWH with unsuppressed viral load in HIV medical care.	SBS Cases closed during period with a referral type including “Unsuppressed Viral Load.” <ul style="list-style-type: none"> • Number of cases assigned • Number located • Number who agree to service • Number already in care • Number linked to medical care • Number elicited for partners • Number of notifiable partners named • Number who receive risk reduction counseling 	<ul style="list-style-type: none"> • Referrals of cases with unsuppressed VL have been prioritized for PS18-1802 implementation. • An eHARS query has been developed. SBS Case Referrals with this referral type may begin when Provide can be programmed to accept and correctly label this referral type. 	<ul style="list-style-type: none"> • 85 cases assigned • 51 cases located • 42 cases agree to service • 34 cases already in care • 8 cases engaged in medical care • 34 cases elicited for partners • 2 notifiable partners named • 6 received risk reduction counseling 	Unsuppressed VL SBS Cases closed in this period: <ul style="list-style-type: none"> # of cases assigned: 313 # of cases located: 112 # of cases accepted service: 94 # of cases already in care: 77 # of cases engaged into care: 14 # of cases asked about partners: 74 # of potentially notifiable partners named: 11 # of cases accessed a risk reduction intervention: 39
3.1.2.4	HIV Care Program	Using retention specialists, retain and/or re-engage in HIV medical care PLWH who have missed appointments or fallen out of care.	<ul style="list-style-type: none"> • TBD by DSU 	<ul style="list-style-type: none"> • Still under construction (See narrative in 2.1.2) 	<ul style="list-style-type: none"> • Still under construction (See narrative in 2.1.2) 	<ul style="list-style-type: none"> • Still under construction (See narrative in 2.1.2)

Strategy 3.1.3 Focus resources on effective, evidence-based strategies, services, and policies that address health disparities and social determinants of health that impact risk for HIV and utilization/access to care.

3.1.3.1	HIV Integrated Planning Program , HIV Prevention Program, Illinois HIV Integrated Planning Group	Review updated CDC guidance, IDPH approved prevention strategies and interventions, and information on best practices, and make recommendations on updates to the Interventions and Services Guidance, including new strategies, interventions, and approaches that address social and structural factors that influence health disparities.	<ul style="list-style-type: none"> • Annual guidance for approved HIV prevention (for positives and negatives) interventions and strategies • Annual analysis of types of prevention services provided in past year 	<ul style="list-style-type: none"> • The ILHPC Interventions and Services Committee reviewed updated CDC Guidance on approved prevention services and interventions and through multiple months of committee discussion and after vote of the full ILHPC, finalized the 2018 Interventions and Services Recommendations and Guidance in August 2017. 	<ul style="list-style-type: none"> • At the June 2018 IHPC meeting, analyses of FFY 2017 HIV prevention services provided by type and region were presented. • The IHPC LTC, RRC, ART, & VS and Primary Prevention Committees researched/reviewed updated CDC Guidance on approved HIV prevention services. Through months of committee discussion, editing, and after vote of the full IHPC, the preliminary draft 2019 Interventions and Services Guidance recommendations were approved in June 2018. The draft remains in Committees at this time for further review and editing. 	<ul style="list-style-type: none"> • At the June 2019 IHPC meeting, analyses of FFY 2018 HIV prevention services provided by type and region were presented. • The IHPC LTC, RRC, ART, & VS and Primary Prevention Committees researched/reviewed updated CDC Guidance on approved HIV prevention services. Through months of committee discussion, editing, and after vote of the full IHPC, preliminary draft recommended changes to the Interventions and Services Guidance for 2020 were presented at the June 2019 IHPC meeting. • The draft remains in Committees for further edits and will be presented to the IHPC for approval at the October meeting.
3.1.3.2	HIV Integrated Planning Program , Illinois HIV Integrated Planning Group Epidemiology/Needs Assessment Committee; HIV Section	Conduct root cause analyses for special populations in which continued inequalities and disparities in PrEP utilization, linkage to care, and viral suppression have been identified in Illinois through measurement of NHAS Indicators; Present results of the root cause analyses to the IHPC and community stakeholders and solicit tangible recommendations on how to address factors identified as influencing the continued disparities.	<ul style="list-style-type: none"> • Results of root cause analyses; • Compiled recommendations to address factors influencing the continued disparities among special populations. 	<ul style="list-style-type: none"> • No update – New activity added in 2019. 	<ul style="list-style-type: none"> • No update – New activity added in 2019. 	The Integrated Planning Program and the IHPC Health Disparities Project Workgroup completed root cause analyses of 3 identified disparities/inequities along the HIV Care Continuum: linkage to care of youth, PrEP utilization and viral suppression among Blacks. The results of the analyses were first presented to the IHPC at its April 2019 meeting, then used to conduct a needs assessment activity involving the full group at its June 2019 meeting.
3.1.3.3	HIV Prevention Program	Provide condoms to individuals at high risk of HIV transmission or acquisition.	<ul style="list-style-type: none"> • Number of risk reduction supplies delivered in prevention sessions documented in Provide 	<ul style="list-style-type: none"> • The following supplies were distributed in calendar year 2017: <ul style="list-style-type: none"> ♦ Latex condoms – 39,000 	<ul style="list-style-type: none"> • The following supplies were distributed in calendar year 2018: <ul style="list-style-type: none"> ♦ Latex condoms – 641,900 	The following supplies documented in prevention sessions in Provide were distributed in CY 2019: Insertive condoms – 140,758 Receptive condoms – 36,705 Oral condoms – 23,271 Lubricant – 122,647
3.1.3.4	HIV Prevention Program	Distribute condoms and lubes to high-risk gathering sites, making them accessible to individuals at high risk of HIV transmission or acquisition.	<ul style="list-style-type: none"> • Number of risk reduction supplies shipped to non-grantee sites requesting condoms, where at least 25% were estimated to be accessed by prioritized populations 	The following risk reduction supplies were distributed to non-grantee sites in this period: <ul style="list-style-type: none"> • FC2 condoms – 5,000 • Lubes – 14,000 	The following risk reduction supplies were distributed to non-grantee sites in this period: <ul style="list-style-type: none"> • FC2 condoms – 34,000 • Lubes – 474,000 	The following risk reduction supplies were distributed to non-grantee sites in this period: Regular condoms: 874,000; XL condoms: 250,000; Lubricant: 433,000; FC2: 28,000

3.1.3.5	HIV Training Program	Provide cultural competency awareness trainings to IDPH-funded HIV grantees/service providers.	<ul style="list-style-type: none"> • Number of trainings provided • Number of participants who attended the trainings 	<ul style="list-style-type: none"> • IDPH did not provide any cultural competency courses in this period. 	<ul style="list-style-type: none"> • IDPH contracted with MATEC to provide 3 LGBTQ cultural competency trainings in this period, 2 downstate. • Cultural competency training is also offered as part of the STD counselor training. 	IDPH did not provide specific cultural competency trainings during this period. Cultural competency training is offered as part of the STD counselor training. MATEC provided "Black MSM: Cultural Considerations for Getting to Zero" training in Chicago and in Springfield during this period. Several of our funded grantees attended.
3.1.3.6 NEW	HIV Integrated Planning Program , Illinois HIV Integrated Planning Group	Conduct a series of interactive discussions at IHIPC in-person meetings, each focusing on an issue under one of the domain areas of the GTZ Plan. There will be a 15 min. overview of the issue(s), current research, impact on GTZ, etc., followed by a 45-min. facilitated interactive group discussion on strategies to address the domain area.	<ul style="list-style-type: none"> • Number of interactive discussions of issues under one of the GTZ-IL domain areas 	No update - New activity added in 2019	No update - New activity added in 2019	No update - New activity added in 2019

Objective 3.2 By 2021, reduce HIV stigma and discrimination.

Strategy 3.2.1 Enhance the delivery of evidence-based public health approaches to HIV prevention and care.

3.2.1.1	HIV Prevention Program ; Regional lead agencies, Prevention grantees Evaluation: HIV Data Team	Increase the proportion of IDPH-funded risk reduction services provided to HIV positives demonstrated to be behavioral- and cost-effective.	<ul style="list-style-type: none"> • Proportion of behavioral- & cost-effective risk reduction sessions delivered to HIV positives • Measure: # CDC Supported EBI sessions/All RRA Sessions • CDC-supported EBIs4Pos = CLEAR, Connect, d-UP-Group, Harm Reduction Counseling, HealthyRel, HEART, MMMV, MPowerment-MGroups, PartnershipForHealth, Promise-Group, POL-Group, Safe In the City, Sister to Sister, START, SmartCOUPLES, Voices/Voces, Willow) • Baseline Provider Types = AAARA, CAPUS, CatC, CGF, Direct, QOL, RIG • SFY2018 Provider Types = AAARA, QOL, RIG • Positive Baseline: 9/2015-8/2016 	Positive Comparison: 9/2016-8/2017 <u>1,185 EBI Sessions</u> =47% 2,519	Ratio for RRA for PLWH: 7/2017-6/2018 <u>1,970</u> = 71.2% 2,766	Ratio for RRA for PLWH: 7/2018-6/2019 <u>2,454</u> = 51% 4,974
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3.2.1.2	<p>HIV Prevention Program; Regional lead agencies, Prevention grantees</p> <p>Evaluation: HIV Data Team</p>	<p>Increase the proportion of IDPH-funded risk reduction services provided to high risk HIV-negatives demonstrated to be behavioral- and cost-effective.</p>	<ul style="list-style-type: none"> • Proportion of behavioral- & cost-effective risk reduction session delivered to HR negatives • Measure: # CDC Supported EBI sessions/All RRA Sessions • CDC-supported EBIs4Neg = Connect, d-UP-Group, Harm Reduction Counseling, MMMV, MPowerment-MGroups, Promise-Group, POL-Group, Safe In the City, Sister to Sister, Voices/Voces,) • Baseline Provider Types = AAARA, CatC, CAPUS, CGF, Direct, QOL, RIG • SFY2018 Provider Types = AAARA, QOL, RIG <p>HR Negative Baseline: 9/2015-8/2016 <u>86</u> = 2% 4,489</p>	<p>HR Negative Comparison: 9/2016-8/2017</p> <p><u>1582 EBI Sessions</u> =55% 2,885</p>	<p>Ratio for RRA for HR Negatives: 7/2017-6/2018</p> <p><u>2309</u> = 79% 2,915</p>	<p>Ratio for RRA for HR Negatives: 7/2018-6/2019</p> <p><u>2,337</u> = 90% 2,607</p>
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3.2.1.3	<p>HIV Prevention Program; Routine Testing Agencies, Prevention grantees/agencies conducting HIV testing, community-based healthcare organizations, any healthcare provider</p>	<p>Promote awareness of the POP Anti-Stigma medical provider campaign.</p>	<ul style="list-style-type: none"> • Number of packets or marketing or training materials requested by mail • Training and marketing materials downloaded from website • Number of providers requesting technical assistance or training on the materials • Number of hits to the websites • Number of agencies reporting sharing or resources or materials or requesting additional resources to implement the POP campaign. 	<ul style="list-style-type: none"> • 3000 patient brochures- English, 800 patient brochures- Spanish, 800 provider brochures, 100 ambassador posters (18x24), 40 routine HIV screening poster (8x10) English, 20 routine HIV screening poster (18x24) English, 40 affirming healthcare poster (8x10) English, 20 affirming healthcare poster (18x24) English, 400 POP buttons, 400 POP stickers, 40 routine HIV screening posters (8x10) Spanish, 40 affirming healthcare posters (8x10) Spanish • All training/marketing materials are sent directly to sites. See number 1 for details. However, 110 people downloaded pictures of themselves in capes taking hero pictures at POP-UP events. • 6 champions trained, 4 site visits conducted, 4 champion technical assistance calls. 4 individualized technical assistance sessions • PHIMC Homepage 2017 Views: 4,021, POP Page 2017 Views: 235 • 330 people reached through face-to-face engagement, 98 people signed up to stay connected to the campaign, 11 presentations to potential new partners, 5 presentations at meetings and conferences with statewide and national reach 	<p>From July 2017-Dec. 2017:</p> <ul style="list-style-type: none"> • Finalized new POP materials for IDPH approval and printing (incl. posters, postcards, and one-pager) • Resumed work on POP videos • Scheduled POP UPs at POP clinics for fourth quarter • Resumed work on POP (after budget impasse) material development and has been able to continue work on POP videos, campaign language, POP Leadership training, POP website, and has finalized new print materials. • All intervention modules were completed at all POP clinics, allowing for full evaluation to be accomplished. The evaluation demonstrated strong efficacy of the POP Campaign to reduce provider-level stigmas towards LGBTQ individuals of color, to increase readiness to screen for HIV, and high intent to use POP in practice. • POP-UPs and outreach efforts yielded new sites. • POP Champions participated in building the POP Champion Forum on the password-protected site. • POP materials remained displayed in clinics to reinforce provider engagement of patients in routine HIV screening. • Over 100 healthcare team members participated in POP over two years; a pilot evaluation demonstrated that the campaign showed efficacy for reducing provider-level stigma toward LGBTQ individuals of color and readiness to routinely screen for HIV. • Evaluators found the mean/mode scores on scaled items for both pilot yrs. to be over 3 on a 4- point scale. 	<ul style="list-style-type: none"> • Activity completed
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Strategy 3.2.2 Mobilize communities and support policies and programs that reduce HIV-related stigma, discrimination, homophobia, and racism.

3.2.2.1	<p>HIV Training Program, IDPH Prevention Program, RW Part B Program, Care grantees</p>	<p>Train staff from IDPH-funded HIV care and prevention grantee/provider agencies on using cultural competency to engage Black and Latino MSM and TSM in HIV services.</p>	<ul style="list-style-type: none"> • Number of trainings provided • Number completing trainings • Pre- vs. post-training evaluations of trainees' changes in cultural competence concepts, knowledge, attitudes, and engagement self-efficacy 	<ul style="list-style-type: none"> • IDPH and CDPH offered two Culturally Appropriate PrEP Services for Black MSM courses in April 2017. 	<ul style="list-style-type: none"> • No trainings provided during this period. 	<p>MATEC provided "Black MSM: Cultural Considerations for Getting to Zero" training in Chicago and in Springfield during this period. Several of our funded grantees attended.</p>
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3.2.2.2	<p>HIV Prevention Program, routine testing lead agencies, routine clinical and clerical staff and site champions</p> <p>Evaluation: Routine Screening Grant Manager</p>	To reduce the expression of homophobic and transphobic stigma toward black and Latino MSM and transgender individuals, train routine HIV screening providers using the POP materials.	<ul style="list-style-type: none"> • Pre- vs. post-training evaluations of providers' changes in knowledge and perceptions • Client satisfaction surveys including indices/measures of change within the clinic environment (safe space), perception of medical providers' interactions with clients • Quarterly reports 	<ul style="list-style-type: none"> • PHIMC is still in process of collecting evaluation data for the 2017 cycle as module implementation has just ended in late October 2017. PHIMC estimates nearly 110 healthcare teams have participated in the POP modules. • PHIMC does not collect client data as this requires internal review board processes, which are too cumbersome at this point. As part of their long-term evaluation plan, they will begin to collect client-level data in the near future. During the 2016 pilot, PHIMC focused on the experience of champions. This year, PHIMC is focusing on the experience of participant's healthcare teams. 	<ul style="list-style-type: none"> • The POP campaign was reinstated in the third quarter of 2017 after a suspension of activities due to the state budget impasse. • PHIMC completed a full evaluation of POP (Protecting our Patients) and was able to determine that the POP campaign reduced provider-level stigmas towards LGBTQ individuals of color and increased readiness to screen for HIV, and a high intent to use POP content in practice. • The completed evaluation of the program indicated that participants felt an increase in knowledge, a shift in attitudes, and they were inspired to behave in ways to reduce interpersonal and organizational stigma. 	<ul style="list-style-type: none"> • Activity completed
3.2.2.3	HIV Care Corrections Program	Provide peer to peer HIV, STI, and HCV education and training within correctional facilities statewide.	<ul style="list-style-type: none"> • Number of education sessions conducted • Number of participants engaged in educational activities • Number of Peer Educators certified to be trainers within the facilities 	<ul style="list-style-type: none"> • 27 educational sessions conducted • 112 participants • 124 certified peer educators 	<ul style="list-style-type: none"> • 25 peer to peer educational sessions conducted in correctional facilities • 97 participants • 152 certified correctional peer educators 	<ul style="list-style-type: none"> • 26 peer to peer educational sessions conducted in correctional facilities • 752 participants • 119 certified correctional peer educators
3.2.2.4	HIV Care Corrections Program	Provide HIV/HCV test kits for Summit of Hope events and HIV 101 training to IDOC medical staff.	<ul style="list-style-type: none"> • Number of medical providers who completed training • Number of test kits provided 	<ul style="list-style-type: none"> • 29 medical providers • 4,850 test kits provided 	<ul style="list-style-type: none"> • 80 medical providers • 6,023 test kits provided 	<ul style="list-style-type: none"> • 173 medical providers • 6,300 test kits provided
3.2.2.5	HIV Care Program, MATEC	Provide educational trainings on HIV/AIDS advancements in treatment, prevention, care, and stigma reduction to HIV providers and other stakeholders statewide.	<ul style="list-style-type: none"> • Number of trainings provided • Number of participants • Evaluation outcomes 	<ul style="list-style-type: none"> • 14 trainings on the following topics: <ul style="list-style-type: none"> ♦ 4 Medical Case Management Trainings ♦ 2 Cultural Competency Trainings ♦ 4 PrEP Trainings ♦ Insurance 101 ♦ Ryan White Eligibility pillars and Assessment ♦ Total of 325 attendees • Assessments were all in that satisfied and very satisfied area. 	<ul style="list-style-type: none"> • 17 trainings on the following topics: <ul style="list-style-type: none"> ♦ 2 Medical Case Management Trainings ♦ 3 Collecting Sexual Health History ♦ 2 Cultural Competency Trainings ♦ 5 PrEP Trainings ♦ 4 Marketplace Enrollment Process ♦ Insurance 101 ♦ Total of 486 attendees • Assessments were all in that satisfied and very satisfied area. 	<ul style="list-style-type: none"> • 36 trainings on the following topics: <ul style="list-style-type: none"> • <input checked="" type="checkbox"/> Surveillance Based Partner Services • <input checked="" type="checkbox"/> Motivational Interviewing • <input checked="" type="checkbox"/> Risk Targeted Testing • <input checked="" type="checkbox"/> ARTAS courses • <input checked="" type="checkbox"/> MCM 1-day Refresher • <input checked="" type="checkbox"/> full MCM training or webinar for case managers on Assessment • <input checked="" type="checkbox"/> MCM Insurance 101 Webinar • <input checked="" type="checkbox"/> MCM Eligibility Assessment Webinar • <input checked="" type="checkbox"/> PrEP Webinar-Consumers • <input checked="" type="checkbox"/> PrEP Webinar-MCM • <input checked="" type="checkbox"/> Income 101 Webinar • <input checked="" type="checkbox"/> Southland HIV Programs (Case-based clinical management seminars for HIV Professionals) • <input checked="" type="checkbox"/> Clinical management seminars for HIV professionals • <input checked="" type="checkbox"/> Eligibility Assessment Webinar • <input checked="" type="checkbox"/> Foundations of HIV Prevention • <input checked="" type="checkbox"/> Sex and Drug Use History Taking • Total Number of Attendees: N/A • Assessments were all in the satisfied and very satisfied area.

3.2.2.6	HIV Integrated Planning Program; HIV Section	Explore the possibility of conducting Undoing Racism training in downstate Illinois by contacting jurisdictions that have implemented the training to discuss their experience; discuss the possibility of acquiring funding support for the trainings from the Regional HHS Office; planning the trainings; and conducting them.	<ul style="list-style-type: none"> • Jurisdictions contacted • Funding support acquired • Trainings planned • Trainings conducted 	• No update – New activity added in 2019.	• No update – New activity added in 2019.	Beginning in Jan 2019, the Integrated Planning and Training Programs and the HIV Section Assist. Chief held meetings with PISAB (the organization that conducts these trainings) and several other entities that had brought the trainings to their jurisdictions or agencies. Funding to support the conduct of 5 trainings in downstate IL was obtained from the Regional HRSA Office and the IDPH grant with MATEC. <ul style="list-style-type: none"> • Invite lists for the regional workshops were compiled and email distribution groups were established. • The 5 workshops have been scheduled and are planned to be conducted Aug-Sept 2019.
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Strategy 3.2.3 Promote community engagement, participation in HIV planning, education, and leadership for Planning Group members and community stakeholders, particularly priority pop. representatives.

3.2.3.1	HIV Integrated Planning Program	To enhance their professional/leadership development, support the participation of the IHIPC Community Co-chair or Co-chair Elect in the CDC National HIV Prevention Conference, HIV Prevention Leadership Summit, United States Conference on AIDS, National African American MSM Leadership Conference on HIV/AIDS and Other Health Disparities, or other approved conference.	Attendance at a national-level conference of relevance to HIV planning	IDPH supported the attendance of two ILHPG members – the Co-chair Elect and a RW case manager representative at the 2017 US Conference on AIDS in September 2016.	The IDPH and Community Co-chairs of the Illinois HIV Integrated Planning Council (IHIPC) were accepted, through a competitive application, to be one of 12 jurisdictions nationwide to represent their integrated planning bodies and participate in a series of Establishing Synergy for Integrated Planning Leadership meetings to be held in October 2018 and March 2019.	The IDPH and Community Co-chairs of the Illinois HIV Integrated Planning Council (IHIPC) participated in a series of two Establishing Synergy for Integrated Planning Leadership meetings held in October 2018 and March 2019.
3.2.3.2	HIV Integrated Planning Program	To promote the professional development of IHIPC membership, PLWH, and other HIV community stakeholders, develop/maintain the IHIPC website and web-streaming all Integrated Planning Group meetings and webinars.	• Meeting attendance rosters and materials for webinar, in-person meetings, and recorded meetings	• In this period, 3 trainings, 7 webinars, and 3 face-to-face meetings of the ILHPG and the Integrated Planning Group were web-streamed, recorded, and archived on the ILHPG website, including meeting materials, attendance/voting logs, minutes, and evaluations.	• In this period, 4 trainings, 4 webinars, 2 2-day and 1 1-day face-to-face meetings of the HPG were web-streamed, recorded, and archived on the IDPH and HPG websites, including meeting materials, attendance/voting logs, minutes, and evaluations.	• In this period, 4 trainings, 4 webinars, 2 two-day in-person meetings of the HPG were web-streamed, recorded, and archived on the IDPH and HPG websites, including meeting materials, attendance/voting logs, minutes, and evaluations.
3.2.3.3	HIV Integrated Planning Program	Develop/publish a quarterly HPG newsletter to educate and promote professional development of HPG members, PLWH, and other HIV community stakeholders in integrated HIV planning.	• Publication of Integrated Planning Group Newsletter Quarterly newsletters	• In this period, 4 issues of the quarterly ILHPG/Integrated Planning Group Newsletter were published and posted on the IDPH and ILHPG websites.	• In this period, 4 issues of the quarterly Integrated Planning Group Newsletter were published and posted on the IDPH and Integrated Planning Group websites.	• In this period, 4 issues of the quarterly Integrated Planning Group Newsletter were published and posted on the Integrated Planning Group webpage on the IDPH website.

3.2.3.4	HIV Integrated Planning Program	Educate IHIPC members and community stakeholders on the opioid epidemic in Illinois, inviting community and provider input.	<ul style="list-style-type: none"> • Meeting documents and minutes • New member orientation curriculum 	• No update – New activity added in 2018.	<ul style="list-style-type: none"> • At the 4/19/18 IHIPC meeting, there were presentations/discussions on 2 Illinois opioid epidemic topics: <ul style="list-style-type: none"> ♦ IDPH Strategic Health Initiatives Addressing the Opioid Crisis, and ♦ Illinois’ Opioid State Targeted Response Grant Activities 	•The IL Dept of Human Services Substance Use Prevention and Recovery Division liaison to the IHIPC provided updates on the State's Opioid Response Plan at the Oct 2018 and June 2019 IHIPC meetings.
3.2.3.5	HIV Integrated Planning Program	Engage representative(s) of the PWID community who can participate in committee/IHIPC meetings and speak to the opioid epidemic in Illinois communities, as voting members on the IHIPC.	<ul style="list-style-type: none"> • Annual Integrated Planning Group New Membership Gap Analysis • New membership selection documentation, • Membership roster and spreadsheets 	• No update – New activity added in 2018.	• In the IHIPC membership gap analysis for 2019, the current number of members representing PWID (3) was determined to be sufficient and in accordance with the HIV epi for that risk population.	• In the IHIPC membership gap analysis for 2020, the current number of members representing PWID (2) was determined to be an under-representation of the needs based on the HIV epi for that risk population. Because we are not un-represented by PWID and because there is a greater gap in Black MSM on the IHIPC, PWID will not be a high priority for recruitment for 2020.
3.2.3.6	HIV Integrated Planning Program	Inform, educate, invite input, and hear concerns from IHIPC members and community stakeholders on the HIV cluster detection and response plan.	• IHIPC meeting agendas and minutes	• No update – New activity added in 2019.	• No update – New activity added in 2019.	<ul style="list-style-type: none"> • The HIV Surveillance and Prevention Programs presented the State's HIV Cluster Detection and Response Plan to the IHIPC at its June 2019 meeting. • Questions were answered and feedback was obtained. The Programs will be scheduling a conference call with the IHIPC, interested community guests, and a legal representative in the Fall of 2019 to answer additional concerns about liability proposed by the community.
3.2.3.7	HIV Care Program; Community Health Workers	Promote PLWH enrollment in Community Health Worker Associate Degree Programs.	<ul style="list-style-type: none"> • Program enrollment of PLWH in CHW degree programs • Successful completion of degree program by participants 	• The RWPB Program, in partnership with IPHA through a CAPUS initiative, enrolled and provided educational support for HIV+ peers in Community Health Worker (CHW) certification courses for formal training and credentialing. 12 of the original cohort of 19 successfully completed this program.	• This project was concluded in federal fiscal year 2016, and not continued in federal fiscal year 2017.	• Activity completed
3.2.3.8	HIV Care Program: Regional care lead agencies; Peer navigators	Sustain RWPB Program HIV peer navigator positions within each RWPB region.	• Number of peer navigators by region	<ul style="list-style-type: none"> • Region 1 – None • Region 2 – 1 Peer Navigator • Region 3 – None • Region 4 – 1 Peer Navigator • Region 5 – 2 Peer Navigators • Region 6 – 2 Peer Navigators • Region 7 – 1 Peer Navigator • Region 8 – 1 Peer Navigator 	<ul style="list-style-type: none"> • Region 1 – None • Region 2 – 1 Peer Navigator • Region 3 – None • Region 4 – 1 Peer Navigator • Region 5 – 2 Peer Navigators • Region 6 – 2 Peer Navigators • Region 7 – 1 Peer Navigator • Region 8 – 1 Peer Navigator 	<ul style="list-style-type: none"> • Region 1 – None • Region 2 – 2 Peer Navigators • Region 3 – 1 Peer Navigator • Region 4 – 1 Peer Navigator • Region 5 – 2 Peer Navigators • Region 6 – 3 Peer Navigators • Region 7 – 1 Peer Navigator • Region 8 – 1 Peer Navigator
3.2.3.9	HIV Care Program; Regional care lead agencies; Client representatives	Sustain RWPB Program HIV client representative positions within each RWPB region.	• Number of client representatives by region	10 RWPB Client Representatives: <ul style="list-style-type: none"> • Region 1 – 1 Client Rep • Region 2 – 2 Client Reps • Region 3 – 1 Client Rep • Region 4 – 2 Client Reps • Region 5 – 1 Client Rep • Region 6 – 1 Client Rep • Region 7 – 1 Client Rep • Region 8 – 1 Client Rep 	10 RWPB Client Representatives: <ul style="list-style-type: none"> • Region 1 – 1 Client Rep • Region 2 – 2 Client Reps • Region 3 – 1 Client Rep • Region 4 – 2 Client Reps • Region 5 – 1 Client Rep • Region 6 – 1 Client Rep • Region 7 – 1 Client Rep • Region 8 – 1 Client Rep 	10 RWPB Client Representatives: <ul style="list-style-type: none"> • Region 1 – 1 Client Rep • Region 2 – 1 Client Rep • Region 3 – 1 Client Rep • Region 4 – 2 Client Reps • Region 5 – 1 Client Rep • Region 6 – 1 Client Rep • Region 7 – 1 Client Rep • Region 8 – 1 Client Rep

3.2.3.10	HIV Care Program; IDOC, Corrections peer educators	Sustain the number of people trained as peer educators within IDOC facilities.	• Number of correctional peer educators	• 124 certified peer educators	• 152 certified peer educators	• 119 certified peer educators
3.2.3.11	NEW HIV Prevention Program Evaluation: HIV Data Administrator; HIV Prevention Grant Managers	Increase the diversity of the HIV Prevention workforce to more closely mirror IL HIV Incidence proportion for: • Black and Hispanic Gay or bisexual MSM • Young adults 18-24 y.o.	Query unduplicated list of all staff who conducted at least 1 risk-targeted intervention (Any kind of Test or RRA, excluding Routine testing) during report period, including first & last name, agency and region into a spreadsheet. Grant Managers & Lead Agents will add race, ethnicity, age and prioritized population peer status where known.	12.9% (26/202) of the CY2017 HIV Prevention Unit's Grantee Workforce had a Risk Group Affiliation of Black MSM or Latino MSM.	12.3% (26/211) of the CY2018 HIV Prevention Unit's Grantee Workforce had a Risk Group Affiliation of Black MSM or Latino MSM.	15.2% (32/210) of the CY2019 HIV Prevention Unit's Grantee Workforce had a Risk Group Affiliation of Black MSM or Latino MSM.
3.2.3.12	NEW HIV Integrated Planning Program	Include a leadership development day in the first in-person IHIPC meeting of each year.	Leadership development day included on annual IHIPC meeting calendar	• No update – New activity added in 2019.	• No update – New activity added in 2019.	• No update – New activity added in 2019.

GOAL 4: Achieve a More Coordinated Response to the HIV epidemic in Illinois.

Objective 4.1 By 2021, increase coordination across IDPH HIV programs and across other state and local service provider agencies, monitoring the appropriate use of IDPH program funds.

Strategy 4.1.1 Streamline data collection and reporting requirements for IDPH-issued grants.

Activity Number	Responsible Parties	Activity Description	Metric	September 2016 - August 2017 Update	July 2017-June 2018 Update	July 2018-June 2019 Update
4.1.1.1	HIV Care Program, Ryan White Part B Program grantees, GTI	Require providers to submit standardized quarterly reports and to use a standardized grants management data system for reporting of client-level, service-level, and contracts/grant management data.	• Provider grant agreements/budgets • Provider quarterly reports • Client and service utilization data	• RWPB grantees enter/maintain required client-level, service utilization, and contract management data in the Provide Enterprise system. Grantees submit budgets, quarterly reports, final progress reports, and other required reports, using the specified formats, via Provide Enterprise. Requirements are outlined in RWPB grant agreements.	• RWPB grantees enter/maintain required client-level, service utilization, and contract management data in the Provide Enterprise system. Grantees submit budgets, quarterly reports, final progress reports, and other required reports, using the specified formats, via Provide Enterprise. Requirements are outlined in RWPB grant agreements.	• RWPB grantees enter/maintain required client-level, service utilization, and contract management data in the Provide Enterprise system. Grantees submit budgets, quarterly reports, final progress reports, and other required reports, using the specified formats, via Provide Enterprise. Requirements are outlined in RWPB grant agreements.

Strategy 4.1.2 Strengthen coordination across data systems and the use of data for program operations, improvement, and planning.

4.1.2.1	HIV Care Program, Prevention, and Surveillance staff; Part A Program, and selected Part C and D Programs	Maintain an integrated data system that allows for data sharing and tracking for continuity of care and services across multiple programs.	• Annual contract with data system vendor (GTI) • Number of unique users or agencies using data system for data tracking and sharing	• We are in year 2 of a 3-year contract with Groupware Technologies to maintain and provide access to the Provide Enterprise data system. • There are currently over 300 users of the system statewide for Ryan White Part B, HIV Prevention and Surveillance.	• We are in year 3 of a 3-year contract with Groupware Technologies to maintain and provide access to the Provide Enterprise data system. • There are currently over 300 users of the system statewide for Ryan White Part B, HIV Prevention and Surveillance.	• We are in year 1 of a 10-year contract with Groupware Technologies to maintain and provide access to the Provide Enterprise data system. • There are currently over 300 users of the system statewide for Ryan White Part B, HIV Prevention and Surveillance.
4.1.2.2	HIV Care Program; Illinois Healthcare and Family Services	Conduct Medicaid-eligibility verifications at every RWPB program eligibility determination and every MAP dispense.	• Number of verification checks performed	• 130,410 Medicaid eligibility verification checks performed	• 132,936 Medicaid eligibility verification checks performed	• 145,144 Medicaid eligibility verification checks performed

4.1.2.3	HIV Care Program , HIV Surveillance Program	Conduct a monthly match of RWPB clients with eHARS and exchange of lab results.	<ul style="list-style-type: none"> • Number of clients matched • Number of lab results 	<ul style="list-style-type: none"> • The RWPB Program does a client match with Surveillance to get CD4 counts and HIV Viral Load results. We matched an average of 32,076 client records each match, giving the Program a return rate of 192,458 lab record results that have been imported into our Electronic Client Record Reporting system. 	<ul style="list-style-type: none"> • The RWPB Program does a client match with Surveillance to get CD4 counts and HIV Viral Load results. We matched an average of 34,804 client records each match, giving the Program a return rate of 17,263 new lab record results that we have imported into our Electronic Client Record Reporting system. 	<ul style="list-style-type: none"> • The RWPB Program does a client match with Surveillance to get CD4 counts and HIV Viral Load results. We matched an average of 36,326 client records each match, giving the Program a return rate of 20,473 new lab record results that we have imported into our Electronic Client Record Reporting system.
4.1.2.4	HIV Care Program , RW Part B contracted dispensing pharmacy	Send/receive daily enrollment and dispensing requests between the IDPH data system and the contracted dispensing pharmacy's data system to coordinate MAP pharmaceutical dispensing.	<ul style="list-style-type: none"> • Number of clients enrolled in MAP • Utilization of drug dispenses 	<ul style="list-style-type: none"> • MAP enrollment 12,086 • 6,839 clients received medication 	<ul style="list-style-type: none"> • MAP enrollment 12,928 • 7,074 clients received medication 	<ul style="list-style-type: none"> • MAP enrollment 13,757 • 7,936 clients received medication
4.1.2.5	HIV Prevention Program Evaluation: HIV Data Team	Using Provide Enterprise's integrated systems, monitor the estimated costs of client health outcomes.	<ul style="list-style-type: none"> • Estimated cost per outcome calculated for interventions from HIV Testing, SBS and Billing Data: • Cost per new HIV Diagnosis –Risk-Based-HIV Testing Provider Types: AAARA, Direct, QOL, RIG = $\frac{\text{Total Billing for RBHT}}{\text{\# of New RBHT Diagnoses}}$ • Cost per Treatment Engagement—RBHT Provider Types: AAARA, Direct, QOL, RIG = $\frac{\text{Total Billing for RBHT}}{\text{\# of HIV+ Engaged in Care}}$ • Cost per Treatment Engagement—SBS Provider Types: RIG = $\frac{\text{Total Billing for SBS}}{\text{\# of HIV+ Engaged in Care}}$ 	<ul style="list-style-type: none"> • Cost estimates aren't available. • Analysis is contingent upon positive test data processing which is currently backlogged due to 75% vacancy rate in testing team past 2 years. 	<ul style="list-style-type: none"> • Cost per new HIV Diagnosis for Risk-Based-HIV Testing (HCT) $\frac{\\$1,137,800}{67} = \\$16,982.09/\text{new Dx}$ Provider Types: AAARA, Direct, QOL, RIG • Cost per Treatment Engagement (RBHT) Provider Types: AAARA, Direct, QOL, RIG $\frac{\\$1,137,800}{78} = \\$14,587.18/\text{engagement}$ • Cost per Treatment Engagement (SBS) $\frac{\\$214,050}{47} = \\$4,554.26/\text{engagement}$ 	<ul style="list-style-type: none"> • Cost per new HIV Diagnosis for Risk-Based-HIV Testing $\frac{\\$1,086,400}{73} = \\$14,882.19/\text{new Dx}$ • Cost per Treatment Engagement for Risk-Based-HIV Testing $\frac{\\$1,086,400}{141} = \\$7,704.96/\text{engagement}$ • Cost per Treatment Engagement for Surveillance Based Services $\frac{\\$142,800.00}{39} = \\$3,661.54/\text{engagement}$
4.1.2.6	HIV Surveillance Program , Regional HIV care and prevention lead agents	Compile/provide regional unmet need analyses and Continua of Care to lead agents for their use in identifying regional disparities/inequities and in regional planning to address these.	<ul style="list-style-type: none"> • Rates of new diagnoses, linkage to care, retained in care, and viral suppression by region, race/ethnicity, transmission risk, and age. 	<ul style="list-style-type: none"> • The IDPH Surveillance Unit compiled 2016 statewide and regional unmet need Continua of Care analyses; these analyses were provided to lead agents for their use in identifying and addressing regional disparities/inequities. 	<ul style="list-style-type: none"> • The IDPH Surveillance Unit compiled 2017 statewide and regional unmet need Continua of Care analyses; these analyses were provided to lead agents for their use in identifying and addressing regional disparities/inequities. 	<ul style="list-style-type: none"> • The IDPH Surveillance Unit compiled 2018 statewide and regional unmet need Continua of Care analyses; these analyses were provided to lead agents for their use in identifying and addressing regional disparities/inequities.

4.1.2.7	HIV Surveillance Program, HIV Prevention Program	Develop/maintain a jurisdiction-wide HIV cluster and outbreak detection and response plan	<ul style="list-style-type: none"> • Jurisdictional Plan to respond to and contain HIV outbreaks with improved early identification and investigation of HIV transmission clusters and outbreaks and improved response to HIV transmission clusters and outbreaks 	<ul style="list-style-type: none"> • No update – New activity added in 2018. 	<ul style="list-style-type: none"> • A workgroup comprised of HIV Section staff incl. Surveillance, Prevention and Evaluation Program Administrators, Epidemiologist, and Career Epidemiology Field Officer (CEFO) was established; workgroup reviewed existing cluster and outbreak detection & response plans to serve as templates for an IL plan. <p>Note: The first draft of the Cluster and Outbreak Detection and Response Plan was drafted in July 2018. A final draft was drafted in November 2018 and will be shared with designated response team members for comment.</p>	<ul style="list-style-type: none"> • The IDPH Cluster and Outbreak Detection and Response Plan was finalized in January 2019 and was distributed to stakeholders.
4.1.2.8	HIV Surveillance Program	Perform monthly data matches between eHARS and the CT, RWPB, ADAP, and CHIC databases to ensure complete reporting of all new HIV diagnoses and to supplement each database with missing information obtained from another database.	<ul style="list-style-type: none"> • Number of monthly queries conducted; • Number of new cases reported in other databases that were not previously reported to eHARS; • Missing information obtained and imported into eHARS 	<ul style="list-style-type: none"> • Monthly queries for data matches were performed for 12 months. • 304 (non-unique) new cases were reported to CT, Ryan White, ADAP, and CHIC databases that were not reported to eHARS. • Missing information was obtained for more than 20% of new diagnoses reported to eHARS. 	<ul style="list-style-type: none"> • 24 queries were performed between eHARS and the STD program: 154 unmatched records (i.e., in STD database with HIV-positive status and not in eHARS); 127 were Chicago cases, 26 were Illinois non-Chicago, 1 had no address. • 12 queries were performed between eHARS and the CT program; missing information was obtained for more than 20% of new diagnoses reported to eHARS. • One (1) query was performed between eHARS and the Ryan White, ADAP, and CHIC databases: 137 unmatched records were identified; 58 were inexact matches, 75 were cases unreported to eHARS, 3 were pending confirmation of HIV status and 1 was an OOJ (Missouri). 	<ul style="list-style-type: none"> • 19 queries were performed between eHARS and the STD program: 222 unmatched records (i.e., in STD database with HIV-positive status and not in eHARS). • 12 queries were performed between eHARS and the CT program to ascertain missing information for newly and previously reported cases in eHARS. • 7 queries were performed between eHARS and the Ryan White, ADAP, and CHIC databases: 720 unmatched records were identified (i.e., in RWPB/ADAP/CHIC database with HIV-positive status and not in eHARS).
4.1.2.9	Perinatal HIV Prevention Program, STD Program, Women's Health Evaluation: Perinatal HIV Prevention Coordinator	Conduct Perinatal HIV Prevention Fetal Infant Mortality Review (FIMR) meetings, including representatives from STD and Women's Health Programs.	<ul style="list-style-type: none"> • Number of FIMR sessions with representation from STD and Women's Health 	<ul style="list-style-type: none"> • Three FIMR-HIV CRT meetings were held during this time; one meeting included representation from OWH only, one meeting included STD only; one included representation from both OWH and STD. 	<ul style="list-style-type: none"> • Four FIMR-HIV CRT meetings were held during this time; each included representation from both OWH and STD. 	<ul style="list-style-type: none"> • Four FIMR-HIV/CS CRT meetings were held during this time; each included representation from both OWH and STD.

Strategy 4.1.3 Promote resource allocation that has the greatest impact on achieving Integrated Plan goals.

4.1.3.1	HIV Care Program; Regional care lead agencies	Using results of needs assessments conducted by regional care lead agents and statewide service utilization trends, determine regional service gaps and needed resources for each HIV core and supportive service category identified by HRSA.	<ul style="list-style-type: none"> • Copies of 3-year needs assessment plans, service utilization reports, and gap analyses from regional lead agents 	<ul style="list-style-type: none"> • See 3-year service utilization table in Attachment 1. • Every region conducted a gap analyses, and the trend is the same with every LA - Case management agencies have shared that case managers are not able to focus solely on the clients on their caseloads. Case managers at many agencies are responsible to serve clients that walk in and need services, and they are required to staff clinics during clinic days. These two activities detract from time available to spend with clients on case load. Also, case managers struggle to remember to document the Karnofsky score in client charts or utilize SMART goals to develop client's Care Plan. Through continuous training and education, the LAs/DF grantees have improved over the years and have worked to reduce this gap. This is evidenced by current client record reviews and the use of Medical Benefit Coordinators in reducing the burden of over whelming caseloads. 	<ul style="list-style-type: none"> • See Attachment 1 -2017 Utilization Report compared to 2016. • HRSA does not require a gap analyses every year, but at minimum every 3 years. The analysis from last year is concurrent for the 2017 award period. • The Department is under construction of new clinical monitoring strategy for the top utilized services, which require, at minimum, 2 outcome goals. In addition, all other supported services will have 1 outcome goal, which focus on viral suppression. The Department intends to roll out the new protocol in January 2019 but has been spending time in the development of this new protocol directed by HRSA. 	<ul style="list-style-type: none"> • See Attachment 1 -2018 Utilization Report compared to 2017. • HRSA does not require a gap analyses every year, but at minimum every 3 years. The analysis from last year is concurrent for the 2018 award period. • Performance measures were developed based on HRSA recommendations and are reviewed quarterly at the state and regional levels. Starting October 2018, we ran baseline numbers for each measurement and met quarterly to discuss progress towards achieving Integrated Plan objectives and strategies for improvement.
4.1.3.2	HIV Prevention Program Evaluation: Regional HIV Prevention Grant Manager	Allocate HIV prevention funding to regions in proportion to weighted HIV incidence/prevalence data.	<ul style="list-style-type: none"> • Regional funding formulas 	<ul style="list-style-type: none"> • CY2017 Regional Prevention Grants allocated available funding to regions in proportion to 2/3 HIV incidence and 1/3 prevalence by current address. 	<ul style="list-style-type: none"> • SFY2018 Regional Prevention Grants allocated available funding to regions in proportion to 2/3 HIV incidence and 1/3 prevalence by current address. 	<ul style="list-style-type: none"> • SFY2019 Regional Prevention Grants allocated available funding to regions in proportion to 2/3 HIV incidence and 1/3 prevalence by current address.
4.1.3.3	HIV Prevention Program Evaluation: Regional HIV Prevention Grant Manager	Considering HIV epi data and services delivered by other funding sources, conduct annual gap analysis of HIV prevention services provided to PLWH and HR HIV-negatives, and use the results to determine regional grant service scopes to be funded by IDPH in each region for the next grant year.	<ul style="list-style-type: none"> • Regional service plans based on regional epi and gap analysis 	<ul style="list-style-type: none"> • CY2017 Regional Prevention Grants funded services in each region considering gaps in services delivered to HIV-positive and HR HIV-negative individuals by other IPDH & DASA funding sources. 	<ul style="list-style-type: none"> • SFY2018 Regional Prevention Grants funded services in each region considering gaps in services delivered to HIV-positive and HR HIV-negative individuals by other IPDH & DASA funding sources. 	<ul style="list-style-type: none"> • SFY2019 Regional Prevention Grants funded services in each region considering gaps in services delivered to HIV-positive and HR HIV-negative individuals by other IDPH & DASA funding sources.
4.1.3.4	HIV Prevention Program Evaluation: HIV Data Team	Increase the proportion of risk reduction activity (RRA) services delivered to PLWH demonstrated to be both behaviorally- and cost-effective.	<ul style="list-style-type: none"> • Proportion of risk reduction services delivered to positives demonstrated to be effective and cost effective (same HIV+ measure as 3.2.1) Positive Baseline:9/2015-8/2016 <u>81 EBI Sessions</u> = 3% 2,511 	<ul style="list-style-type: none"> • Positive Comparison: 9/2016-8/2017 <u>1,185 EBI Sessions</u> =47% 2,519 	<ul style="list-style-type: none"> • Ratio for RRA for PLWH: 7/2017-6/2018 <u>1,970</u> = 71.2% 2,766 	<ul style="list-style-type: none"> • Ratio for RRA for PLWH: 7/2018-6/2019 <u>2,454</u> = 51% 4,974

4.1.3.5	HIV Prevention Program Evaluation: HIV Data Team	Increase the proportion of risk reduction activity (RRA) services delivered to HR HIV-negatives demonstrated to be both behaviorally- and cost-effective. [Revision Justification: To be cost-effective, an intervention must be established to be effective. The cost per infection averted can't be assessed until the number of infections averted has been established.]	<ul style="list-style-type: none"> Proportion of risk reduction services delivered to high risk HIV-negatives demonstrated to be effective and cost effective (same HIV-neg measure as 3.2.1) HR Neg Baseline: 9/2015-8/2016 <u>86 EBI Sessions</u>= 2% 4,489 	<ul style="list-style-type: none"> HR Neg Comparison: 9/2016-8/2017 <u>1582 EBI Sessions</u> =55% 2,885 	<ul style="list-style-type: none"> Ratio for RRA for HR Negatives: 7/2017-6/2018 <u>2309</u> = 79% 2,915 	<ul style="list-style-type: none"> Ratio for RRA for HR Negatives: 7/2018-6/2019 <u>2,337</u> =90% 2,607
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4.1.3.6	HIV Prevention Program Evaluation: Routine HIV Screening Grant Manager	Increase the number of routine HIV screening tests billed to third party public and private insurer and reimbursed to health care providers and local health departments assisted by the Third-Party Billing Project. [Revision Justification: The proportion's denominator, total HIV tests done in Illinois, is not discoverable. Instead, focus on the numerator.]	<ul style="list-style-type: none"> Revenues generated for routine HIV screening from 3rd party billing for providers using ezEMRx Baseline: 9/2015-8/2016 \$744.01 Number of Billing Project-assisted agencies successfully billing private insurance, Medicaid, or Medicare for routine HIV screening Baseline: 9/2015-8/2016 16 agencies Source: Billing Project Grantee \$ generated from third-party payers to sites billing for routine HIV testing services number of sites successfully billing third-party payers for routine HIV testing List both the interval income stat and the % increase from baseline stat. 	<ul style="list-style-type: none"> Revenues generated for routine HIV screening from 3rd party billing for providers using ezEMRx \$1,800.78 142% increase above baseline Number of Billing Project-assisted agencies successfully billing private insurance, Medicaid, or Medicare for routine HIV screening 19 agencies billing 19% (19/16) increase above baseline 	<ul style="list-style-type: none"> Revenues generated for routine HIV screening from 3rd party billing for providers using ezEMRx \$2,271.56 205% increase above baseline Number of Billing Project-assisted agencies successfully billing private insurance, Medicaid, or Medicare for routine HIV screening 20 agencies billing 25% (20/16) increase above baseline 	<ul style="list-style-type: none"> Revenues generated for routine HIV screening from 3rd party billing for providers using ezEMRx: \$17,976.52 Number of Billing Project-assisted agencies successfully billing private insurance, Medicaid, or Medicare for routine HIV screening: 21 agencies billing.
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Objective 4.2 By 2021, develop improved mechanisms to monitor and report on progress toward achieving Integrated Plan goals.

Strategy 4.2.1 Strengthen the timely availability and use of data.

4.2.1.1	HIV Care Program	Build a report in Provide data system to capture progress on Integrated Plan objectives/strategies.	<ul style="list-style-type: none"> Report available in the data system 	<ul style="list-style-type: none"> A comprehensive report is under construction that will simplify reporting and enable us to report on progress toward achieving Integrated Plan objectives and strategies. 	<ul style="list-style-type: none"> Reporting structure is still being built within the data system but SQL queries have been constructed and utilized to provide data for reporting purposes until the report can be finalized. 	<ul style="list-style-type: none"> Reporting structure is still being built within the data system but SQL queries have been constructed and utilized to provide data for reporting purposes until the report can be finalized.
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4.2.1.2	HIV Prevention Program	All IDPH-funded Prevention grantees shall submit quarterly reports on achievement of all process and outcomes objectives within the required timeline.	<ul style="list-style-type: none"> Percentage of grantees submitting quarterly reports on achievement of their outcomes 	<ul style="list-style-type: none"> 100% of HIV Prevention Grantees submitted quarterly reports on achievement of process and outcome objectives. 	<ul style="list-style-type: none"> 100% of HIV Prevention Grantees submitted quarterly reports on achievement of process and outcome objectives. 	RIG LAs: 4/4 =100% QOL: 10/11 = 91% TPB: 1/1 =100% AAARA: 5/7 = 71% HIV/STD Hotline: 1/1=100% Direct: 100% / 100% ECM: 100% Perinatal Hotline: 100%
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Strategy 4.2.2 Annually or more often as required by funding sources, report on Illinois' progress in achieving HIV Engagement Plan and Integrated Plan goals and objectives.

4.2.2.1	HIV Integrated Planning Program, Integrated Planning Group	Develop, implement, and monitor the annual HIV engagement plan to identify and enhance the engagement of key community stakeholders, HIV care and prevention providers, and other programs, in statewide HIV planning.	<ul style="list-style-type: none"> Updated HIV Engagement Plan Integrated Planning Group meeting attendance rosters 	As reported to CDC in progress reports: <ul style="list-style-type: none"> The Engagement Plan was updated for 2017. Over 100 new community stakeholders participated in ILHPG/Integrated Planning Group meetings during this time. 	As reported to CDC in progress reports: <ul style="list-style-type: none"> The Engagement Plan was updated for 2018. Over 100 new community stakeholders participated in Integrated Planning Group meetings during this period. 	As reported to CDC in progress reports: <ul style="list-style-type: none"> The Engagement Plan was updated for 2019. Over 100 new community stakeholders participated in Integrated Planning Group meetings and trainings during this period.
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4.2.2.2	HIV Prevention Program	Report on progress toward achieving Integrated Plan goals as required by CDC Prevention and Surveillance Grant Guidance.	<ul style="list-style-type: none"> Integrated Plan progress updates 	<ul style="list-style-type: none"> Integrated Plan progress reports were submitted to CDC as required. 	<ul style="list-style-type: none"> Integrated Plan progress reports were submitted to CDC as required. 	<ul style="list-style-type: none"> Integrated Plan progress reports were submitted to CDC as required.
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4.2.2.3	HIV Care Program	Review comprehensive report on a regular basis and use the information to report to HRSA on progress towards achieving Integrated Plan goals and objectives.	<ul style="list-style-type: none"> Report available in the data system. 	<ul style="list-style-type: none"> We plan to use the comprehensive report on a yearly basis, starting in October 2018, to update and report the metrics and progress towards achieving Integrated Plan objectives and strategies. 	<ul style="list-style-type: none"> We plan to use the comprehensive report on a yearly basis, starting in October 2018, to update and report the metrics and progress towards achieving Integrated Plan objectives and strategies. 	<ul style="list-style-type: none"> Performance measures were developed based on HRSA recommendations and are reviewed quarterly at the state and regional levels. Starting October 2018, we ran baseline numbers for each measurement and met quarterly to discuss progress towards achieving Integrated Plan objectives and strategies for improvement.
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Strategy 4.2.3 Enhance HIV Program accountability.

4.2.3.1	HIV Integrated Planning Program, Integrated Planning Group	Review Integrated Plan goals and objectives, and report to the IHIPC on Illinois' progress in implementation of Plan strategies and activities, with recommended modifications as needed.	<ul style="list-style-type: none"> Annual progress report/update on implementation of Integrated Plan 	<ul style="list-style-type: none"> A 2017 report on progress in the implementation of Integrated Plan goals, objectives, and activities is underway and scheduled to be presented to the IHIPC at its Dec 2017 meeting. 	<ul style="list-style-type: none"> A 2017 report on progress in the implementation of Integrated Plan goals, objectives, and activities was presented to the IHIPC in Dec 2017. The 2018 report is underway and will be presented to the IHIPC at its Dec 2018 meeting. 	<ul style="list-style-type: none"> A 2018 report on progress in the implementation of Integrated Plan goals, objectives, and activities was presented to the IHIPC in Dec 2018. The 2019 report is underway and will be presented to the IHIPC at its Dec 2019 meeting.
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4.2.3.2	IDPH HIV Integrated Planning Program, Integrated Planning Group	Inform and provide the Integrated Planning Group with opportunities to make recommendations on Integrated Plan updates, modifications, and enhancements.	<ul style="list-style-type: none"> Planning Group informed of proposed changes to the Integrated Plan Recommendations on updates to the Integrated Plan made by the Planning Group Integrated Plan components updated as needed 	<ul style="list-style-type: none"> All updates to the Plan for 2018 were informed by the Integrated Planning Group. Updates were summarized at the Aug. 2017 meeting where the updated IL HIV Care Continuum and 2017 report on Illinois' Progress in achieving NHAS goals/ indicators were presented. An updated Integrated Plan Activities Worksheet for 2018 is scheduled to be presented to the IHIPC in December 2017. 	<ul style="list-style-type: none"> All updates to the Plan for 2019 were informed by the Integrated Planning Group. Updates were summarized at the October 2017 meeting where the updated IL HIV Care Continuum and 2018 report on Illinois' Progress in achieving NHAS goals/ indicators were presented. An updated Integrated Plan Activities Worksheet for 2019 is scheduled to be presented to the IHIPC in December 2018. 	<ul style="list-style-type: none"> All updates to the Plan for 2020 were informed by the Integrated Planning Group during this period. Additional updates, incl. the updated IL HIV Care Continuum and 2018 report on Illinois' Progress in achieving NHAS goals/ indicators, will be presented at the Oct 2019 IHIPC meeting. An updated Integrated Plan Activities Worksheet for 2020 is scheduled to be presented to the IHIPC in December 2019.
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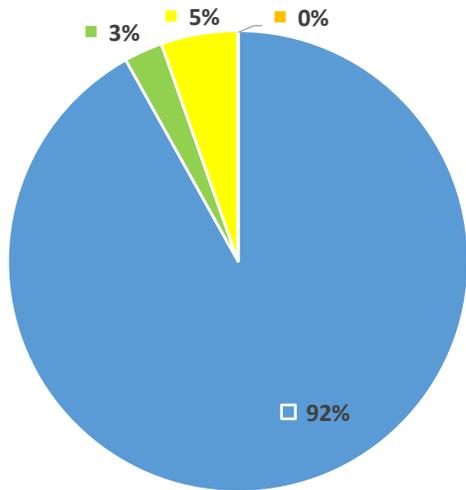
4.2.3.3	IDPH HIV Integrated Planning Program, Integrated Planning Group Membership and Steering Committees	Evaluate the effectiveness of all IHIPC meetings and use the results to enhance meaningful engagement of key HIV community stakeholders in HIV planning.	<ul style="list-style-type: none"> • Surveys of all IHIPC meetings conducted • Survey results reviewed by IHIPC Membership and Steering Committees 	• No update – New activity added in 2018.	• Surveys were conducted for all IHIPC meeting; the effectiveness of community engagement at the meetings was evaluated; and the survey results were reviewed by the IHIPC Membership and Steering Committees, which made recommendations for improvement that were then implemented.	• Surveys were conducted for all IHIPC meetings; the effectiveness of community engagement at the meetings was evaluated; and the survey results were reviewed by the IHIPC Membership and Steering Committees, which made recommendations for improvement that were then implemented.
4.2.3.4	HIV Prevention Program	Assess that testing programs meet CDC performance standards for new positives: seropositivity, linkage to care, and partner services.	<p>HCT Positives Report</p> <ul style="list-style-type: none"> • RBHT = AAARA, Direct, QoL, RIG • RHS = Cat B, CAPUS, RT • New Positives = No prior Surv Case Report in eHARS OR Confirmed positive result date on or before eHARS First Diagnosis Date • New Preliminary or Confirmed seropositivity Rate = # New Dx / Total Testing Events • % of Preliminary or Confirmed positives engaged in medical care = Medical Appointment, VL or CD4 result dated after First Reactive Test results • % of new confirmed positives asked about at-risk partners = For confirmed positives only: # asked about partners / total confirmed positives 	<p>Statistics per Provide Enterprise reports as of 11/22/2017 may be subject to change as further positive outcomes are reported.</p> <p>New Preliminary or Confirmed Positives:</p> <ul style="list-style-type: none"> • 0.57% new positives- RBHT • 0.44% new positives- RS • 48% positives care-engaged in 30 days- RBHT • 31% positives care-engaged in 30 days-RS • 100% confirmed positives asked about partners- RBHT • 47% confirmed positives asked about partners- RS 	<ul style="list-style-type: none"> • 0.58% new positives- RBHT • 0.22% new positives- RS • 47.2% positives care-engaged- RBHT • 23.7% positives care-engaged- RS • 76.7% positives asked about partners- RBHT • 47.4% positives asked about partners- RS 	<ul style="list-style-type: none"> • 0.42% new positives- RBHT • 0.03% new positives- RHS • 47.2% positives care-engaged- RBHT • 23.7% positives care-engaged- RHS • 76.7% positives asked about partners- RBHT • 47.4% positives asked about partners- RHS
4.2.3.5	HIV Prevention Program Evaluation: HIV Data Team	Increase the proportion of all risk reduction interventions sessions delivered to HIV-positive and high-risk HIV-negative individuals that have been determined by the CDC to be cost-effective.	<ul style="list-style-type: none"> • Percent of all interventions delivered that are cost-effective (Same statistics as 3.2.1) • Positive Baseline: 9/2015-8/2016 <u>81 EBI Sessions</u> = 3% 2,511 • HR Negative Baseline: 9/2015-8/2016 <u>86 EBI Sessions</u>= 2% 4,489 	<ul style="list-style-type: none"> • Positives Ratio: 9/2016-8/2017 <u>1,185 EBI Sessions</u> =47% 2,519 • HR Negative Ratio: 9/2016-8/2017 <u>1582 EBI Sessions</u> =55% 2,885 	<ul style="list-style-type: none"> • Positives Ratio: 7/2017-6/2018 <u>1,970</u> = 71.2% 2,766 • HR Negatives Ratio: 7/2017-6/2018 <u>2309</u> = 79% 2,915 	<ul style="list-style-type: none"> • Positives Ratio: 7/2018-6/2019 <u>2,454</u> =51% 4,974 • HR Negatives Ratio: 7/2018-6/2019 <u>2,337</u> = 90% 2,607

Strategy 4.2.3 Plan, conduct, and evaluate HIV need assessment activities statewide.

4.2.4.1	HIV Integrated Planning Program; IHIPC Needs Assessment Workgroup; IDPH-funded HIV Prevention and Care Lead Agencies	Provide guidance and instruction to IDPH-funded HIV care and prevention lead agencies in planning, conduct, and evaluation of a series of HIV community stakeholder engagement/needs assessment meetings to be held in the 8 care and prevention regions in 2019.	<ul style="list-style-type: none"> • Protocol and discussion guide for needs assessment activity • Meeting agenda and handouts • Meeting agenda, presentation template, and handouts; • Meeting evaluations • Report summarizing the results of the needs assessment activities conducted 	<ul style="list-style-type: none"> • No update – New activity added in 2018. 	<ul style="list-style-type: none"> • Integrated Planning Needs Assessment Workgroup was formed in Dec. 2017. • Workgroup met twice in this period, reviewed the GTZ needs assessment results, and is in the final stages of developing the protocol/discussion questions to be used for these needs assessment activities to be conducted at the regional community stakeholder engagement meetings. 	<ul style="list-style-type: none"> • Integrated Planning Needs Assessment Workgroup finalized development of the protocol and discussion questions for the series of eight regional community engagement meetings to be conducted in 2019. • The Integrated Planning Program developed a template regional presentation and provided each region with a slideset of HIV incidence, prevalence, and Continuum of Care data analyses slides. Instructions were provided to the lead agents for facilitating the needs assessment activity and gathering notes from the group discussions. • All regional community engagement meetings are scheduled to be conducted July-Nov 2019.
4.2.4.2	HIV Integrated Planning Program; IHIPC Needs Assessment Workgroup; IDPH HIV Training Coordinator; IDPH-funded HIV Prevention and Care Lead Agencies	Plan, facilitate, and evaluate a series of 5-6 statewide focus groups, to be conducted with high-risk populations, to identify HIV prevention/care needs, gaps, barriers, challenges, and strategies.	<ul style="list-style-type: none"> • Focus group protocols, documentation, and reports summarizing the results of the needs assessment activities 	<ul style="list-style-type: none"> • No update – New activity added in 2018. 	<ul style="list-style-type: none"> • These are planned to begin in 2019. The protocol and the discussion questions have not yet been developed. 	<ul style="list-style-type: none"> • During this period the Integrated Planning Program and the IHIPC Needs Assessment Workgroup met monthly and developed the protocols, education component, discussion questions, infographic handouts, and other materials for a series of 5-6 risk-targeted focus groups to be conducted Sept. 2019-June 2020.
4.2.4.3	HIV Integrated Planning Program; IHIPC Needs Assessment Workgroup; IDPH HIV Training Coordinator; Illinois Youth Detention Centers	Plan, facilitate, and evaluate a minimum of two focus groups with At-Risk Youth within Juvenile Justice System facilities.	<ul style="list-style-type: none"> • Focus group protocol, documentation, and reports summarizing the results of the needs assessment activities 	<ul style="list-style-type: none"> • No update – New activity added in 2018. 	<ul style="list-style-type: none"> • The protocol, discussion questions, and survey tool originally developed by the ILHPG Evaluation Committee, have been modified by the Integrated Planning Program. The documents have been shared with the Juvenile Justice System facilities and are in the final stages of development. • Focus groups at two facilities are planned in Nov. 2018 and Jan 2019. 	<ul style="list-style-type: none"> • During this period the protocol, discussion questions, and survey tool for the youth focus groups/surveys within the Juvenile Justice System facilities were completed. The focus groups/surveys were conducted - one in Sangamon County in Nov 2018 and the other in Will County in Jan 2019. • The documents were modified and used to conduct a focus group at an LGBT Youth Support Group in Springfield in March 2019. • The survey was distributed to youth attending an IDOC Summit of Hope in Springfield in June 2019. • The final report on the Youth Needs Assessment activities was compiled and distributed in June 2019.

ILLINOIS INTEGRATED PLAN PROGRESS REPORT DASHBOARD July 1, 2018-June 30, 2019

GOAL 1: Reduce new HIV infections.



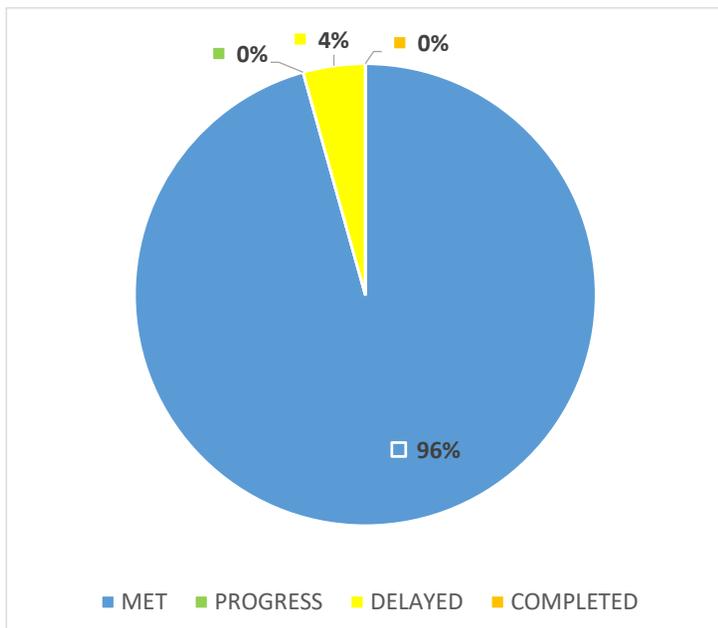
■ MET
 ■ PROGRESS
 ■ DELAYED
 ■ COMPLETED

GOAL 1: Reduce new HIV infections.

MET	34
PROGRESS	1
DELAYED	2
COMPLETED	0

GOAL 1:		
OBJECTIVES	DESCRIPTION	STATUS
1.1.1.1	Provide updated HIV and STD epi profiles to IHPC.	MET
1.1.1.2	Propose recommended changes to risk group definitions.	MET
1.1.1.3	Develop, launch, and monitor implementation of GTZ IL Plan.	MET
1.1.1.4	Increase capacity for delivering PrEP and nPEP in each region.	MET
1.1.1.5	Develop/conduct PrEP and nPEP trainings.	MET
1.1.1.6	Conduct PrEP prescriber/provider trainings.	MET
1.1.1.7	Deliver at least 1% of regional prevention grant service to transgender persons.	MET
1.1.1.8	HIV Prevention services in each region target young MSM.	MET
1.1.1.9	Intensify the delivery of HIV testing to young MSM.	MET
1.1.1.10	Deliver risk-targeted HIV testing with partner services and LTC for identified positives.	MET
1.1.1.11	Deliver routine HIV screening with partner services and LTC for identified positives.	MET
1.1.1.12	Deliver first and third trimester routine HIV screening to pregnant women.	MET
1.1.1.13	Deliver effective behavioral and biomedical interventions for HIV-negatives.	MET
1.1.1.14	Deliver effective behavioral and biomedical interventions for PLWH.	MET
1.1.1.15	Provide ECM and expert medical technical assistance via Perinatal hotline.	MET
1.1.1.16	Deliver partner services and HIV testing for partners of positives.	MET
1.1.1.17	Deliver partner services to RWPB clients engaging in risky behaviors.	MET
1.1.1.18	Conduct HIV and HCV testing at Summits of Hope.	MET
1.1.2.1	Provide High-Impact Prevention (HIP) services to HIV-negatives.	MET
1.1.2.2	Provide perinatal HIV prevention trainings to RW and Women's Health Family CMs.	NOT MET/ PROGRESS
1.1.2.3	Conduct a training needs assessment for Care and Prevention providers.	MET
1.1.3.1	Publicize current, accurate information about HIV on the IDPH website.	MET
1.1.3.2	Publicize current, accurate information about HIV on IDPH/ HPG social media.	DELAYED
1.1.3.3	Prepare messages and infographics for HIV Awareness Days.	MET
1.1.3.4	Publicize current, accurate information through the IL HIV/STD Hotline.	MET
1.1.3.5	Engage prioritized pops into HIV prevention via social media, marketing, and networking.	MET
1.2.1.1	Build electronic Care-to-Prevention referral within Provide™.	DELAYED
1.2.1.2	Conduct statewide integrated Prevention and Care planning meetings.	MET
1.2.1.3	Conduct cross-match of PLWH with cases or recent STIs.	MET
1.2.1.4	Increase the percentage of PLWH referred to RWPB case management.	MET
1.2.2.1	Conduct RWPB and HOPWA quality assurance site visits.	MET
1.2.2.2	Provide MAP and PAP services.	MET
1.2.2.3	Coordinate post-incarceration transitions to RWPB case management/ medical care.	MET
1.2.3.1	Increase engagement of new community stakeholders in HPG meetings/ activities.	MET
1.2.3.2	Renew IGA with IDOC for Corrections services.	MET
1.2.3.3	Provide peer to peer education and training in correctional facilities.	MET
1.2.3.4	Provide HIV 101 training and HIV/HCV test kits in correctional facilities.	MET

GOAL 2: Increase access to care and improve health outcomes for people living with HIV.

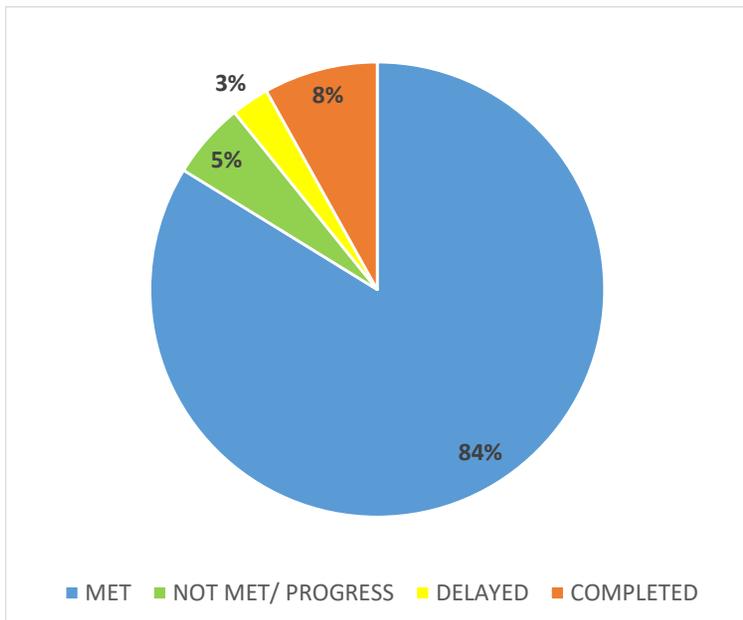


GOAL 2: Increase access to care and improve health outcomes for PLWH.

MET	22
PROGRESS	0
DELAYED	1
COMPLETED	0

GOAL 2:		
OBJECTIVES	DESCRIPTION	STATUS
2.1.1.1	Provide Fundamentals of HIV Risk-Targeted Testing Course.	MET
2.1.1.2	Increase identification of new diagnoses and LTC through routine testing.	MET
2.1.1.3	Increase identification of new diagnoses and LTC through targeted testing.	MET
2.1.1.4	Link newly diagnosed infants to HIV medical care.	MET
2.1.1.5	Link newly diagnosed individuals identified for SBS to medical care.	MET
2.1.2.1	Conduct SBS for PLWH with no evidence of HIV medical care.	MET
2.1.2.2	Create/ support retention specialist positions.	MET
2.1.2.3	Provide medication counseling prior to MAP services.	MET
2.1.2.4	Conduct treatment adherence counseling at benchmark visits.	MET
2.1.2.5	Monitor medical appointment attendance for RWPB clients.	MET
2.1.2.6	Mail/ send recertification notices to RWPB clients with expiring eligibility.	MET
2.1.2.7	Evaluate client eligibility expirations and ART prescriptions.	MET
2.1.2.8	Promote and incorporate telemedicine as an option for outpatient medical services.	NEW
2.1.3.2	Implement LTC protocol for former clients lost to care and new strategies to increase VS rates for individuals enrolled in ADAP, but not in case management, who are not virally suppressed.	NEW
2.1.3.1	Schedule medical appointments for DOC inmates before release; track attendance.	MET
2.1.3.2	Transition HIV-positive inmates to a medical provider and CM before release.	MET
2.2.1.1	Conduct monthly queries cross-matching eHARS and new STI dx for SBS referrals.	MET
2.2.1.2	Conduct mo. queries to identify RWPB clients with new STIs for case management referrals.	DELAYED
2.2.1.3	Provide transmission cluster information to Care and Prevention programs.	MET
2.2.1.4	Facilitate cluster investigation/intervention across the care continuum thru partner services.	MET
2.2.1.5	Improve engagement in care for newly dx positives and previously dx. not in care.	MET
2.2.2.1	Conduct regional community engagement meetings.	MET
2.2.3.1	Contract with HIV service providers per regional needs assessments.	MET
2.2.4.1	Provide short-term mortgage, rent, and EFA to eligible clients.	MET
2.2.4.2	Assist PLWH recently released from correctional facilities in locating housing.	MET

GOAL 3: Reduce HIV-related disparities and health inequities.



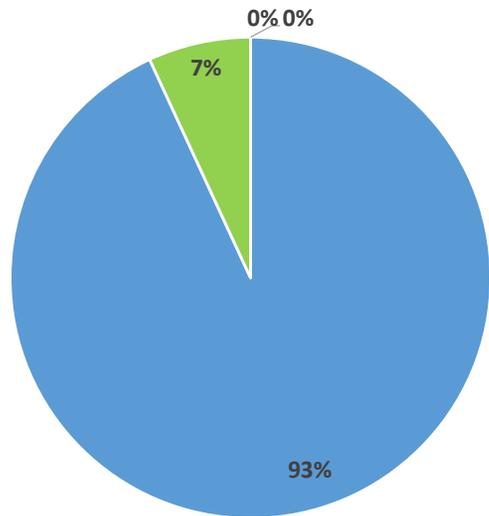
GOAL 3: Reduce HIV-related disparities and health inequities.

MET	31
NOT MET/ PROGRESS	2
DELAYED	1
COMPLETED	3

GOAL 3:		
OBJECTIVES	DESCRIPTION	STATUS
3.1.1.1	Explore and compile community viral load data	MET
3.1.1.2	Provide input to ensure that prevention resources are appropriately allocated	MET
3.1.1.3	Make recommendations on risk group definitions	MET
3.1.1.4	Fund risk-targeted testing for highest incidence populations	MET
3.1.1.5	Conduct SBS for PLWH with no evidence of HIV medical care	MET
3.1.1.6	Increase MAP enrollment of PLWH in minority communities	MET
3.1.1.7	Conduct outreach and education in minority communities to identify PLWH	MET
3.1.2.1	Develop, initiate, and follow up on RWPB quality improvement initiatives for VS	MET
3.1.2.2	Review and address client VL results at each eligibility assessment	MET
3.1.2.3	Conduct SBS to engage PLWH with unsuppressed VLs in medical care	MET
3.1.2.4	Retain/ re-engage PLWH in medical care through retention specialists	DELAYED
3.1.3.1	Review information to make recommendations on I&S Guidance updates	MET
3.1.3.2	Conduct root cause analyses for special populations	MET
3.1.3.3	Provide condoms to prevent HIV transmission/ acquisition	MET
3.1.3.4	Distribute condoms and lubes at gathering sites of high-risk populations	MET
3.1.3.5	Provide cultural competency trainings to grantees/ providers	NOT MET/ PROGRESS
3.1.3.6	Conduct interactive discussion on GTZ-IL domain area issues at in-person IHIPC meetings.	NEW
3.2.1.1	Increase behaviorally and cost effective risk reduction services for PLWH	MET
3.2.1.1	Increase behaviorally and cost effective risk reduction services for PLWH	MET
3.2.1.2	Increase behaviorally and cost effective risk reduction services for HIV-negatives	MET
3.2.1.3	Promote awareness of the POP Anti-Stigma campaign	COMPLETED
3.2.2.1	Train HIV prevention and care providers on cultural competency for Black and Latino MSM.	NOT MET/ PROGRESS
3.2.2.2	Train routine HIV screening providers using POP materials	COMPLETED
3.2.2.3	Provide peer-to-peer HIV, STI, and HCV education within correctional facilities	MET
3.2.2.4	Provide HIV/HCV test kits for SoH and HIV 101 training to IDOC medical staff	MET
3.2.2.5	Provide educational training to HIV care providers	MET
3.2.2.6	Explore possibility of conducting Undoing Racism training in downstate IL	MET
3.2.3.1	Support IHIPC leadership participation in professional development conferences	MET
3.2.3.2	Develop/maintain IHIPC website and web-stream all meetings	MET
3.2.3.3	Develop/publish quarterly IHIPC newsletter	MET
3.2.3.4	Educate IHIPC on opioid epidemic in Illinois	MET
3.2.3.5	Engage representatives of PWID community as voting members on IHIPC	MET
3.2.3.6	Inform/solicit input from IHIPC and community on HIV cluster/outbreak response plan	MET
3.2.3.7	Promote PLWH enrollment in CHW Programs	COMPLETED
3.2.3.8	Sustain RWPB peer navigator positions	MET
3.2.3.9	Sustain RWPB client representative positions	MET
3.2.3.10	Sustain the number of people trained as peer educators within IDOC facilities	MET
3.2.3.11	Increase the diversity of HIV prevention workforce conducting risk targeted interventions.	MET

GOAL 4: Achieve a more coordinated response to the HIV epidemic.

ILLINOIS INTEGRATED PLAN PROGRESS REPORT DASHBOARD July 1, 2018-June 30, 2019



■ MET ■ PROGRESS ■ DELAYED ■ COMPLETED

GOAL 4: Achieve a more coordinated response to the HIV epidemic.

MET	27
PROGRESS	2
DELAYED	0
COMPLETED	0

GOAL 4:		
OBJECTIVES	DESCRIPTION	STATUS
4.1.1.1	Require standardization of providers' reports & use of grants management system.	MET
4.1.2.1	Conduct mo. crossmatch of eHARS & STI cases with RWPB clients for case mgmt. f/u.	MET
4.1.2.2	Conduct Medicaid-eligibility verifications of RWPG clients.	MET
4.1.2.3	Conduct a mo.match of RWPB clients with eHARS for exchange of lab results.	MET
4.1.2.4	Send/receive daily MAP enrollment/dispensing requests to/from dispensing pharmacy.	MET
4.1.2.5	Monitor client health outcomes using Provide data.	MET
4.1.2.6	Compile regional unmet need/CoC analyses for regions.	MET
4.1.2.7	Develop/maintain a jurisdictional HIV cluster/outbreak response plan.	MET
4.1.2.8	Perform data systems' matches to ensure complete reporting & supplement missing info.	MET
4.1.2.9	Conduct Perinatal HIV Prevention FIMR meetings.	MET
4.1.3.1	Determine regional service gaps and needed resources for each HIV Care region.	MET
4.1.3.2	Allocate HIV prevention funding to regions in proportion to weighted HIV epi data.	MET
4.1.3.3	Conduct gap analysis of HIV prevention services to determine regional service scopes.	MET
4.1.3.4	Increase the proportion of cost-/behaviorally-effective RRA delivered to PLWH.	NOT MET/ PROGRESS
4.1.3.5	Increase the proportion of cost-/behaviorally-effective RRA delivered to HIV negatives.	MET
4.1.3.6	Increase number of routine screenings billed to/reimbursed by 3rd Party Insurers.	MET
4.2.1.1	Build report in Provide to capture progress on Integrated Plan objectives/strategies.	NOT MET/ PROGRESS
4.2.1.2	Prevention grantees shall submit quarterly reports on objectives.	MET
4.2.2.1	Develop/implement/monitor HIV Engagement Plan.	MET
4.2.2.2	Report to CDC on progress on Integrated Plan goals/objectives.	MET
4.2.2.3	Report to HRSA on progress on Integrated Plan goals/objectives.	MET
4.2.3.1	Report to IHPC on progress on Integrated Plan goals/objectives.	MET
4.2.3.2	Inform/provide IHIPC with opportunity to make Integrated Plan recommendations/updates.	MET
4.2.3.3	Evaluate effectiveness of IHIPC meetings.	MET
4.2.3.4	Assess that testing programs meet CDC performance standards.	MET
4.2.3.5	Increase proportion of cost-effective RRA delivered to HIV+ and HIV- .	MET
4.2.4.1	Provide guidance to regional lead agents in planning/conduct/eval of community engmt. mtgs.	MET
4.2.4.2	Plan, facilitate, evaluate statewide focus groups for risk populations.	MET
4.2.4.3	Plan, facilitate, evaluate youth focus groups.	MET