Illinois HIV Planning Group (ILHPG)/Ryan White Advisory Group Integrated Meeting

March 17, 2016, 10:25 am-12:40 pm Minutes - Draft 1

After some audio issues were resolved, the meeting restarted at 10:25 pm.

- Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)
  Before the welcome and introductions, Janet reinforced why we are here and do what we do. The primary goal of the Integrated Planning Group is to help guide activities of the integrated meetings and the direction of the integrated plan development to ensure it is a comprehensive plan that addresses a coordinated response to HIV prevention, care, and treatment and addresses the goals of the NHAS.

  The integrated group is comprised of members of the ILHPG and the RW Advisory Group as well as a wide array of community providers and key stakeholders that can inform the integrated plan. We also hope to inform and educate them about the HIV epidemic in Illinois, resources, needs, challenges, etc., and to seek their input in addressing these issues and challenges.

  The co-chairs, facilitator, and presenters were welcomed to the meeting and the work of the Epi/NA Committee in helping guide development of the epi presentation was acknowledged.

  People who have passed away and those living with HIV as well as David Roesler, the former Executive Director of Open Door Health Center who unexpectedly passed away this week, were acknowledged and a moment of silence recognized. David was a true leader and champion for the HIV community and will be missed.

- Review agenda –*The agenda was reviewed. The main presentations will be 1. a Region 8 panel presentation, which includes representatives from the Region 8 HIV care and prevention programs as well as representatives from CDPH and CAHISC, and 2.an overview of the updated HIV epidemiologic profile in Illinois. There will be time for discussion, questions, as well as take-away messages so that participants leave the meeting with an understanding of how the information presented and resulting discussion is linked to the role of the integrated group and development of the plan.*
- Webinar process; Attendance; Announcements; Updates (10 minutes)
  - Webinar meeting, online meeting survey, and online discussion board instructions - *Instructions were provided.*
  - Attendance will be taken by tracking members logged in and sign-in sheets from host sites -*Participants were told they would be tracked by their log-ins. People participating from a host site or in a location with others were told to be sure to sign in and the hosts*

were asked to send those sheets to Marleigh or Janet. Participants could also submit a message via the Chat feature during the webinar itself letting the facilitator know they were present.

- Introduce Integrated Planning Steering Committee leadership
  Janet recognized the members of the Integrated Planning Steering Committee for all the valuable work they have done over the last year and a half to guide integrated planning activities and meetings.
- Announcements
  Janet reminded members about recorded trainings and meetings that could still be viewed from the ILHPG website, tomorrow's ILHPG webinar meeting, and the release of the spring 2016 ILHPG newsletter.
- Review meeting objectives –*Objectives for today's webinar were reviewed.*
- Brief update from Integrated Planning Steering Committee -*Janet provided an update from the Integrated Planning Steering Committee. The committee has received a draft of the plan, which although not yet complete and still needing updates and additional information and data, is a pretty solid draft of the plan. The committee will review and provide comments and suggestions back to the HIV Section and its consultant over the next month. After those recommendations and changes are considered and incorporated and hopefully, some of the missing elements received, the plan is to have a pretty solid updated draft ready for distribution to the full integrated group by the May meeting. There will be other pieces, such as the Interventions and Services guidance and updated resources inventory/assessment that may not be completed until later and will be included as appendices. We plan to have a near-final solid draft ready to send through IDPH Communications for approval by the end of June or July at the latest.*
- Concurrence checklist – *Janet reviewed the essential elements of concurrence that will be part of the concurrence process and vote on concurrence with the plan by the full integrated group. Over the next couple of months, the RW program will provide training and information to its membership. We will ensure that the ILHPG and the RW Advisory Group have been informed and provided input into the plan and that they understand the concurrence process and the elements of concurrence that need to be considered prior to the actual vote.*

- Region 8 Care and Prevention Panel Presentation(45 minutes)
  Bashirat Osunmakinde, AIDS Foundation of Chicago and Amy Morales, CORE Center
  Silas Hyzer and Ayla Karamustafa, Public Health Institute of Metropolitan Chicago
  Patrick Stonehouse, Chicago Department of Public Health, HIV/STI Bureau
  - Input, Questions & answers, Take-away (10 minutes)
    Prior to the presentation, Janet referenced that in lieu of a Region 8 specific epi update as part of the panel, Cheryl had developed a 2-3 page Region 8 Epi Highlights document. That has been posted on the ILHPG webinar website for viewing and downloading. Janet highly encouraged people to do so. Each of the presentations still has some reference of the demographic and distribution aspects of HIV in the region, the clients served and the services.
    Ayla Karamustafa and Silas Hyzer:

Region 8 has a population of approximately 2.5 million, 33% of whom are in poverty. Region 8 has the highest prevalence and incidence of HIV following the city of Chicago. Looking at new diagnoses in 2014, 82% were male, 71.6% MSM, 50.4% Black, and 38.8% 20-29 years old.

Challenges and Strategies: *One of the current challenges is the state budget impasse that has resulted in a 39% decrease in HIV testing and an 80% decrease in HIV positive clients diagnosed, comparing Jan 2014-June 2015 with July 2015-Dec 2015 data. Another challenge is the disproportionately high number of young Black MSM impacted by HIV in the region and resulting issues such as lack of outreach workers to serve that population and issues with cultural competency. Other related issues that cause challenges are limited or restricted public housing, inadequate transportations options, and food access/security issues. These challenges have resulted in trying to find more collaborative solutions and strategies – conserving resources, developing/enhancing a referral guide for the region, trying to incentivize services, participating on a variety of integrated planning groups and committees, providing a greater variety of and more targeted trainings for providers.*

<u>Bashirat Osunmakinde and Amy Morales:</u>

AFC receives funding from multiple sources for its HIV care lead agency, case management, rehabilitative, corrections, and housing services. Needing the separate data systems to communicate with each other is a continuous issue. Several forms of case management services are provided. A retention specialist will soon be added to the array.

Gaps and Solutions: *There is a lack of providers in suburban Cook County and AFC has tried to remedy that through its RFP process but has received only one application from a suburban provider agency. Transportation continues to be an issue as more clients have transitioned to Medicaid managed care which is more complex to navigate. The region has added Uber services but has overspent in this area this year. Because of wait lists for public housing there is a greater need for emergency housing assistance. Three new dental providers have been added in the last year to address those needs. There is not enough funding for copays. This service started in the middle of last year and the program has run out of funds several times.*

Amy Morale, the Case Management Supervisor at the CORE Center, presented. The COE Center served 5,400 unduplicated HIV patients in 2014. The CORE Center is known as an HIV center even though it serves clients for other conditions and illnesses. The population it serves is primarily poor, medically indigent and minority.

Gaps and Barriers for PLWH: *homelessness/housing, substance use/mental health issues, transportation, insurance issues, stigma, issues with undocumented status, issues with being in the jail/prison system.*

<u>Patrick Stonehouse:</u>

Patrick spoke about the agencies and services funded outside the city of Chicago. Ryan White funded services are provided to clients in the Chicago eligible metropolitan area (EMA). Prevention services are provided only in the city of Chicago. CDPH has had the same issue of agencies in the suburbs not applying for RFAs/RFPs, even though CDPH has disseminated the information to them. This has caused gaps or barriers to services or lack of providers in some areas. For example, DuPage County currently has no funded providers for ambulatory medical care, mental health and substance abuse. The rate of unmet need in the Chicago EMA is highest in Chicago and Cook County, with Lake County next. Unmet need is lowest in Kendall, McHenry, and Grundy counties.

Gaps in services: *These were identified through a survey conducted of agencies outside the city of Chicago specifically for the purpose of this presentation. Agencies are also asked to report on gaps, barriers, and challenges in their grant reports. Transportation was identified as an issue by all providers. Other gaps identified included: Not enough housing services/options in Lake County; Ryan White service deserts; shortage of bilingual providers; limited mental health services -3 month wait list for insured, challenges for uninsured to access services, no bilingual mental health providers; limited providers in general in the collar counties.*

Barriers to services: *Store options are limited and not convenient to access; gas cards are limited; limited or lack of far reaching public transportation; burden of multi point data entry and reporting; not having on-site medical benefits coordinators; not working effectively with managed care organizations for prior authorizations, referrals, care coordination, etc.*

Challenges: *Distributing resources to the region has to involve collaborations to develop and build the capacity of providers to be able to apply for grants and provide services, meeting all the requirements. CAHISC is exploring the option of lowering the threshold for some RW service providers such as allowing LSCWs to provide services rather than clinical psychiatrists.*

Questions/Comments:

Q: Dr. Pat stated that when she was in the collar counties and on the part B Advisory Group, the group tried to aggressively recruit providers, offering to mentor them in grant writing, but still had no luck. There were issues with cultural competency concerns.

A: Roman Buenrostro stated that the reporting requirements and expectations of RW providers have increased. A lot don't see the benefit of providing services because the funding amounts aren't sufficient for the amount of work required.

Q: Curt Hick asked Patrick if the CDPH Care RFA explicitly segments funding by County for each service category, so that applicants seeking to serve DuPage, for example, can see they must only compete with other providers seeking to serve DuPage? Funding segmentation would also incentive Chicago providers to set up satellite service locations in underserved EMA counties in order to access that designated suburban funding. If the RFA does not clearly segment the funding by County, does that not force smaller, less experienced suburban providers to compete with larger, more experienced city providers, resulting in nearly all the money going to City-located services? If the RFA requires suburban providers to compete "outside their weight class," would that not explain why nearly all of them have given up trying to compete?

A: Patrick said that that was complicated to answer and that he would follow up with the RW program for its input. In terms of prevention, if agencies are not located in a specific area, they have to justify in their application why they should be funded and how they will provide those services. He said that may need to incentivize more agencies that apply to provide services in areas where there are gaps in providers.

Q: Chris stated that the ILHPG is currently accepting recommendations for vetting new or enhanced Prioritized Populations...what are CDPH prioritized populations and how are they defined with relation to prevention interventions. Is there a difference between those prioritized populations defined by the ILHPG and/or CAHISC.[Chris Wade] [chris-wade@live.com] [Q: 11:50 AM] [A: 11:54 Chris Wade asked if the priority populations identified by CDPH and CAHISC were similar to those identified by IDPH and the ILHPG. He asked how those were determined.

A: Patrick stated that CAHISC follows a similar process and reviews those annually. Ayla said that she would find out more information about CAHISC's priority populations and provide that information to Chris. Patrick said that that information could also be found at the cahisc.org website.

With no more comments or questions proffered, Janet wrapped up the session by thanking all the presenters and saying this was all good information about the needs, gaps, and barriers that we are seeing, some of which may be unique but many are common throughout the state. It is good to see that entities are working to address these gaps and issues by entering into partnerships and collaborations, coordinating with other programs to expand and maximize efforts. We need to ensure we continue to keep each other informed as we continue with these efforts.

- *Brief break (5 minutes)*
- Illinois HIV Epidemiologic Profile, Unmet Need, MMP Overview (35 minutes)
  Cheryl Ward, IDPH HIV Surveillance Administrator
  ILHPG Epidemiologic Profile/Needs Assessment Committee
  - Input, Questions & answers, Take-away (5 minutes)
    Cheryl provided a comprehensive overview of the HIV epi data, its limitations, its significance, and its usefulness in planning and program implementation, monitoring, and evaluation. A 7-8 page document with Statewide HIV Epi Highlights is posted on the webinar website for easy viewing and download. (Please refer to that document for a listing of important HIV epi stats). We currently estimate that about 12.8% of HIV positive cases have not tested and are undiagnosed. An estimated 22% of cases in eHARS have no reported risk (NRR) or no identified risk (NIR). The Surveillance Unit publishes and posts monthly updates on the IDPH website and has released numerous HIV fact sheets on special topics. Chicago has a larger proportion of young adults, Blacks, and Hispanics than the rest of the state as a whole. The estimated rate of new HIV infections for Black men in Illinois, excluding Chicago, is nine times that of white men and three times that of Hispanics. The estimated rate of new HIV infections for Black females is 15 times that of white women. Late testing and presentation of HIV infection is a missed opportunity for HIV prevention and care. The percentage of new HIV diagnoses testing late is lower in Chicago than in the rest of the state combined. ***Challenges:*** *Not all genders, racial/ethnic and age groups are affected equally by HIV; data on transgender population is limited.*

    Successes: *Linkage to care initiatives are reaching more people: Unmet need has declined 15.3% since 2004; An estimated 90% of people in care are on ART; 80% of people in care are virally suppressed; HIV testing efforts are finding more positives; HIV surveillance data are used to identify specific cases eligible for LTC and partner services.*
- Public Comment Period (5 minutes)
  Chris Wade asked the group to dedicate today's meeting to the memory of David Roesler.
- Adjourn –*The meeting was adjourned at 12:40 pm*