Illinois HIV Integrated Planning Council (IHIPC) Webinar Meeting
Minutes

9:30 am: Welcome; Introductions; Moment of Silence

IHIPC Co-chairs

Co-Chairs J. Nuss and N. Holmes welcomed all members/guests to the meeting. Webinar and housekeeping instructions were reviewed. Following this, the group was led in a moment of silence for all people living with HIV past and present and for all those working to end the epidemic in Illinois.

9:35 am: Meeting Process/Instructions

» Attendance/Roll call

All present IHIPC members were announced, and the attendance of guests was recorded

» Call meeting to order; Review of: agenda, meeting objectives, IHIPC purpose; Announcements; Updates

The Co-Chairs reviewed the meeting objectives, meeting agenda, and the IHIPC concurrence checklist.

The following announcement were made at the meeting:

- Minutes from all IHIPC standing committee meetings continue to be posted on the IHIPC webpage: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg/meetings.
- The release of the Summer issue of the IHIPC newsletter has been delayed due to COVID response priorities. It will be released once it is approved by IDPH Communications.
- Member updates: Voting members C. Rodriguez and S. Fletcher have resigned. F. Carabello and R. Jimenez have transitioned from at-large members into the vacant voting positions.
- The IHIPC is accepting applications for 2021 membership until September 15. Recruitment priorities were reviewed at the meeting, and all interested parties are encouraged to apply. The membership application and accompanying cover letter were available with the meeting documents.

9:45 am: Increase Access to Health Care/Improve Health Equity: Linkage: 2021 Prevention Grant and Integrated Plan/ HIV Prevention Regional Gap Analysis – 45 mins with discussion

Curt Hicks, IDPH HIV Prevention Program Administrator

C. Hicks presented information about the HIV Surveillance and Prevention Program's application and budget for PS18-1802 (CDC funded grant). PS18-1802 Priorities, Strategies, and Outcomes were reviewed. Their alignment with the National HIV/AIDS Strategy was demonstrated (please see presentation slides for more information).

The following changes will be implemented for PS18-1802-funded services in 2021:

- Comprehensive Prevention for Positives: expanded routine screening from a newly awarded capacity building grant; CDC trainings and implementation of Testing Together; Stay Connected added for Treatment Engagement; Partner Services form updates; TWIST added for HIV+ transgender women; and enhanced data collection and monitoring for fast growing clusters.
- Program Coordination and Service Integration: capacity building for tuberculosis testing.
- Evidence-based Interventions for Highest Risk HIV-negatives (for grants cycles beginning in 2021 only, not renewals): a new Harm Reduction Contact unit for materials distribution only; and a shift in PWID testing from HIV to HCV.
- Policy Initiatives: HIV Care Provider "Report Cards" for non-Ryan White providers; alignment of Ryan White and Prevention Partner Elicitation; automatic electronic cross-jurisdiction Partner Services; transition of the Third-Party Billing Grant to IDPH's Division of Infectious Disease; and enhanced HIV Cluster Response reporting per new CDC guidelines.
- Regional HIV Prevention Grant: a new SBS provider will be designated to conduct services in Region 5; and the next grant cycle will occur in SFY22-24.

C. Hicks then reviewed the 2021 HIV Prevention Regional Gap Analysis. First, the 2021 budget and funding formula for the RIG grant was reviewed. The presentation continued by explaining how RIG grant activities fill gaps in service that are not fulfilled by other state grants (African American AIDS Response Act, Quality of Life, Direct Grant, etc.). It was explained that in the analysis, each region's HIV incidence proportion by prioritized population (16 categories by transmission category/ race) is compared to services rendered to each prioritized population by other state grants, then any identified gaps per prioritized population are determined to be scopes in the RIG grants. Results of the statewide gap analysis were presented and explained. It was noted that although some prioritized populations have 0% scopes in the RIG grants, RIG providers can still test/provide services for persons outside of targeted scopes through supplemental services.

Discussion (Q: Question, C: Comment, A: Answer):
Q: Who prioritizes and allocates funding for Prevention services through IDPH?
A: C. Hicks responded: For 18-1802, priorities for Illinois outside of Chicago are based on epidemiology and CDC-identified strategies and activities. Chicago receives its own 18-1802 funding for Prevention services, which is overseen by the Chicago Department of Public Health.
Q: Thank you for discussing services delivered to Black and Hispanic MSM. What are we doing to help agencies reach these population to ensure equitable service delivery? I am wondering if IDPH/IHIPC has thought to consider incorporating the goals/strategies from the Black AIDS Institute *We the People Plan* into its work as the plan indicates ways to effectively make structural and systematic changes within systems of care to best serve people of color. I also wonder if agencies can do more to hire Black and Brown workers and/or partner with other Black and Brown agencies. *Note: the goals of the *We the People Plan* were shared in the chat box and can be found here: https://blackaids.org/we-the-people/.
A: C. Hicks and J. Nuss responded: The *We the People Plan* could be brought to IHIPC committees for consideration, but it may be especially fitting for review by the newly formed Health Equity Workgroup (the first meeting of this group will be on August 28). The primary focus of the Workgroup initially is to look at the impact of systematic racism on service delivery among black MSM, and the group will discuss how to incorporate these ideas into grants and other activities.
Q: How will the IHIPC use the strategies that incorporate collaboration to close the testing gap?
A: C Hicks responded: All IDPH-sponsored activities would not be possible without collaborations with grantees that are in the field to conducting services/testing. Collaborative efforts between IDPH and grantees to close testing gaps among Black and Hispanic MSM include hiring and training of peers; and social marketing/social media/social app outreach specifically for MSM. These collaborations have helped facilitate the gains we have made in serving MSM of color.
Q: One of the data slides shows HIV diagnoses in Illinois among males by race. The slide reflects an increase in 2012 among Blacks and Hispanics. Do we have any data to support reasons for these increases?
A: C. Hicks responded: The increase seen on the data slides represents Black and Hispanic MSM only (not all Black and Hispanic people). The change in trends (from increasing in 2012 to decreasing in years after) is most likely a result of restructuring services to be epidemiologically based. Other factors might have also contributed to 2012 increases, such as a general shift of prioritization from risk reduction activities to successfully treating people living with HIV. Overall, we have seen declines since then and want to keep supporting this trend with risk-based testing/interventions.

10:30 am: Results of our 2019-2020 Risk-Targeted Focus Groups – 55 mins with discussion

Marleigh Andrews-Conrad, IDPH HIV Community Planning Specialist

M. Andrews-Conrad presented the results of the 2019-2020 Targeted-Population Focus Groups conducted thus far, which included needs assessment activities for the following populations: Black Women, Transgender People, and PrEP Users. The presentation began with an overview of the planning and purpose of focus groups in HIV planning. Logistics of each focus groups, summaries of the meeting questions, summaries of the results, and identified recommendations for each focus group were then reviewed (please see the meeting presentation for details). A summary of the recommendations included the following:

- Black women: HIV outreach and testing efforts should incorporate specific strategies to engage Black women in services (including those in monogamous relationships); and peer-led services and support groups should be prioritized in HIV prevention and care, especially for Black women.
- Transgender People: More education is needed for medical providers to ensure gender affirming care for transgender patients; holistic services should be made available to transgender people to address social determinants of health and to ensure wellness; PrEP and PEP services should be widely marketed for transgender people and should specifically include transgender representation in imaging/messaging; and transgender people should be included in the planning and implementation processes to ensure best practices.
- PrEP users: PrEP should be widely advertised in public spaces and online to increase community awareness; more coordination among PrEP providers is needed to make PrEP successful; and peer-led services/access to PrEP navigators should be expanded for PrEP services, especially to support new PrEP users.

Limitations of the focus groups were reviewed, including the notation that the results of each focus groups were not representative of the entire selected populations. New limitations for future needs assessment activities due to COVID-19/social distancing were also discussed.

Discussion (Q: Question, C: Comment, A: Answer):
Q: Are the infographics available somewhere? They might be helpful for prevention providers to use when doing health education.
A: M. Andrews-Conrad responded: Yes, they are available on the IDPH website: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/infographics.
C: The sexual health and HIV prevention needs of women, especially Black/Brown women who are not heterosexual or who do not fall into an 'at risk' group, are not understood by health services. There is a particular lack of understanding of women's sexuality, relationships, and sexual fluidity when it comes to HIV prevention and service providers.
A: M. Andrews-Conrad responded: Thank you for sharing and emphasizing this. We need to know how to target and provide affirming services to everyone regardless of if they identify with a priority population.
Q: Could we consider community surveys where we over-sample for traditionally marginalized groups? Or perhaps each funded agency could be responsible for recruiting participants for these assessment activities from specific demographics?
Q: Maybe we could use a survey link to answer questions, or maybe use social media to ask these question, especially to target risk groups. The surveys links could be available on websites like Grindr ™, Adam4Adam ™, etc.
A: M. Andrews-Conrad responded: Surveys could be doable. We did work with service providers to try to recruit for the focus groups, but for some, the recruitment efforts were not as successful as we had hoped. We would have to continue to strategize for best recruitment.
C: In the future, perhaps a focus group with people who declined PrEP enrollment might be helpful. A focus group with medical providers who deliver PrEP services might be helpful as well.
A: M. Andrews-Conrad responded: Yes, these are great ideas as we could specifically ask about barriers to PrEP to help us identify what is working and what isn't in the field.
Q: Are incentives or compensation available for focus group participants? That might help address barriers for participation especially among harder to reach populations (help with transportation, recognize the value of their time and input, etc.).
A: M. Andrews-Conrad responded: For these focus groups, we were able to offer participants a catered meal and a $25 gift card. I am not sure if incentives could be offered for activities like surveys.
Q: For persons not engaged in IDPH prevention, has social media recruitment been utilized with platforms such as Snapchat (or tikTok) with ads to links or specific IDPH channels? CDC and other public health programs have implemented channels and ads with links here and to apps such as Grindr, etc.
A: M. Andrews-Conrad responded: I am aware of IDPH grantees advertising on dating apps, but I am not aware of advertising on other sites or apps. This could be good for more generalized outreach.
C: SSHARC's PrEP program offers incentives to internal and external clients which helps in educating more people and having an opportunity to address their concerns. It's important that organizations understand and support this initiative.
A: M. Andrews-Conrad responded: That is good to know. It is important for us to get creative with incentives for engagement given funding restrictions. The participants at the PrEP User focus group told us that Jackson County gives PrEP clients palm cards to give out in the community. If they are returned by a new PrEP client, the person who gave them the card gets an incentive.

11:25-11:30 am: 5 Minute Break

11:30 am: <u>Improve Health Equity</u>: Recommended 2021-2023 Risk Group Definition Changes- 30 mins/ 15 mins for discussion/vote

Curt Hicks, IDPH HIV Prevention Program Administrator
Mike Maginn and James Charles, IDPH Epi/Needs Assessment Committee Co-chairs

C. Hicks and M. Maginn presented the recommended changes for the 2021-2023 Priority Population Definitions on behalf of the Epi/NA Committee. Rationale for prevention prioritization and an explanation of the data sets that were analyzed to determine the definitions were reviewed. This year, three recommendations for changes to the definitions were submitted to the Committee for vetting. Those recommendations and the Committee's response to each recommendation are below.

- For HRH, add Black females whose sexual partner(s) was incarcerated within the last year: based on previous seropositivity data collected for this consideration, the Epi Committee recommended to exclude this from the 2021-2023 definitions.
- For PWID, consider prioritizing HCV testing in place of HIV testing: due to extremely low HIV seropositivity rates and high HCV seropositivity rates among PWID in the most recent testing data analysis, the Epi Committee recommended to include this in the 2021-2023 definitions.
- Throughout the definitions and Points of Consideration, revise language to be gender affirming: The Epi Committee recommended that current language should be revised, but it is important to note that this language did not change or add any priority groups (i.e. non-binary people were not included as a priority population in the definitions).

A summary of the changes to the Priority Populations Definitions document were as follows (please see slides for specific language:

- Use of "Prioritized Population Definitions" rather than "Prioritized Risk Definitions.";
- Updated percentages of testing by type using CY2019 data;
- A statement added to the preface emphasizing the evidence-based nature of prioritization;
- Use of "man" and "woman" instead of "male" and "female" to indicate gender. For the 13-19 year old MSM subgroup, the term "boy" was used;
- A clarification that PWID are no longer prioritized for HIV testing, but remain prioritized for other services;
- For prioritized populations with no gender specification (PWID and PWHIV-OR), the phrase "person of any gender" is used to underscore inclusion;
- Points of consideration moved behind the priorities; and
- New language was added to the Points of Consideration to emphasize the following: equitable service allocation to Black and Hispanic MSM; the disproportionate affect of HIV aged 20-39 years; and information regarding gender as it relates to prioritization.

Discussion (Q: Question, C: Comment, A: Answer):

Q: Can you all talk a little bit about the difference in HCV and HIV, relative to why PWID are contracting HCV even though they are clearly taking steps to prevent new HIV transmission?

C: I think there needs to be more testing for HCV and there are also people who spontaneously clear the virus. It seems as though PWID do not access medical care as often unless they get really sick, enter treatment, or go to correctional service. I think all of that impacts what the numbers look like for testing, diagnosis, and treatment. I think there is a lack of perceived risk when PWID clears the HCV virus. I still feel there needs to be more education about equipment contamination that can lead to HCV transmission (cotton, rinse water, bloody surfaces, cookers).

A: C. Hicks responded: In the past, there may have been a bigger emphasis on HIV testing and treatment among PWID, but now that we are seeing less HIV incidence among this population, there is a greater focus on HCV. This may account for high HCV seropositivity as we are identifying more old, undiagnosed cases. Reinfection of HCV might also be a factor.

Q: The most recent seropositivity data we have for HRH females with partners released from Corrections is from 2012-2013? Are there any Illinois datasets with more recent data for this group?

A: C Hicks responded: There is no new data for this, but the results of the data from 2012-2013 very strongly indicated that seropositivity was not correlated solely to having a previously incarcerated partner.

Q: Should the terminology ""High Risk Heterosexual"" be reconsidered? People who fit the risk criteria for HRH do not necessarily identify as heterosexual even if they are having sex with someone of a different gender.

A: The term "high risk heterosexual" is used by the Surveillance Unit, and we have tried to keep the same name for risk groups across programs. Any gender-specific definitions are based on seropositivity data analyses.

Q: How much money/how many HIV tests are going toward PWID in Illinois outside of the RIG grants? I'm concerned about eliminating a culturally competent, community-entrenched testing source for PWIDs in Illinois if we don't have comparable services outside the RIG grant.

A: C. Hicks responded: Although I am not aware of the specific quantity of testing/funding outside of IDPH grants, it is important to note that HIV seropositivity has become so low throughout all of Illinois that it is no longer cost effective to heavily invest in these efforts, especially when compared to HCV. Additionally, Prevention grantees can use supplemental dollars to provide HIV testing to PWIDs, so no one will be turned away if an HIV test is needed/requested.

Q: Can you please explain again the reason for the change from man to boy for that population?

C: In most situations, the word "boy" is not a problem. Used to describe an African American man, however, the word is troublesome. That's because historically, whites routinely described Black men as boys to suggest African Americans weren't on equal footing with them. Both during and after enslavement, African Americans weren't viewed as full-fledged people but as mentally, physically, and spiritually inferior beings to whites. Calling Black men "boys" was one way to express the racist ideologies...can we rethink this term?

C: For ages 13-19, can or has the phrase "adolescent man" be considered? The use of the word "boy" can have some stigmatizing connotations rooted in racist language with specific black and brown men of color.

A: M. Maginn and C. Hicks responded: There were very lengthy discussion on the wording for how to refer to teenagers so that it was in line with recommendations for the Gender Language Workgroup. "Boy" can be changed to "adolescent man" in the document.

Q: Does all the data from the routine, risk-based, and equality testing outcome considers cultural and linguistic barriers?

A: Although the data doesn't specifically measure cultural or language barriers, we do our best to make sure that our service delivery is engaging and affirming to people most impacted by HIV. This includes funding agencies that specialize in serving specific communities and hiring peers.

Vote: At 12:27pm, the motion was made by J. Nuss and seconded by W. Bradley to accept the 2021-2023 Risk Definitions for the Priority Populations as recommended and presented by the IHIPC Epi/NA Committee with the following exception: changing "boy" throughout the definitions to "adolescent man".
Discussion for vote:
C: I think we should take this discussion back to the Epi/NA Committee and Gender Language Workgroup for more consideration before voting.
A: J. Nuss responded: Because the motion has already been made, we must vote on it. If the motion does not pass, we can entertain a new motion with this recommendation.
Result: The motion carried with 19 in favor, 3 opposed, 2 abstentions, 9 absent/no vote cast, and 1 vote not cast due to a member's temporary suspension.

12:35 pm: Public Comment Period/Parking lot

There were no requests for Public Comment and no items in the Parking lot.

12:37 pm: Adjourn

The meeting adjourned at 12:37pm.

Member Name	Member Type	Date: 6/2/20 Time: 9:15 am **Motion 1:** A motion was made by C. Crause and seconded by N. Holmes on 6/2/20 at 9:15 am to adopt the agenda for the 8/20/20 IHIPC Meeting as approved by the Steering Committee. The motion was sent to members 6/9/20 at 1:00 pm; they were given until 12:00 pm 6/19/20 to submit votes.	Date: 8/20/20 Time: 12:27 pm **Motion 2:** A motion was made by J.Nuss and seconded by W. Bradley to accept the 2021-2023 Risk Defintions for the Priority Populations as recommended and presented by the IHIPC Epi/NA Committee with the following exception: changing "boy" throughout the definitions to "adolescent man".
Benner, M.	Voting	X	A
Box, T.	Voting	Y	Y
Bradley, W.	Voting	Y	Y
Carabello, F.	Voting		Y
Carter, D.	Voting	Y	X
Charles, J.	Voting	Y	X
Choat, L.	Voting	Y	Y
Crause, C.	Voting	Y	N
Dispenza, J.	Voting	TS	TS
Erdman, J.	Voting	Y	A
Filicette, J.	Voting	Y	Y
~~Fletcher, Scott~~	~~Voting~~	X	
Gaines, Michael	Voting	Y	X
~~Gaylord, Sanford~~	~~Voting~~		
Hendry, Chad	Voting	Y	N
Holmes, Nicole	Voting	Y	Y
Hoots, Cheri	Voting	Y	Y
Howard, Tawana	Voting	Y	X
Hunt, Don	Voting	Y	X
Jimenez, Ricardo	Voting		Y
Johnson, Rashonda	Voting	Y	Y
Jones, Shanett	Voting	Y	X
Kowalsky, James	Voting	Y	Y

Y: In favor;
N: Opposed;
A: Abstain;
X: Absent or No vote cast/received
TS: temporarily suspended

Laskowski, Casie	Voting	Y	X
Lewis, Karen	Voting	Y	Y
Maginn, Mike	Voting	Y	Y
Meirick, Andrea	Voting	Y	X
Meyer, Len	Voting	Y	N
Nuss, Janet	Voting	Y	Y
Olayanju, Bashirat	Voting	Y	Y
Rehrig, Susan	Voting	Y	Y
~~Rodriguez, Christofer~~	~~Voting~~		
Roeder, Lisa	Voting	Y	Y
Wheeler, Rose	Voting	Y	X
Williams, Mark	Voting	Y	Y
Williamson, Mildred	Voting	Y	Y
Zamor, Sara	Voting	Y	Y
Type of Vote: Hand Count, voice, electronic		**electronic**	**electronic**
Results: Carried/Defeated		**carried**	**carried**
Results: Vote Count		30 in favor , 0 opposed, 0 abstentions,4 members absent or "no vote cast/received" , 1 TS	19 in favor , 3 opposed, 2 abstentions, 9 members absent or "no vote cast/received" , 1 TS

*Planning Group presentations/discussions are centered on IHIPC functions/processes, the goals/indicators of the National HIV/AIDS Strategy (NHAS), the steps of the HIV Care Continuum, and the Getting to Zero Illinois (GTZ-IL) Plan domains.

NHAS Goals:

Goal 1: Reduce new HIV infections.
Goal 2: Improve access to health care/
Improve health outcomes for PLWH.
Goal 3: Reduce HIV-related health disparities.
Goal 4: Achieve a more coordinated national response to the HIV epidemic.

Steps of the HIV Care Continuum:

1. Linkage to Care
2. Engagement in Care
3. Retention in Care
4. Antiretroviral Therapy
5. Viral Suppression

GTZ-IL Domains:

I. Build the future workforce.
II. Increase access to healthcare.
III. Improve health equity.
IV. Increase efficiency through governmental coordination.
V. Care for linked, co-occurring conditions.
VI. Measuring our progress through Surveillance and other data.