Illinois HIV Planning Group (ILHPG) Meeting Minutes

February 17, 2017, 9:30 am – 12:00 pm

- 9:30 am: Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)
  The Co-chairs welcomed everyone to the webinar meeting, introduced presenters then led the group in acknowledging a moment of silence for our HIV community.
- Review formally adopted agenda
  The Co-chair reviewed the agenda items with participants. The Co-chair noted the new symbols that will be placed next to the agenda topics and used to identify the NHAS indicator and/or Continuum of Care steps that each presentation/discussion area will address.
- Webinar process; Attendance; Announcements; Updates (15 minutes)
  - Webinar meeting, online meeting survey, and online discussion board instructions
    Instructions for the webinar and accessing meeting documents, the online meeting survey, and the discussion board were explained.
  - Announce logged in members and take roll call of other voting members to verify quorum
    The names of members who had logged into the webinar were announced and roll call of other voting members was called. Quorum was verified.
  - Review goal of the ILHPG and meeting objectives
  - Announcements
    - Member updates
      All new members have been assigned mentors and committees.
    - 2017 Cumulative voting and non-voting member meeting attendance log
      These documents will be provided to members on a monthly basis after the last scheduled committee meeting of each month. Members were instructed to track their own attendance. The ILHPG Co-chairs and Committee co-chairs will also be tracking attendance and following up with members as needed. The Co-chair referenced a slide in the presentation that demonstrated we engaged 113 new community/agency representatives (other than current voting and non-voting membership of the ILHPG and the RW Advisory Group) in either ILHPG or Integrated Planning group meetings in 2016. That is something of which we should be proud.
      Posted Reports/Updates:
      - Committee, Liaison and Regional Lead Agent, RIG Rep, and IDPH HIV Section reports
        These documents have all been posted and will be maintained on the ILHPG webinar webpage.
    - Review goal of the ILHPG, meeting objectives and Concurrence checklist
      The primary goal of the ILHPG, the objectives for today's meeting, and the essential elements of the concurrence checklist were reviewed with participants. Members were reminded that they should review the concurrence checklist after each meeting to ensure we are capturing the essential elements of concurrence in our committee work, meeting presentations, discussions, and decision-making recommendations.

- 9:50 am: Results of 2015 Illinois Youth Risk Behavioral Surveillance (YRBS) Survey/Discussion of Prevention Planning for Youth – (30 minutes)
  : *NHAS Goal 1 (Reduce New HIV Infection); Steps of the HIV Care Continuum: Primary Prevention*
  Reginald Patterson, Illinois State Board of Education, Project Director CDC/DASH Health Grant and Liaison to the ILHPG
  - Questions & Answers, Discussion, Input - (15 minutes)

The YRBS is conducted every 2 years. The Illinois State Board of Education is responsible for managing the survey outside of Chicago; The Chicago School System manages the survey within Chicago schools. Six types of health-risk behaviors are measured in the survey. A sampling of students in grades 9-12 from 40 schools outside of Chicago and 40 in Chicago were surveyed. The student response rate was approximately 80%. The combined responses were analyzed for the purpose of this presentation.

Reginald Patterson provided an overview of the 2015 Illinois Youth Risk Behavior Survey results, focusing on the trends and disparities Indicator 3 of the National HIV/AIDS Strategy: "By 2010, reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by at least 10 percent." CDC has directed jurisdictions to measure this indicator by measuring the following data for young gay and bi-sexual men (grades 9-12) who reported ever having sexual intercourse with only males or with both males and females who engaged in any of these three risk behaviors: from the jurisdiction's bi-annual YRBS: ever injected illegal drugs, sexual partners in the past 3 months, and no condom last time had sex. Here is a summary of some of the results:

- The percentage of all students who ever had sexual intercourse was 38.6%. The percentage for Black students was 52.5% compared to 35.7% for White students.
- The overall percentage of students who ever had sexual intercourse has steadily decreased over the years, from 54.7% in 1993 to 38.6% in 2015.
- The percentage of students who were currently sexually active (sexual intercourse with at least one person during the past 3 months) was 29.7% overall, with a higher percentage for Black students (36.1%) compared to Hispanic (32.4%) and White (28.3%).
- The overall percentage of students who were sexually active and who used a condom during last sex was 56.2% with that percentage being highest among Black students (63.3%).
- Overall, condom use had decreases over the last several years. The year with the highest percentage was 64.8% in 2007.
- Black students reported the highest percentage (12%) of forced physical sex compared to Hispanic students (10.2%) and White students (6.9%).
- Ever-injected illegal drugs: Illinois males: 4.5% (trending slightly upward across a decade in both genders).
- Three or more sexual partners in past 3 months: Illinois males 11.1% (trending downward across a decade in both genders).
- Only 86.7% of students reported ever having had sex education in school.
- Only 89.1% of students reported ever having had HIV education in school.

Reggie talked about the work that ISBE does in providing technical assisting to all school districts, especially its 10 priority school districts, through its CDC Division of Adolescent Sexual Health grant, focusing on three areas: school health services, safe and supportive school environments, and sexual health education.

Question: Is Chicago Public Schools one of the school districts in your 10 priority school systems?

Response: No. Chicago Public Schools receives its own DASH grant from CDC and provides the same services within the city of Chicago that ISBE provides to schools in the rest of the state.

Question: Great presentation- thank you. Has there been discussion about collecting information on sexual orientation and/or more comprehensive options for gender identity? I wonder what the data may look like if you could control for LGBTQ students.

Response: There are mandatory questions on the survey as well as questions that states can opt to or not to select. Reggie was not sure if these were included on the survey. Janet Nuss stated that while preparing the Integrated Plan, she had confirmed with Jessica, the ISBE consultant who oversees the Illinois YRBS, that there were questions about sexual identity (heterosexual, gay or lesbian, bisexual) in the questionnaire. There was also a new question that ISBE would be adding to its 2017 questionnaire.

Note: Janet later recalled the archived email correspondence with Jessica and found that the question to be added was on how others may view your gender expression.

Question: Great presentation. Was there any STI testing offered to survey participants?

Response: This was just an online survey.

Comment: Since young people of color bear the highest burden of HIV, it seems our programs might be working on getting more HIV testing to this group.

Response: That is what we try to encourage through our State school Health Advisory Committee.

Question: Did ISBE make an effort to reach out to school districts, particularly in Southern Illinois rural communities where the participation was very limited?

Response: There are over 800 high schools outside the city of Chicago. An effort was made to inform and seek participation from all high schools, but ultimately, the superintendents make that decision.
Question: Will there be any data in the future to address diversity in sexual orientation and gender identity in the future?
Response: Janet or Marleigh will contact Jessica to see if the results presented today can be further analyzed by sexual orientation and gender identity.

Important Note: The below questions and comments were received after the presentation time and were forwarded to Reggie Patterson and Jessica Gerdes at ISBE. The following responses were received:
Question: Did the 2015 survey questionnaire include the questions on sexual orientation (67 and 68) that will be included in the 2017 survey? If so, can the male responses you reported out be further broken down by those who identify as gay and bisexual vs those not sure and those heterosexual? Looking at that breakdown now and in the future might help us better explore our progress in meeting the NHAS indicator for at-risk youth as described below.
Response: No, the 2015 survey did not include the two new questions on sexual orientation that will be included in the 2017 survey questionnaire. ISBE does not currently have capability of doing further data analysis; we have a data analysis department but they are scrambling to get just required federal and state data completed. Anyone who wants to further analyze the data is free to obtain the raw data from CDC. CDC always asks ISBE if it's permissible to release the raw data to a researcher and so far we've always said yes. But your question specifically was not in 2015.
Question: Given that roughly 87% of students are now receiving comprehensive sex education, what can possibly explain the epidemic of STI's in youth and the continued rising trends.
Response: Health education (children and adults) always is subject to behaviors; in other words, knowledge alone does not change behavior. If it did, there would be fewer of many diseases, such as heart disease, obesity, lung cancer, etc. We need to provide knowledge and foster change in attitudes and hope for change in behavior to reduce many diseases and poor health conditions.
Question: Thank you for your presentation! Excellent data! Also, when referring to sexual intercourse, was the data collected only for vaginal-penile intercourse or was anal sex included in the question?
Response: The questions are phrased as "intercourse" and the various means / methods of intercourse are left up to the student to decide. There is no specific mention of vagina, penile, anal, or oral intercourse anywhere in the survey.
Question: I know you mentioned injection drug use, what data if any was found in the Illinois YRBS about use of prescriptions drugs?
Response: See the attached 2015 IL HS questionnaire. The entire set of data reports can be sent to anyone via email or a flash drive.
Question: Will there be more data results in the future that reflect mixed race students?
Response: The question on race allows more than one race to be selected. Any researcher who wants to review the raw data and provide their own results to reflect mixed race may do so.
Question: As a service provider, sometimes it's difficult connecting with the appropriate Chicago Public School Administrator to offer HIV and STI education and testing. *(This may also be true outside of Chicago).* What would you suggest to make this process easier?
Response *(from another member):* There are currently testing programs within some schools and several agencies have partnered to provide testing for adolescent youth in CPS.
Response (from presenter): Testing can only be done within the clinical setting of a school based or school linked health center due to lab regulations and staff training. Those school based centers are under the jurisdiction of their sponsor, a hospital, health department, or community clinic. Contact the district school nurse to determine if there is a clinical testing service available in the school. As far as health education (quite different from testing), contact the district lead health educator or superintendent office. Reginald Patterson may have contact information for the program staff in the Chicago health education curriculum.
Question: Was there a question in the survey regarding STI/STD screening or how many have had an STI/STD screening within the past 12months, if that's more appropriate?
Response: See the attached questionnaire. The only question regarding screening or testing was for HIV.
Question: Can you explain weighted data?
Response: Weighted data means that the responses can be expected to be accurate to a reasonable extent because there were enough responses to calculate. In order to obtain weighted data, CDC has calculated that at least 60% of the students selected for the survey responded. If there were fewer, then all we can say is that the students who responded said this or that. With weight, we can say, if we asked ALL students the same questions, the results would be similar, give or take a few percentage points (I believe plus or minus 4 for the Illinois survey.)

- 10:45 am: How PrEP4Illinois and Current Care and Prevention Service Models Can be Used to Meet the NHAS PrEP Indicator and to Address Disparities among MSM of Color, Young MSM, AA and Latina Women, and Transgender People – (30 minutes)

  : *NHAS Goal 1 (Reduce New HIV Infection) and Goal 3 (Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All Steps*

  Jeffrey Maras, IDPH Ryan White Part B, MAP, and PAP Administrator
  Curt Hicks, IDPH HIV Prevention Administrator

  - Questions & Answers, Discussion, Input - (15 minutes)

  Jeffrey Maras began by mentioning how PrEP is included in the portfolio of activities or services within each program in the HIV Section. There are numerous points of engagement/entry where interested individuals can access information about and/or be linked to PrEP. We have the infrastructure in place now in the IDPH HIV Section to coordinate application, co-pay assistance, and delivery of PrEP meds for people with an existing health plan (public and private) and people uninsured. Gilead has a pharmaceutical assistance program that can provide PrEP to people uninsured, including non-U.S. citizens. ADAP and RW Part B funds cannot and are not being used to support this initiative. Medicaid allows now for PrEP as well as assists with co-pays and deductibles for PrEP-related lab and medical visits.

  Dr. Maras then provided a live demonstration of the PrEP4 Illinois website that was fully vetted with our community partners prior to launching. He walked us through accessing basic information about PrEP and PrEP medications, info about how to get PrEP and assistance with payment, the directory of medical providers and facilities that have been identified as PrEP prescribers, the application process, and links to other PrEP-related resources.

  Curt Hicks then presented on the variety of various services that IDPH and its grantees have provided or can provide related to PrEP, including multiple forms of PrEP training/education and PrEP counseling and support for high risk negatives. PrEP training has been provided to medical case managers and HIV prevention counselors. We will need to educate and provide more training to licensed PrEP providers, especially outside of Chicago. PrEP is promoted by IDPH through medical case management encounters, risk-based testing, effective behavioral interventions (EBI) for HIV-negatives, PrEP incorporation into CDC-approved EBIs, and EBIs for HIV positives (regarding available services for partners). Our risk-based targeted testing program reaches about 12,000 people per year. We need to scale up testing in order to reach all the high risk people who would benefit from PrEP. PrEP can be supported through the provision of Comprehensive Risk Counseling Services (CRCS). Counselors using this strategy/intervention can assess clients for risk factors for PrEP eligibility and help clients navigate through the PrEP application, medical referral, prescription fills, medication adherence, and medical re-evaluations. Curt demonstrated how Provide users could document PrEP discussions as well as PrEP referrals and access during delivered CRCS prevention sessions. Curt reinforced that scopes for HIV+ prevention services are great opportunities to provide PrEP information and counseling for partners. Curt referenced an objective related to expanding implementation of PrEP that the Interventions and Services Committee is currently working on in 2017. He said that in addition to PrEP4 Illinois website access counts, IDPH will be working on accessing information about PrEP prescribing from major pharmaceutical companies and Medicaid.

  Question: How many clients are utilizing the IDPH PrEP program and how much has IDPH paid out in "remaining costs" for these clients?

  Response: The website was completely launched in late fall 2017, and the uptake has been slow to start. We have only enrolled 5 clients to date. Jeff said he was unsure of the expenditure amount.

  Question: Thanks for the presentation, Curt. I am sorry if you covered this and I missed it- but since CRCS is no longer offered as an in-person training by the CDC, will the Department be offering CRCS training- or will the CRCS materials on the CDC website satisfy the training need for a "new" navigator?

  Response: The CRCS training materials currently on the CDC website can be used and we will contact the Training Unit to see if they can provide in-person training.

  Question: Thanks- in the meantime, will navigators be able to implement PrEP navigation under CRCS or not?

  Response: Yes, those who are currently CRCS-certified can implement PrEP navigation.

  Comment: In terms of CRCS training, it is also helpful if providers have had PCM training.

  Response: Yes.

  Question: What is PCM?

  Response: Prevention Case Management, which has evolved into CRCS. Those certified to deliver PCM are accepted as certified to deliver CRCS.

- 11:40 am: Planning for and Enhancing HIV Prevention in the Transgender Community and Increasing Viral Suppression among HIV+ Transgender Women- (20 minutes)

: *NHAS Goal 1(Reduce New HIV Infection), Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: Primary Prevention, Viral Suppression*

Marleigh Voigtmann, IDPH HIV Community Planning Intern

– Questions & Answers, Discussion, Input - (15 minutes)

Before facilitating discussion and questions/comments from participants, Marleigh provided an overview of the following issues relevant to transgender individuals: the new NHAS indicator r/t transgender women, literature about HIV transmission risk and the many associated psycho-social-economic-structural factors, HIV-related health disparities, recent Illinois HIV data, and best practices.

NHAS indicator: Increase the percentage of transgender women in HIV medical care who are virally suppressed to at least 90%>

Literature review:

- Globally, it is estimated that approximately 19% of transgender women are living with HIV.
- It is estimated that transgender women are 49% times more likely to acquire HIV when compared to other adults.
- 56% of Black transgender women, compared to 17% of white transgender women and 16% of Hispanic transgender women were newly identified as HIV positive.
- From 2009-2011, CDC reported that transgender individuals were found to have a higher percentage of HIV positive test results (2.4%) compared to cisgender males and females (0.9% and 0.2% respectively).

Recent Illinois data:

- Marleigh mentioned that the IDPH HIV Surveillance Unit has updated and posted a more comprehensive Transgender Factsheet on its website and that it has been posted with other handouts for today's meeting. Data collection of gender at birth and current gender began in Illinois eHARS in 2009. There are still issues with incompleteness of reports so the transgender population could be quite larger than portrayed in the data. Illinois does not have a lot of data on female to male transgenders.
- The biggest disparity we see among transgenders diagnosed as HIV positive is with non-Hispanic (NH) Blacks, where we see the largest number of diagnoses.
- Most of our reported cases of HIV among transgenders are in Chicago and Cook County, with a small number in the East St. Louis and surrounding county area.
- The Retained in Care estimate on the Transgender Continuum of Care chart in the Factsheet should be interpreted with caution because this analysis did not use the HRSA definition of retained in care. Instead, it used: "*Persons who had at least one CD4 or viral load or HIV-1 genotype during the one year period*". Therefore, the Retained in Care estimate in this graph is higher than that estimated by the state in the Continuum of Care included in the Integrated Plan.

Best practices:

There are currently two funded Special Project of National Significance (SPNS) Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color initiatives being funded in Chicago (see slide set for more details):

- Chicago House and Social Service Agency (TransLife Care Project)
- Howard Brown

The funding period for these projects is 2012-2017, so we should be on the lookout for future evaluation reports.

Marleigh thanked Livia Navon and Cheryl Ward for the Illinois data included in this presentation. She also thanked Marissa Miller and other Howard Brown staff with whom she consulted and who provided input into this presentation.

Question: For the first "Illinois Data" slide that shows age of first HIV diagnosis and race, I see the data spans from 1986-2015. Unless I am mistaken, I do not believe data was properly collected for transgender individuals that far back- and collection tools did not accurately gather that data until relatively recently. I wonder if there was any discussion about this potential data collection issue when developing this slide?

Response: Marleigh said that she will follow up with Livia on a response. Curt said that physicians are supposed to update reports with new information so data that once was not collected could have been updated on a report submitted at a later time.

Question: Hi Marleigh, great presentation. One of the best strategies for working with transgender populations is providing Community-based Participatory Research and including the population in the program creation, implementation and delivery. I can share information about Project Elevate which focuses on both young cis- and trans-women. Also we should get data from Dr. Rob Garofalo at Lurie's who has been doing research on transgender individuals.

Response: Marleigh thanked Cynthia and said it would be great to receive that information and she would share it with the group.

- 12:10 am: Public Comment Period/Parking Lot (Brief Review of Member Demographic Survey Results, time-permitting) (10 minutes)
  The Co-chair noted that there were several questions remaining regarding the YRBS presentation, but that Reggie Patterson had left the webinar so they will be placed on the Discussion Board for the meeting and the Co-chair will follow up with the presenters for responses. These responses will be posted in the meeting minutes.
  The Co-chair mentioned that the voting and non-voting member demographic survey responses have been compiled and the reports were posted in materials/handouts for today's webinar. She encouraged everyone to review these results at their leisure. Since we are in the process of forming an entirely new planning group by the end of this year, she won't review the results with the group in their entirety. The results this year are solely for the purpose of documenting the demographic and expertise characteristics of the current membership of our planning group. They will not be used to guide our 2018 member recruitment.
- 12:15 am: Adjourn
  The meeting was formally adjourned.

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