



State of Illinois  
Illinois Department of Public Health

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# Illinois Department of Public Health Jurisdictional HIV Prevention Plan

2012-2016

Final Draft, August 2012

## **EXECUTIVE SUMMARY**

The 2012-2016 Illinois Jurisdictional HIV Prevention Plan was developed by the Illinois Department of Public Health (Department) in partnership with the Illinois HIV Prevention Community Planning Group (PCPG) and with the support of the Illinois Public Health Association. The plan, based on guidance from the U.S. Centers for Disease Control and Prevention (CDC) as set forth in the CDC PS-12-1201 HIV Prevention Funding Opportunity Announcement (FOA) to health departments, clearly describes the Department's HIV prevention plan for 2012-2016. The plan includes a description of current resources for HIV prevention services, care and treatment; how the prevention services, interventions, and/or strategies are currently being delivered; identified needs for HIV resources; identified gaps in services; goals and objectives for HIV prevention; and specific prevention activities and strategies to be implemented within the jurisdiction to accomplish these goals.

The plan is closely keyed to the goals, objectives and priorities that are defined in the 2010 National HIV/AIDS Strategy (NHAS) and the 2012 Illinois HIV/AIDS Strategy:

- Reducing new HIV infections
- Increasing access to care and improving health outcomes for people living with HIV
- Reducing HIV-related health disparities and health inequities, and
- Creating a more coordinated response to the HIV epidemic

As such, the plan provides an excellent opportunity to analyze how the jurisdiction's HIV prevention funding, planning and services align with those strategies. Creating the jurisdictional plan represents many months of research, analysis, decision-making, and prioritizing on the part of both the Illinois PCPG and Department staff. The partnership between the PCPG and the Chicago Department of Public Health (CDPH) represents a long-standing commitment to excellence, continuous quality improvement, and community service. It is our hope that this plan provides important and relevant information on the HIV epidemic and the state of HIV prevention within the jurisdiction that will be used by our partners and other key stakeholders engaged in HIV prevention activities to inform, guide and implement more effective HIV prevention services and activities.

It is anticipated that the jurisdictional plan will evolve, be refined and updated over the five-year planning period, in response to the newly released CDC "HIV Planning Guidance," as well as changes in the HIV epidemic, the needs of impacted populations, economic conditions, and other factors that cannot now be foreseen. Every year, the plan will be updated to reflect these changes and to identify new priorities for the current project year.

## TABLE OF CONTENTS

<b>Executive Summary</b>	i
<b>List of Tables and Attachments</b>	v
<b>Acknowledgements</b>	vi
<b>Abbreviations and Acronyms</b>	vii
<b>Introduction</b>	1
<b>Section I. Overview of HIV/AIDS in Illinois</b>	3
<b>Section II. NHAS, IHAS and the PCPG Strategic Plan</b>	4
National HIV/AIDS Strategy 2010 (NHAS)	4
NHAS Goals	4
Illinois HIV/AIDS Strategy 2012 (IHAS)	5
IHAS Goals	5
IHAS Defined Areas of Need for Resources, Infrastructure, and Service Delivery and Goals and Objectives for Addressing These Areas of Need	5
PCPG Strategic Plan, 2012	7
2012-2016 IDPH / PCPG Work Plan for Development of Jurisdictional Plan and Plan Updates, PCPG Planning Cycle Summary	8
<b>Section III. 2012 HIV Prevention Planning in Illinois</b>	9
PCPG Role and Structure	9
IDPH HIV Engagement Plan	10
Epidemiological Profile Review and Population Prioritization	11
HIV/AIDS 2011 Epidemiological Analysis and Gaps Analysis (Tiers One and Two)	12
Steps in Tier One – Review of Epidemiologic Data	12
Highlights of Epidemiologic Analysis Presentations (Table 1)	14
Steps in Tier Two	15
2012 PCPG Priority Populations (Table 2)	16
2012 PCPG Priority Populations - Recommendations	17
2012 PCPG Prioritized Populations - Risk Group Definitions and Points of Consideration	19
2012 PCPG Approved Interventions, Process and Final Product	21
PCPG / ISC 2011 Process for Approved Interventions for 2012	21
PCPG/ISC 2011 Provider Survey	21
PCPG/ISC 2011 Provider Survey Findings	22

2012 PCPG Approved Interventions and Services to be Provided –	
General and Additional Recommendations	23
2012 Recommendations for Adapting Evidence-based Interventions and Developing Homegrown Interventions	26
Other Recent PCPG/IDPH Needs Assessment Activities	28
HIV Prevention Community Forums	28
PCPG 2012 Prevention Provider Survey	28
PCPG and IDPH HIV/AIDS Section Direct Service Unit Joint Survey, 2012	28
<b>Section IV. HIV Prevention Regional Grant Process and Gaps Analysis (Tier Three)</b>	<b>30</b>
Service Allocation Through Regional Plans	31
HIV Prevention and Care Regions – IDPH	31
Illinois Regional HIV Prevention Map	32
Service Allocation Through Gap Analysis (Tier Three, Gaps Analysis)	33
Gaps Analysis, Tier Three, Example: Region 1, Regional HIV Prevention Grant Available Service Units (Table 3)	34
Regional Grant Funding Award Allocation Based on HIV Epidemiology	35
2012 IDPH Regional Grant Awards by Region, Based on HIV Epidemiology (18 Month Funding Cycle) (Table 4)	35
Epidemiologically-proportioned Service Allocation to Target Populations	36
Service Class Allocation	36
2012 IDPH Regional Grant Awards by Service Class and Region (18 Month Funding Cycle) (Table 5)	36
Expected RG Service Units, 2012 IDPH Regional Grant Awards by Service Class and Region	37
Expected RG Service Units, 2012 IDPH Regional Grant Awards by Service Class and Region (18 Month Funding Cycle) (Table 6)	37
<b>Section V. Description of Existing, <i>Non-RG</i> Funded Resources for HIV Prevention, Care and Treatment and Key Features on How Prevention Services, Interventions and Strategies are Currently Being Used or Delivered in the Jurisdiction</b>	<b>38</b>
Existing <i>NON-RG</i> Funded HIV Prevention Resources and Services	38
HIV Resource Inventory	38
STD Services	39
Illinois HIV/AIDS Hotline	39
Illinois Department of Corrections	40
IDHS/DASA HIV Prevention Services	40
Red Ribbon Lottery Ticket Quality of Life Grant Program	40
Housing Support for PLWHAs	41
Harm Reduction / Syringe Disposal	42
Families and Children AIDS Network (FCAN)	43
HIV Care Treatment and Prevention and Services – Ryan White Program Services	44
RWP Part A	44
RWP Part B	44
ADAP	45
Core Services	45

Support Services	45
Early Identification of Individuals With HIV/AIDS (EIIHA)	45
RWP Part C	46
RWP Part D	46
RWP Part F	47
ATEC Services	47
Minority AIDS Initiative, Part A Grantees	47
Minority AIDS Initiative, Part B Grantees	47

**Section VI. 2012 – 2016 Prevention Activities and Strategies to be Implemented Within the Jurisdiction** 49

High Impact Prevention and Scalability of Activities	49
Program Collaboration and Service Integration (PCSI)	51

Category A Activities and Strategies 52

Illinois Regional Grant Prevention Service Classes/Units to be Delivered in Regions 1-8 (18 Month Budget Period and Calendar Year 2012) (Table 7)	52
Targeted HIV Testing	53
Community-based Organizations Under Regional Lead Agents in Category A	53
Comprehensive Prevention With Positives	55
Specific Prevention Intervention Approaches for HIV-positive People	56
Behavioral Interventions for PWHIV	56
Behavioral Interventions for PWHIV by Percent of Program Funding and Number of Service Units to be Delivered in 2012 (Table 8)	56
Biomedical Interventions for PWHIV	57
Adherence Counseling	57
PrEP and nPEP Cost-Effectiveness Analysis	57
Post-exposure Prophylaxis	58
Pre-exposure Prophylaxis	58
Circumcision	58
Structural Interventions for PWHIV	58
Evidence-based Interventions for HIV-negative Persons at Highest Risk for Acquiring HIV	58
Illinois Harm Reduction and Syringe Disposal Program	59
Condom Distribution	59
Policy Initiatives	59
Perinatal Prevention	60

Category B Activities and Strategies, IDPH Expanded HIV Testing for Disproportionately Affected Populations 63

Routine Opt-out HIV Testing	63
In Health Care Settings	64
In Non-health Care Settings	64

Category C Activities and Strategies 66

MSM and Transgender of Color Project – IDPH	66
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## **List of Tables**

1.	Highlights of Epidemiologic Analysis Presentations (Reviewed at July 2011 PCPG Meeting)	14
2.	2012 PCPG Priority Populations, Voted on and Approved at 08/12/11 PCPG Meeting	16
3.	Gaps Analysis, Tier Three, Example: Region 1, Regional HIV Prevention Grant Available Service Units	34
4.	2012 IDPH Regional Grant Awards by Region, Based on HIV-Disease Epidemiology (18 Month Funding Cycle)	35
5.	2012 IDPH Regional Grant Awards by Service Class and Region (18 Month Funding Cycle)	36
6.	Expected Regional Grant Service Units, 2012 IDPH Regional Grant Awards by Service Class and Region (18 Month Funding Cycle)	37
7.	Illinois Regional Grant Prevention Service Classes / Units to be delivered in Regions 1-8 (18 Month Budget Period and Calendar Year 2012)	52
8.	Behavioral Interventions for PWHIV by Percent of Program Funding and Number Service Units to be Delivered in 2012	56

## **List of Attachments**

Attachment 1.	PCPG 2012 Strategic Plan - Finalized 11-16-11	68
Attachment 2.	IDPH HIV Engagement Plan - Final August 2012	80
Attachment 3.	Interventions Provider Questionnaire –PCPG Interventions and Services Committee (edited draft)	96
Attachment 4.	2012 PCPG Priority Population Approved Interventions	98
Attachment 5.	State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources – May 30, 2012	113

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## Abbreviations and Acronyms Used in the 2012-2016 Illinois Jurisdictional HIV Prevention Plan

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AVHP	Adult Viral Hepatitis Prevention
AVHPC	Adult Viral Hepatitis Prevention Coordinator
CBO	Community-based Organization
CDC	U.S. Centers for Disease Control and Prevention
CDPH	Chicago Department of Public Health
CTR	Counseling, Testing and Referral
DASA	Illinois Division of Alcohol and Substance Abuse
DEBI	Diffusion of Effective Behavioral Interventions
Department	Illinois Department of Public Health
DIS	Disease Information Specialist
EDIS	Enhanced Disease Investigation Services
GIS	Geographic Information Systems
GLI	Group Level Intervention
GPS	Group Prevention and Support
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDHS	Illinois Department of Human Services
IDPH	Illinois Department of Public Health
IDOC	Illinois Department of Corrections
IDU	Injection Drug User
IHAS	Illinois HIV/AIDS Strategy, Final Draft
ILI	Individual Level Intervention
LGBT	Lesbian/Gay/Bisexual/Transgendered
LHD	Local Health Department
LTC	Linkage to Care
MAI	Minority AIDS Initiative
MATEC	Midwest AIDS Training and Education Center
MSM	Men Who Have Sex With Men
NHAS	National HIV/AIDS Strategy for the United States, July 2010
PACPI	Pediatric AIDS Chicago Prevention Initiative
PCPG	Prevention Community Planning Group
PIR/TA	Parity, Inclusion, Representation and Technical Assistance
PLWHA	Persons Living With HIV or AIDS
PSCI	Program Collaboration and Service Integration
PHIMC	Public Health Institute of Metropolitan Chicago
RG	Regional Grant(s) (Illinois Department of Public Health HIV Prevention Regional Grants)
RFA	Request for Proposals
RWP	Ryan White Program
SAMHSA	U.S. Substance Abuse and Mental Health Services Administration
SMART	Specific Measurable Appropriate Realistic Time-phased (relates to service goals/objectives)
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection
XPEMS	“X” - Program Evaluation and Monitoring System (A Regionally-developed Version of CDC’s PEMS)
VIBES	Very Informed Brothers Engaged for Survival

## **INTRODUCTION**

The overall purpose of the Illinois Department of Public Health 2012-2016 Jurisdictional HIV Prevention Plan is to describe the goals and objectives, collaborative efforts and processes of the Department, the Illinois Prevention Community Planning Group (PCPG) and other Illinois prevention partners and stakeholders to develop an HIV prevention plan for 2012-2016 that will accomplish the requirements set forth in CDC PS-12-1201 HIV Prevention Funding Opportunity Announcement (FOA) guidance, namely:

1. Use of HIV and STI epidemiological and other available data sources to identify those populations in the jurisdiction with the greatest burden of the epidemic.
2. Identification and prioritization of those populations at greatest risk for HIV transmission and acquisition.
3. Assurance that existing prevention resources are allocated and disseminated across the Illinois jurisdictional regions to the areas with the greatest HIV burden.

The Illinois 2012-2016 Jurisdictional HIV Prevention Plan includes the required components listed below, as set forth in the CDC PS-12-1201 FOA guidance, as well as other sections necessary to clearly describe the Illinois 2012-2016 plan, its process, its goals and objectives, and the expected outcomes of the plan.

1. A description of existing resources for HIV prevention services, care and treatment and key features on how the prevention services, interventions, and/or strategies are currently being used or delivered in the jurisdiction
2. Need (e.g., resources, infrastructure and service delivery)
3. Gaps to be addressed and rationale for selection
4. Prevention activities and strategies to be implemented within the jurisdiction
5. Scalability of activities
6. Responsible agency/group to carry out the activity (i.e., Prevention Unit, Ryan White-funded agencies, and Housing Opportunities for People Living with AIDS (HOPWA))
7. Relevant timelines

In addition to responding to CDC PS12-1201 FOA guidance requirements, the jurisdictional plan serves multiple functions and is intended to benefit several audiences. First and foremost, the plan is closely keyed to the 2010 National HIV/AIDS Strategy (NHAS) and the Illinois HIV/AIDS Strategy (IHAS Final Draft) goals, objectives, and defined areas of need, and attempts to operationalize, at both broad and specific levels across the jurisdiction, the key components of these larger strategic plans. As such, it provides the Department and the PCPG with a clear blueprint that will guide prevention planning, activities, and services of not only the Department and the PCPG, but also the partners, community service organizations, and other stakeholders who are engaged in HIV prevention activities in the state. Further, the plan is constructed, organized and detailed in such a way as to ensure that larger audiences who may not be familiar with HIV disease prevention planning and activities in the Illinois jurisdiction can understand the process that went into development of the jurisdictional plan and the prevention activities that are planned for 2012-2016, and hopefully use these as a reference point for informing, guiding and making more effective their own activities to further HIV prevention in the state.

It is anticipated that the jurisdictional plan will evolve, be refined, and updated over the five-year planning period, in response to changes in the HIV epidemic, the needs of impacted populations, economic conditions, and other factors that perhaps cannot now be foreseen.

The other major change that will influence the jurisdictional plan will be the Department's implementation of new HIV prevention planning policies in response to the July 2012 "HIV Planning Guidance" recently released by CDC. The Department's HIV/AIDS Section leadership and PCPG leadership are reviewing the new CDC guidance and have planned to form an ad-hoc committee to develop an action plan for moving forward into 2012 and beyond in response to the planning guidance. The Department's initial HIV prevention planning policies for the jurisdiction will most likely not be completed when the 2012-2016 jurisdictional plan is sent to the CDC this fall.

A five-year planning cycle has been developed that supports an annual review of the current epidemiology with supporting data, documentation and presentations as are needed to determine if there are any significant shifts in the epidemiology that may call for reprioritization of the targeted populations and reallocation of resources. In addition, for each of the five years of the plan, the Department and the PCPG will focus their attention on one of the key activities of the overall planning process, e.g., needs assessment activities, resource assessment or inventory, interventions and services, allocation of resources, etc. This is described in greater detail in Section II, in the discussion of the 2012-2016 Department/PCPG work plan.

## **SECTION I. OVERVIEW OF HIV/AIDS IN ILLINOIS**

Illinois ranks eighth among the 50 states in cumulative reported AIDS cases. As of December 31, 2010, there were 34,396 people living and diagnosed with HIV in Illinois, and 20,000 deaths since 1981, according to the Department's HIV/AIDS Surveillance Unit and Reporting System. IDPH also estimates there have been about 16,000 additional reported non-AIDS HIV cases. However, an estimated 7,300 people living with HIV or AIDS (PLWHA) remain undiagnosed. Every year, more and more people are diagnosed in the state; in 2009, at least 1,414 people were diagnosed. One-third of PLWH in Illinois go undiagnosed for approximately a decade after acquiring HIV. In the past five years, 1,735 Illinoisans living with HIV have lost their lives.

In 2010, there were 1,711 new diagnoses of HIV disease in Illinois. The majority were diagnosed in Chicago (53 %), which is located in Illinois' most populous county, Cook County. Roughly 16 percent of all new cases reported in 2010 resided in suburban Cook County at the time of diagnosis, followed by the surrounding collar counties adjacent to Cook. Outside Cook County and the surrounding collar counties, the East St Louis area has the next highest incidence/prevalence, and the remainder resided in communities across Illinois.

Males comprise the largest proportion of cases diagnosed in Illinois in 2010 (81%). Non-Hispanic blacks comprise only 15 percent of the Illinois population, yet remain overrepresented among new cases of HIV disease with more than 50 percent of new cases occurring in this group. Non-Hispanic whites accounted for 25 percent of all new diagnoses in 2010 followed by Hispanics, representing 15 percent of all new infections. Younger populations are being infected with HIV. In 2010, persons aged 20-29 years comprised 32 percent of all new HIV diagnoses. Persons aged 30-39 years-old comprised 26 percent of all diagnoses. MSM continues to contribute the largest proportion of new diagnoses overall (72%), followed by HRH which accounts for 15 percent of cases. The combination category MSM+IDU contributed another 9 percent of cases. Newly reported cases due to perinatal transmission were less than 1 percent of all new diagnoses in 2010.

The proportion of newly-reported HIV/AIDS cases with risk not specified is high (39%). Most of these cases are re-assigned to other categories upon further investigation by surveillance staff at the Department and local health departments (LHD), usually within the first year of diagnosis.

In 2010, there were 988 new diagnoses of AIDS which includes 584 cases diagnosed with AIDS less than one year after an initial HIV diagnosis. These cases are referred to as "late testers". The proportion of "late testers" has increased from 56 percent (785 out of 1,390) in 2005 to 59 percent in 2010. Late testers are more often male (83% compared to 77% among all AIDS cases), non-Hispanic black (48% compared to 54% among all AIDS cases), between the ages of 30-49 (58% compared to 59% among all AIDS cases) and MSM (43% compared to 41% among all AIDS cases).

## **SECTION II. NHAS, IHAS AND THE PCPG STRATEGIC PLAN**

### **National HIV/AIDS Strategy (NHAS)**

In July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015. The NHAS defines three key goals, with related quantitative objectives. These are: a

#### **1) Reducing New HIV Infections**

- a) By 2015, lower the annual number of new infections by 25 percent (from 56,300 to 42,225).
- b) Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV).
- c) By 2015, increase from 79 percent to 90 percent the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

#### **2) Increasing Access to Care and Improving Health Outcomes for People Living With HIV**

- a) By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 percent to 85 percent (from 26,824 to 35,078 people).
- b) By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least three months apart) from 73 percent to 80 percent (or 237,924 people in continuous care to 260,739 people in continuous care).
- c) By 2015, increase the number of Ryan White clients with permanent housing from 82 percent to 86 percent (from 434,000 to 455,800 people). (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.)

#### **3) Reducing HIV-Related Health Disparities**

- a) Improve access to prevention and care services for all Americans.
- b) By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
- c) By 2015, increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.
- d) By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

Following the release and intent of the NHAS, the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) defined five key "Measurable Outcome Performance Goals":

1. Decrease the annual HIV incidence rate in communities where HIV is most heavily concentrated.
2. Decrease the rate of HIV transmission by HIV-infected persons.
3. Decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV.
4. Increase the proportion of HIV-infected people in the United States who know they are infected.
5. Increase the proportion of HIV-infected persons who are linked to prevention and care services.

## **Illinois HIV/AIDS Strategy (IHAS)**

In response to the NHAS and the NCHHSTP-defined five key “Measurable Outcome Performance Goals,” the Illinois HIV/AIDS Inter-Agency AIDS Task Force (IATF) launched a plan to develop a state strategy based on the National HIV/AIDS Strategy (NHAS) in 2010. NHAS goals were presented to the PCPG, and the PCPG Executive Committee decided in November 2010 that the Illinois jurisdictional prevention plan would align with goals of the Illinois HIV/AIDS Strategy (IHAS), final draft, that was developed in 2011 and 2012. Once finalized, the entire final version of the IHAS can be accessed at the following link on the Department’s website:

[www.idph.state.il.us/aids/materials.htm](http://www.idph.state.il.us/aids/materials.htm)

IHAS progress updates have been made at PCPG meetings on the status of the plan and the formation and progress of five topical workgroups for development of the IHAS. Five workgroups developing the IHAS were charged with conducting and completing the research necessary to make recommendations and goals for an Illinois HIV/AIDS Strategy for the years 2012 through 2015.

The workgroups focused their work on the following strategic areas:

1. HIV in Hardest Hit Areas/Hardest Hit Populations
2. Health Care Delivery and Health Outcomes
3. Stigma, Discrimination and HIV
4. Perinatal and Youth Populations Affected by HIV/AIDS
5. HIV in Corrections and Re-entry Populations

Additional recommendations were made in the areas of housing for people living with HIV/AIDS, as well as the need for greater recruitment and retention of persons living with HIV/AIDS in scientific research initiatives.

## **Illinois HIV/AIDS Strategy – IHAS Goals**

The overall goal of the IHAS is to reduce morbidity, mortality, and related health disparities in the Illinois HIV epidemic by reducing new infections, increasing access to care, improving health outcomes for people living with HIV, promoting health equity, and providing a more coordinated response to the epidemic.

## **IHAS-defined Areas of Need for Resources, Infrastructure, and Service Delivery and Goals and Recommendations for Addressing These Areas of Need**

An overview of IHAS-defined needs and the major goals and recommendations for meeting them are summarized below.

1. Reduce HIV in Hardest Hit Areas and Populations
  - a. Increase effective HIV testing and condom distribution opportunities to the highest hit areas/populations.
  - b. Support policy initiatives to address social determinants of health and improve service delivery.
  - c. Improve transitions between testing, treatment, care and secondary prevention.

- d. Foster innovative prevention approaches focused on reducing HIV stigma, homophobia, and increasing health literacy in the highest-hit areas and populations, including social marketing and education campaigns for the general public.
2. Coordinate and Improve Health Care Programs
    - a. Facilitate linkage to care
    - b. Improve data tracking and sharing
    - c. Increase collaboration among providers
    - d. Increase the number and diversity of providers in clinical and related services for PLWH/A
    - e. Maintain PLWHAs in care
    - f. Address housing issues for PLWH/A with co-occurring health conditions and those who have challenges meeting basic needs
  3. Reduce HIV Stigma and Discrimination
    - a. Engage communities to welcome and support PLWHA
    - b. Encourage public leadership by people living with HIV/AIDS
    - c. Promote public health approaches to HIV prevention and care
    - d. Strengthen and enforce civil rights laws
  4. Perinatal and Youth Populations Affected by HIV/AIDS
    - a. Reduce new HIV infections among pregnant women, their infants, and youth by 2015
    - b. Increase access to care and improve health outcomes for pregnant women, infants and youth living with HIV or AIDS by 2015
    - c. Reduce HIV-Related health disparities by 2015 for pregnant women, infants and youth
  5. Corrections and Re-entry Populations
    - a. Reduce new HIV infections
    - b. Increase access to care and improve health outcomes
    - c. Reduce HIV-Related health disparities and health inequities
    - d. Achieve a more coordinated response

Several PCPG members joined the workgroups that developed the IHAS. Some members also served as co-chairs of the workgroups. The co-chair of the Hardest Hit Communities Workgroup presented the proposals of that work group at the July 2011 PCPG meeting, to assure that the HIV prevention Gaps Analysis, Population Prioritization and Approved Interventions processes being completed in July and August 2011 would be informed by the conclusions and recommendations of the IHAS workgroups, as well as other data the PCPG would be using in these processes.

The needs for resources, infrastructure and service delivery identified in the IHAS were further defined and informed by quantitative analysis and conducted in a three-tiered process, carried out by the Department's HIV/AIDS Section staff and the PCPG, that included:

- 1) A thorough review of Illinois' HIV/AIDS epidemiology incidence, prevalence, late diagnoses and mortality data

- 2) Use of quantitative and qualitative data, including impact of social determinants, data from other sources (needs assessments, community forums, behavioral risk youth surveys, census data), to conduct a closer examination of populations most impacted by HIV and “stand-out” data in the epidemic. From all these sources, further recommendations were developed for prioritizing the hardest hit areas/hardest to reach populations (e.g., young men who have sex with men (MSM) of color) to achieve the best outcomes for the most impacted populations with the resources available.
- 3) Evaluation of existing HIV care and prevention services to PLWHA and populations at highest risk for HIV infection, and identification of gaps in prevention services recently delivered to Illinois’ prioritized and most impacted populations, the goal being to identify and target those populations with the greatest burden of the epidemic, those at greatest risk for HIV transmission and acquisition and ensure that prevention resources from the CDC grant are allocated and disseminated regionally to the areas and populations with the greatest HIV burden.

These processes and the outcomes are detailed in Section III of the jurisdictional plan.

### **PCPG Strategic Plan**

In the second half of 2011, the PCPG began developing a strategic plan that would be responsive to the goals and objectives of both the NHAS and the IHAS and provide a clear action plan for moving toward realization of goals set out in those documents. Using the PCPG’s HIV prevention planning goals as a starting point, each of the PCPG’s six standing committees (i.e., Epidemiology / Needs Assessment, Evaluation, Executive, Interventions and Services, Materials Review, and Parity, Inclusion, Representation and Technical Assistance (PIR/TA) Committees) worked to develop clear goals and objectives, with specific strategies, activities, and timelines for making progress toward the goals of the PCPG, NHAS and the IHAS. The “PCPG 2012 Strategic Plan” was finalized on November 16, 2011. It is included in the jurisdictional plan as Attachment 1.

In addition, the PCPG developed a “2012-2016 Department/PCPG Work Plan for Development of Jurisdictional Plan and Plan Updates, PCPG Planning Cycle Summary”, outlining proposed activities for the 2012-2016 jurisdictional planning period covered in this document. This five year plan is included below.

**2012-2016 Department/ PCPG Work Plan for Development of Jurisdictional Plan and Plan Updates, PCPG Planning Cycle Summary**

<b>(Based on five year planning cycle 2012-2016)</b>	<b>Areas of focus:</b>	<b>Products to be developed:</b>	<b>Due dates</b>
<b>2011 (Do the preparation, analysis and planning component details development needed for a five year plan to cover 2012-2016)</b>	Comprehensive analysis of HIV epidemic, including social determinants	HIV Jurisdictional Prevention Plan (2012-2016)	September 30, 2012
<b>2012</b>	Needs assessment	Plan update for 2013	Unknown
<b>2013</b>	Needs assessment	Plan update for 2014	Unknown
<b>2014</b>	Service delivery	Plan update for 2015	Unknown
<b>2015</b>	Resource assessment/inventory	Plan update for 2016	Unknown
<b>2016 (New planning cycle)</b>	Comprehensive analysis of HIV epidemic, including social determinants	HIV Jurisdictional Prevention Plan (2017-2021)	Unknown

Note: In each year of the five year planning cycle, the PCPG plans to focus its work on one planning area: analysis of the epidemic, needs assessment activities, service delivery analysis, and resource assessment/inventory, while still reviewing and assessing the other planning areas for significant changes/updates.

In November 2011, the PCPG Executive Committee decided they would institute a five year plan and planning process. The 2012 jurisdictional plan will be a 2012-2016 Jurisdictional HIV Prevention Plan. In 2011, the PCPG completed an intensive review of the HIV epidemiology and full gap analysis to determine priority populations as a basis for this five year cycle. In each of the years during the five year cycle, the Department and the PCPG will review the current epidemiology with such supporting documentations and presentations as are needed, in order to determine if there are any significant shifts in the epidemiology that may call for reprioritization of the populations. This will allow the Department and the PCPG in alternate years to focus on needs assessment activities, resource assessment or inventory, interventions and services, or allocation of resources, as the plan above projects. At the subsequent meeting of the entire PCPG, there was full consensus for this five-year plan from the PCPG membership. It is hoped that this will enable the Department and the PCPG to explore special needs areas and emerging issues more thoroughly, and also allow more time for instruction and capacity building within the group. Each year, the Department and the PCPG will develop an addendum to the 2012 – 2016 jurisdictional plan, detailing updates to the jurisdictional plan, including the HIV engagement plan.

## **SECTION III. HIV PREVENTION PLANNING IN ILLINOIS, 2012 – 2016.**

### **PCPG Role and Structure**

It is Illinois' goal to facilitate a collaborative, inclusive, comprehensive HIV prevention planning process that contributes to the reduction of HIV infection in the jurisdiction. At the heart of this process is the PCPG, whose members work closely under the guidance of and in collaboration with the Department's HIV/AIDS Section PCPG Coordinator throughout the year. One of the PCPG's key roles is to provide the Department's HIV/AIDS Section with recommendations and guidance regarding the CDC-funded prevention services in Illinois' jurisdiction, outside the city of Chicago. The overall goals of HIV prevention community planning, as established by the PCPG, are to:

1. Ensure community planning supports broad-based community participation in HIV prevention planning.
2. Ensure community planning identifies priority HIV prevention needs.
3. Ensure that HIV prevention resources target priority populations and interventions in the comprehensive prevention plan.

PCPG goals and the PCPG strategic plan are closely tied to NHAS and IHAS goals and objectives and are aimed at identifying those populations with the greatest burden of the epidemic and those populations at greatest risk for HIV transmission and acquisition as well as ensuring that existing prevention resources are allocated and disseminated regionally to the areas with the greatest HIV burden, targeting highest risk populations with interventions and services that can reach a significant portion of those in need in a cost-efficient manner and that demonstrate population-level impact to reduce HIV transmission. The bulk of the group's activities in 2011 and 2012 were focused on gathering, reviewing and analyzing relevant data and information to support and guide four key processes:

1. **Gaps analysis** to determine where resources are most needed.
2. **Population prioritization** based on thorough analyses of recent HIV and STI prevalence and incidence data, as well as consideration of other co-factors, e.g., impact of social determinants and co-morbidities.
3. **Approved interventions** for each prioritized population, based on data-driven evidence of intervention effectiveness and appropriateness with each targeted group.
4. **Annual review of the Department's HIV prevention grant application and jurisdictional plan**, to assure it aligns with the intent and specific guidance the PCPG developed through the three above activities.

The PCPG currently has six committees where much of the actual work of the group is conducted. Each committee has two co-chairs with expertise in that specific area, and committee activities focus on conducting the necessary research, analysis, outreach, and education to guide the entire group through key planning process activities. These six committees are:

1) Epidemiology and Needs Assessment, 2) Evaluation, 3) Executive (steering committee), 4) Interventions and Services, 5) Materials Review, and 6) PIR/TA. The Department's HIV/AIDS Prevention and Ryan White Direct Services Units are exploring the idea of forming a joint Linkage to Care (LTC)/ Prevention With Positives Committee with Ryan White Advisory Group and PCPG members.

For 2012, the PCPG will continue their usual pattern of monthly meetings of the full body January – October, with one meeting being a two-day planning retreat, and an annual Executive Committee meeting to review the previous year’s activities and develop a strategic plan for the following year. In 2011 and 2012, the PCPG has rotated its meetings throughout the regions, and many members participated in community forums held the day prior to the PCPG meeting, that brought together prevention and care lead agents, services providers, professionals, consumers and other stakeholders from that region of the state. At the forums, regional HIV epidemic trends, services, and challenges were shared, and input was solicited from attendees on key questions developed by the Department and the PCPG. Upon formal release by CDC of the recently updated final HIV prevention planning guidance (Draft released in April 2012), the Department along with guidance from the PCPG, will determine the community planning meetings schedule and prevention planning process for 2013 and beyond.

The Department and the PCPG collaborate closely to identify and obtain key stakeholders input through a variety of strategies to ensure broad-based community participation in the planning process. The PCPG planning process proactively takes steps throughout the year to build a planning process characterized by parity, inclusion and representation. The PCPG currently has 31 voting and 19 non-voting members, representing the Department’s HIV/AIDS Section, Center for Minority Health Services, and Sexually Transmitted Diseases (STD) Section; researchers, epidemiologists, health educators, program evaluators; representatives from corrections and substance abuse treatment agencies; public education institutions; community-based HIV prevention and service (including housing) agencies; faith leaders; and persons living with HIV/AIDS. Annually, the Department’s PCPG Coordinator prepares an analysis of voting and non-voting members, comparing the results to the demographics of the HIV epidemic in the jurisdiction. This analysis, which is presented to the full PCPG body, is used to identify gaps in membership by region, race/ethnicity, age, gender, and exposure category based on the proportion of members representing those groups either as a member or as a service provider in comparison to the HIV epidemic data. Professional/community representation and skills/expertise of members are analyzed to assure a knowledgeable, capable planning group is in place to conduct community planning. Targeted recruitment for new membership is based on identified and prioritized demographic gaps noted. PCPG bylaws currently call for 21-35 voting members.

As of August 2012, the PCPG Coordinator, in collaboration with the PCPG Executive Committee, had developed a final draft of the Illinois Department of Public Health 2012 HIV Engagement Plan. Prior drafts of this plan had previously been presented to the entire PCPG membership, as well as distributed to the Department’s HIV/AIDS and STD Section staff, for further recommendations and strategies for increasing coordination across HIV programs (i.e., prevention, care and treatment) throughout the state jurisdiction. The complete Illinois Department of Public Health HIV Engagement Plan, Final Draft August 2012 is included in this document as Attachment 2.

### **Illinois Department of Public Health HIV Engagement Plan**

The Illinois Department of Public Health HIV Engagement Plan, Final Draft August 2012, included as Attachment 2, details goals, objectives, and key strategies and activities for increasing coordination across HIV care, treatment, and prevention programs across the state, jurisdiction, and localities to strengthen and enhance the relationships across governments and communities and ultimately, to reduce rates of new HIV infection.

The PCPG has used a variety of methods to engage partners in HIV prevention planning – conducting community service assessment activities such as community forums, focus groups, and surveys; rotating meetings throughout the prevention regions; including care lead agents and providers in monthly PCPG meetings; posting notices of the Open Meetings; analyzing current membership annually to identify gaps by region, race/ethnicity, exposure categories, expertise/affiliation, etc.; exhibiting and presenting at the annual HIV/STD conference; and active recruitment of new members. The PCPG will continue to assist the Department in the implementation of these methods as well as other methods of engagement that are identified in the engagement plan.

The PCPG Executive Committee has taken the lead on development of the engagement plan, developing strategies to increase coordination across HIV programs and across the state, jurisdiction, and regions to reduce rates of new infection. The PCPG Executive Committee met in November 2011 to develop a draft plan, including goals and objectives, who to engage, strategies for engagement and retention for previous and new partners; prioritizing activities; creating an implementation plan; monitoring progress; and maintaining the partner relationships. Input was then solicited from the full PCPG; the HIV/AIDS Section Chief and administrators of the Section's Prevention, Direct Services, Evaluation, Training, and ADAP Units; and the Ryan White Advisory Group. The engagement plan is now part of the 2012 PCPG Strategic Plan and the 2012-2016 Jurisdictional HIV Prevention Plan. The plan was implemented January 2012. The PCPG Executive Committee will monitor the accomplishment of the plan's tasks/activities, providing updates to the Department, PCPG members, and key stakeholders at monthly PCPG meetings and at quarterly meetings of the Ryan White Advisory Group.

The PCPG will continue to collaborate with the Department, the Direct Services Unit and other key stakeholders to determine other community services/needs assessments to conduct in 2012 and upcoming years. An HIV engagement plan will be developed annually based on priorities developed by the PCPG and the Department. This may include hosting additional community forums, facilitating focus groups, conducting key informant interviews, or conducting more detailed and targeted surveys. Whatever decision is made, it will be a collaborative effort with representatives from prevention, care, and other support services being included in the planning, conduct, recruitment, and evaluation of the activities.

### **Epidemiological Profile Review and Population Prioritization**

In July and August 2011, the PCPG completed and finalized their epidemiologic profile review, population prioritization and approved intervention processes. The processes conducted in July and August 2011 by the PCPG were the culmination and review of the dozens of presentations, discussions and analyses of information received by the PCPG over a period of the previous six months, including the most current and complete HIV and STD surveillance data, presentations on service delivery from prevention and care providers and agencies from all regions of the state, progress reports from each of the PCPG committees, review of co-morbidity data among highest risk populations, consideration of social determinants of HIV, and geographic information system (GIS) mapped HIV surveillance data for all prevention regions.

The outcomes of the PCPG epidemiologic profile review and population prioritization and approved interventions processes detailed below describe both the prioritized population and interventions to be used in the prevention jurisdiction.

The rationale for selection of the prioritized populations was driven by PCPG analysis and review of the most current HIV epidemiological data. The process including identifying those populations with the greatest burden of the epidemic and those populations at greatest risk for HIV transmission and acquisition, exploring gaps in delivery and availability of HIV prevention services, and ensuring that funding for needed prevention resources would be allocated and disseminated regionally to the areas and populations with the greatest HIV burden.

The rationale for selection of approved interventions was driven by PCPG review of the available interventions for each prioritized population, ensuring that interventions and prevention services provided would be based on data-driven evidence of intervention effectiveness and appropriateness with each targeted group.

Following is a brief outline that overviews the three-tiered process that was used by the PCPG and the Department's HIV/AIDS Section staff to conduct the epidemiologic review, population prioritization, and first steps of the gaps analysis to determine the 2012 priority populations. Early in 2011, the PCPG recommended that a three-tier process be used to conduct the steps of the overall gaps analysis. In the first tier of this process, incidence, prevalence, and late diagnoses, as well as other epidemiologic data, were considered to determine the quantitative ranking of the risk populations for population prioritization. In the second tier of the prioritization process, once the rankings had been established in tier one, written recommendations for each risk population to enhance the population prioritization list were made, based on strong quantitative or qualitative evidence (e.g. needs assessment data such as survey results, community forums, focus groups, and research results) to support each recommendation. In the third tier of the process, the Department's HIV/AIDS Section Prevention Program Administrator was responsible for ensuring that funding was allocated to match the PCPG prioritized populations and epidemiology of the distribution of the epidemic across the jurisdiction by region, taking into account services already available and provided by other funding streams, whenever possible. This included the final steps of the gaps analysis, encompassing an evaluation of existing non-RG funded HIV care and prevention services to PLWHA and populations at highest risk for HIV infection, and identification of gaps in prevention services recently delivered to Illinois' prioritized and most impacted populations. The primary objectives were to identify and target those populations with the greatest burden of the epidemic, those at greatest risk for HIV transmission and acquisition and ensure that prevention resources from the CDC PS-12-1201 grant and general revenue funds (GRF) resources in the Department's 2012 Regional Grants' process were allocated and disseminated regionally to the areas and populations with the greatest HIV burden and most *underserved*, relative to epidemiologic proportions.

## **HIV/AIDS 2011 Epidemiological Analysis and Gaps Analysis (Tiers One and Two)**

### **Steps in Tier One – Review of Epidemiologic Data**

#### 1) Review of HIV Epidemiological Profile of the State, May 2011.

In May 2011, the PCPG brought together data from several sources that had been reviewed in previous months by the group, in order to begin their final 2011 HIV/AIDS epidemiology analyses. Data sources included: presentations on concentrations of poverty and HIV in Illinois; maps of incidence by race/ethnicity, gender, and risk factor; and most particularly, the HIV/AIDS epidemiologic profile with data through 2010. The epi profile data was reviewed by the PCPG in a

series of several presentations by Department staff over a period of months in the first half of 2011, and included consideration of such factors as HIV/AIDS prevalence and incidence analysis by age, race, gender, exposure category, concentrated areas of HIV/AIDS epicenters in Illinois, new diagnoses (last three years), exposure category population profiles by age, race, gender, location, five -year trends in HIV incidence, late diagnoses, and AIDS mortality.

2) Analysis of the distribution of the epidemic in Illinois, May 2011

- a) Examined the prevalence, incidence, late diagnoses, and mortality of PLWHA by gender, risk, race/ethnicity, geographic location, and age. Considered trends of new diagnoses in the past five years. Considered prevalence rates to account for health disparities. Using GIS mapping, compared HIV prevalence to concentration of poverty.

3) Review of Services Provided, June 2011

In June, the PCPG turned their attention to comparing the epidemiology and distribution of Illinois' HIV cases to the CTR and HERR services delivery.

4) Comparison of CTR and HERR services delivered to the distribution of the epidemic, June 2011

- a) Examined the CTR services provided by gender, risk, race/ethnicity, geographic location, age, positivity results, and funding stream. Compared these to the trends of new diagnoses in the past five years. Also compared positivity rates to distribution of tests and by funding stream. Each variable was considered independently and highlights are considered.
- b) HERR was similar to the analysis above, except it was broken down by HIV status. NOTE: In 2011, number of sessions was used as the unit to consider in the analysis, but future analysis needs to include a measure of units of service and cost per unit. The cost per session was not considered in the 2011 data analysis outlined above.

5) Determination of Prioritization Process, July 2011

- a) Determined what sources of data will be used in the prioritization process
  - i) Considered all sources of data that were possibly available for the prioritization process, including qualitative sources. Criteria to include sources of data included: relevance to new infections, reliability of the source, and whether data is available for all populations. The pros and cons of various data sources were reviewed to determine what weight each data source would have in the population prioritization process.
- b) Determined the weights of each data source
  - i) Weighed the importance and accuracy of each source of data and what role each would play. Data describing the epidemic according to incidence, prevalence, and late diagnoses from the epi review was used to guide this activity. At the July 2011 PCPG meeting, the motion was passed to adopt a scale/formula for weighting data sources as follows for the final population prioritization process: 90 percent incidence, 5 percent prevalence, and 5 percent late diagnoses.
- c) Application of the weights for Step 1
  - i) Applied the weights to the relative distribution of the epidemic. This step determined the ranking of the priority populations. The rankings were then presented to the entire PCPG membership for to be voted on and approved.

The table below summarizes highlights and key findings reviewed in July 2011 that had emerged from analyses of all the various epidemiologic and related data presented to and considered by the PCPG in the first half of 2011.

**Table 1. Highlights of Epidemiologic Analysis Presentations, reviewed at July 2011 PCPG meeting**

<b>MSM</b>	Prevalence	Estimated prevalence rate for MSM in Illinois is > 6%, compared to 0.14% for all other groups.
<b>Black MSM</b>	Prevalence	Estimated statewide prevalence rate for black MSM is >15%.
<b>Black MSM</b>	Prevalence	In CHAT Study, 1 in 3 black MSM were HIV+ and 66% did not know their status.
<b>Hispanic MSM</b>	Prevalence	In CHAT Study, 12% of Hispanic MSM were HIV+ and half were unaware of their infection.
<b>Young Black MSM</b>	Prevalence	In CHAT Study, 1 in 4 black MSM 18-24 years old were HIV+.
<b>Black and Hispanic MSM</b>	Prevalence	Over 69% of HIV+ Latino and Black MSM 18-24 years old did not know their status.
<b>MSM</b>	Services	Although MSM account for 61% of all incident cases in Illinois (excluding Chicago), in 2010, they received <17% of CTR sessions provided.
<b>Males</b>	Prevalence	Majority of diagnoses among males attributed to MSM (67%) followed by IDU (19%).
<b>Females</b>	Prevalence	Majority of diagnoses among females attributed to HRH (50%) followed by IDU (45%).
<b>Unmet Need</b>	Services	Quantified estimate of unmet need (NOT in care for HIV infection) for 2009 is 49.7%, up 1.7% from 2008.
<b>CTR</b>	Services	In 2010, 62% of Counseling, Testing, and Referral (CTR) sessions delivered to males
<b>HERR</b>	Services	Of 19,350 Health Education/Risk Reduction (HERR) sessions conducted in 2010, 50.1% were to African Americans, 34.5% to Whites, and 12.7% to Hispanics.
<b>HERR</b>	Services	By risk groups: 22.3% MSM, 17.7% IDU, 37.7% heterosexual
<b>Mother/Child Transmission</b>	Prevalence	Of the 7,206 women living with HIV/AIDS in Illinois, 68% are of reproductive age (20-49)
<b>Mother/Child Transmission</b>	Prevalence	Maternal exposure that leads to HIV diagnosis is decreasing (17 cases in 2000, compared with 7 in 2007).
	Statistics	94% of mothers tested for HIV before delivery, 6% are not.
	Statistics	Without ARV drugs, risk of transmission is 1 in 4; with preventative measures risk can be less than 1 in 50.
<b>Epi HIV Age Trends</b>	Prevalence	PLWHA is highest among people ages 30-39, followed by 20-29, regardless of gender
<b>New Diagnoses</b>	Prevalence	Blacks, aged 20-29, made up majority of new diagnoses of HIV from 2006-09.
<b>Late</b>	Prevalence	Latinos had the highest rate of late diagnoses (40.1%),

<b>Diagnoses</b>		followed by blacks (26.3%), and whites (26.2%).
<b>AIDS Mortality</b>	Mortality	AIDS mortality as of 2010 highest for IDU, followed by MSM.
<b>HIV/AIDS Mortality</b>	Mortality	Males comprise majority of HIV diagnoses, but majority of deaths occur among females
<b>Incidence</b>	Incidence	Illinois experienced 23% increase in number of new infections between 2007 and 2009.
<b>MSM</b>	Incidence	Proportion of cases attributed to MSM has increased between 2006 and 2009 (67% to 75%).
<b>Incarceration</b>	Prevalence	45,000 prisoners in IL department of corrections, ~1% prevalence of inmates known to be infected with HIV.
<b>Telemedicine</b>	Services	Telemedicine provides care to resource limited populations through video and audio linkage.
<b>Latino Pop.</b>	Prevalence	As of 2001, Latinos represented 11% of the Illinois population and accounted for 12% of all new reported HIV/AIDS cases
<b>Latino Youth</b>	Prevalence	Latinos/Hispanics accounted for 16% of reported IL AIDS cases in adolescents ages 13-19
<b>STDs</b>	Prevalence	Disparities between racial/ethnic groups: African Americans 13.3 times more likely to be infected with chlamydia, 33.5 times more likely to have gonorrhea, 18.8 times more likely to have syphilis
<b>MSM HIV Co-infections</b>	Prevalence	High rate of HIV/syphilis co-infection among MSM
<b>Treatment</b>	Priorities	Prompt treatment of Chlamydia and gonorrhea needed to reduce infectiousness and prevent transmission
<b>HIV/STD Co-infection</b>	Prevalence	HIV and STDs linked by both behavior and biological mechanisms
<b>Transmission</b>	Study Results	Condom use in combination with antiretroviral therapy (ART) is the best way to protect partners from risk of HIV transmission

## Steps in Tier Two

- 1) Recommendation of population prioritization
  - a) Additional recommendations were drawn from the committee's secondary research and presentations delivered throughout the first half of 2011. Most of these sources of data were not available for all populations, so it was not possible to include them in the first step of the prioritization process. Never the less, these data sets contributed valuable information about particular populations or geographic regions, so data from these sources was incorporated into the process for developing the written recommendations after the list of priorities was developed. In this way, the PCPG was able to show the ranking, and also include recommendations about what sub groups or behaviors are driving new infections. Sources of data considered for Tier Two included: STD surveillance, risk behavior surveys (some conducted in Chicago, some conducted statewide, some national), census counts that allowed the group to calculate incidence and prevalence rates.

The finalized “2012 PCPG Priority Populations” list approved by the PCPG on 08/12/2011 is shown below in Table 2.

<b>Table 2. 2012 PCPG Priority Populations</b>					
Priority Pop. And Rank	Weighted Priority (%)	Sub-populations and Rank	Weighted Priority (%)	Female (%)	Male (%)
<b>1: MSM</b>	<b>61.2</b>	<b>1.1 NH White MSM</b>	<b>25.7</b>	<b>-</b>	<b>25.7</b>
		<b>1.2 NH Black MSM</b>	<b>22.7</b>	<b>-</b>	<b>22.7</b>
		<b>1.3 Hispanic MSM</b>	<b>9.7</b>	<b>-</b>	<b>9.7</b>
		<b>1.4 Other MSM</b>	<b>3.1</b>	<b>-</b>	<b>3.1</b>
<b>2: Het. Cont.</b>	<b>23.9</b>	<b>2.1 NH Black HRH</b>	<b>12.8</b>	<b>8.6</b>	<b>4.3</b>
		<b>2.2 NH White HRH</b>	<b>6.3</b>	<b>4.5</b>	<b>1.8</b>
		<b>2.3 Hispanic HRH</b>	<b>3.9</b>	<b>2.0</b>	<b>1.8</b>
		<b>2.4 Other HRH</b>	<b>0.9</b>	<b>0.7</b>	<b>0.2</b>
<b>3: IDU</b>	<b>10.8</b>	<b>3.1 NH Black IDU</b>	<b>6.0</b>	<b>2.1</b>	<b>3.8</b>
		<b>3.2 NH White IDU</b>	<b>3.5</b>	<b>1.9</b>	<b>1.6</b>
		<b>3.3 Hispanic IDU</b>	<b>0.9</b>	<b>0.4</b>	<b>0.5</b>
		<b>3.4 Other IDU</b>	<b>0.4</b>	<b>0.2</b>	<b>0.3</b>
<b>4: MSM/IDU</b>	<b>4.1</b>	<b>4.1 NH Black MSM/ISU</b>	<b>1.7</b>	<b>-</b>	<b>1.7</b>
		<b>4.2 NH White MSM/IDU</b>	<b>1.9</b>	<b>-</b>	<b>1.9</b>
		<b>4.3 Hispanic MSM/IDU</b>	<b>0.4</b>	<b>-</b>	<b>0.4</b>
		<b>4.4 Other MSM/ISU</b>	<b>0.1</b>	<b>-</b>	<b>0.1</b>
<b>PERINATAL</b>	<b>Not Included</b>				
<b>TOTAL</b>	<b>100</b>		<b>100</b>		

*Note: Voted on and approved at the August 12, 2011 PCPG Meeting.*

## 2012 PCPG Priority Populations - Recommendations

The recommendations developed by the PCPG in the Tier Two activities to accompany the 2012 priority populations are detailed in full below.

It was strongly recommended that statewide HIV prevention services should reach each priority population and subpopulation in equal proportion to the percentages specified in the table above. Priority populations and corresponding recommendations and points of consideration were derived using statewide HIV and STD co-infection surveillance data on the epidemic (excluding Chicago), primarily including HIV disease incident cases and late diagnosis cases between 2006 and 2009 and HIV disease prevalence as of December 31, 2010. In order to maximize proportional accuracy, this process only considers cases with known exposure category. The prioritization process was approved by the PCPG on July 14, 2011, and weights of 90 percent, 5 percent, and 5 percent, for incidence, prevalence, and late diagnosis, respectively, were applied to each set of data. The numbers on the table above are rounded to the nearest 10<sup>th</sup> percent. Priority populations should include information on risk category and race/ethnicity whenever possible.

### Points of Consideration

- HIV positive individuals falling within any of the risks identified above should be prioritized within each subpopulation category.
- Transgender individuals with any of the risks identified above should be prioritized within each subpopulation category.
- Young adults with any of the risks identified above should be prioritized within each subpopulation.

## Recommendations by Risk Group

### MSM

1. HIV prevention services need to reach MSM. MSM account for the majority (61%) of new HIV cases in the past five years. MSM also represent the vast majority of the increase in new cases over this period. CTR and HERR services need to prioritize reaching this group's share of incident cases.

2. New cases among young MSM are growing faster than any other group and need to be prioritized. MSM between the ages of 20 and 30 years represented the largest share of the statewide increase in new HIV cases between 2006 and 2009.<sup>1</sup> Yearly incidence among 20 to 30 year-old black MSM went up by 40 percent in statewide data including Chicago between 2006 and 2009. By contrast, new infections among most groups other than young MSM went down or stayed the same.

3. Geographic differences of MSM incident cases across race/ethnicity need to be taken into account. White MSM incident cases are distributed in low density across the state while the majority of black MSM incident cases are concentrated around fewer metropolitan areas. Latino MSM cases are highly concentrated in the Chicago metropolitan area (Regions 7 and 8).

<sup>1</sup> In 2009, there were 109 more cases than in 2006, statewide. Although most groups experienced a decrease in new cases, MSM 13-29 accounted for 83 cases of the increase in new cases. It should be noted that there were 128 more cases with no risk identified (NRI) in 2009 than there were NRI cases in 2006. As the NRI cases are investigated, MSM and other groups will most likely also see a proportional increase in numbers given that these cases tend to mirror cases with known exposure category.

## **Heterosexual Exposure**

4. Targeting with precision among high risk individuals is needed. Heterosexual exposure accounts for one quarter of the new HIV cases between 2006 and 2009. Although the number of services reaching this group is the largest of any exposure category, the positivity rate among heterosexuals is low. Furthermore, the proportion of cases attributed to HRH has decreased since 2006. At the same time, HRH are twice as likely to be diagnosed late when compared to MSM. This seeming contradiction indicates that efforts need to be made not to provide more services to individuals with some heterosexual risk, but rather, that the mechanism to target high risk heterosexuals needs to be prioritized and high risk individuals need to be prioritized within this risk group.

## **IDU**

5. Proven services to IDU need to be maintained to sustain the decline in new cases among IDU. New cases among IDU averaged 10 percent of the epidemic between 2006 and 2009; however, there has been a notable declining trend over this same period of time. This decline might be attributable, in part, to successful interventions that need to be continued in order to prevent a return of previous figures. Targeting efforts might need to be emphasized given that IDUs (like HRH) are twice as likely as MSM to have a late diagnosis.

## **MSM/IDU**

MSM/IDU represent about 4 percent of diagnoses between 2006 and 2009 and present a unique challenge given the combined risk of MSM and IDU above.

Other recommendations:

6. Special attention should be paid to populations with high rates of late diagnoses who fall within any of the risks identified above. Relative to whites, Hispanics were 47 percent more likely to have a late diagnosis. There was no difference between whites and blacks. Females were 37 percent less likely to have a late diagnosis than males. Older individuals are more likely to be diagnosed late. Regions 7 and 8 have the highest proportion of late diagnoses.

7. Regional allocation of services needs to match regional changes in new cases. Regions 4, 7 and 8 have experienced significant increases in new cases between 2006 and 2009. Trends by race/ethnicity and age should be taken into account in regional allocation. Overall, nearly 60 percent of 2006-2009 diagnoses were between the ages of 20-39 at the time of diagnosis. However, diagnoses among African Americans tended to happen at a younger age.

## 2012 PCPG Prioritized Populations - Risk Group Definitions and Points of Consideration

Approved at the Aug. 12, 2011, PCPG meeting: Clarification made to HRH and transgender definition Dec. 16, 2011.

### 2012 Risk Group Definitions and Points of Consideration

1. **HIV positive and HIV negative men who have sex with men (MSM):** A high-risk MSM is defined as a) any male or transgender individual who has had condom-less anal sex with a male or transgender individual in the past 12 months, or b) any male or transgender individual who has had condom-less anal sex with a male since his last HIV test. A high-risk MSM youth is defined as any male or transgender individual, age 13-19 years, who reports ever having had anal or oral sex with a male or transgender individual, or who states he is sexually attracted to males or transgender individuals (for Health Education/Risk Reduction services only).

2. **HIV positive and HIV negative high risk heterosexuals (HRH):** Females and males (including transgender individuals not included as MSM) engaging in condom-less vaginal and/or anal sex with partners of the opposite sex, defined as any of the following:

- HIV positive individuals
- Persons with HIV positive partner(s) of the opposite sex
- Persons with IDU partner(s) of the opposite sex
- Female partners of MSM
- Heterosexual males and females with two or more STDs in 12 months
- Persons who have had sex with six or more partners in the past month
- Females who have had unprotected sex with a male(s) released within the past year from an incarceration of one year or longer in any county, state or federal correctional facility

#### Points of Consideration for HRH individuals only:

The positivity rate of HRH increases as age increases. Blacks and Hispanics are more likely to test positive than whites. Women are less likely to test HIV positive if they report using condoms, but males who reported condom use were *not* less likely to test positive. Oral sex with someone of the opposite gender was *not* found to be a predictor of new positive tests. Females who reported having sex with known HIV positive individuals, MSM or IDU are more likely to test positive than the heterosexual population tested.

3. **HIV positive and HIV negative injection drug user (IDU):** A high-risk IDU is defined as a person who:

- a. Discloses sharing injection equipment or supplies in the last 12 months or since his or her last HIV test; or
- b. Does not disclose injection risk, but displays visible signs of recent non-prescribed drug injection (specifically, fresh injection sites, injection abscesses, nodding off).

4. **HIV positive and HIV negative MSM/IDU:** An MSM/IDU is defined as any male who meets the combined definitions of MSM and IDU (#1 and #3 above).

## **Other Important Points of Consideration:**

**Prevention with HIV positive individuals** falling within any of the risks identified above should be a top priority within each subpopulation category and specific strategies to engage this population should be developed, including linkage to care and treatment. Prevention with positives should include reproductive health education for females and their partners, including linkage to perinatal care.

**Transgender individuals** are considered a priority within each of the priority populations due to the alarming national HIV prevalence rates in this population and the severe social determinants impacting this population.

Transgender identity does not mean an individual engages in risk behaviors and transgender individuals should be prioritized within each of the risk groups *based on their personal risk history and their current gender identification*.

### *Examples:*

A transgender female-to-male who has had recent unprotected receptive anal sex with a male would be categorized as a male who has sex with males.

A transgender male-to-female who has had recent unprotected vaginal or receptive anal sex with a male injection drug user would be categorized as a high risk heterosexual.

## **Steps in Tier Three:**

In Tier Three<sup>3</sup>, the Department's HIV/AIDS Section Prevention Program Administrator used a formula to apply the weights to each region and include information on services provided by other funding streams. This final stage of the gaps analysis process used several steps to ensure that gaps to be addressed were identifying and targeting those populations with the greatest burden of the epidemic, those populations at greatest risk for HIV transmission and acquisition and should ensure that existing prevention resources are allocated and disseminated regionally to the areas and populations with the greatest HIV burden, including working with regional lead agents to assess regional epidemiological trends, resources and gaps to determine the best allocation of limited resources to have the greatest impact on reducing new infections. Steps in Tier Three of the gaps analysis, as well as the 2012 IDPH HIV Prevention Regional Grant Process, are detailed in Section IV of the jurisdictional plan.

## **2012 PCPG Approved Interventions, Process and Final Product**

The CDC requires the community planning group to identify the most effective strategies and interventions to reach the prioritized populations for HIV prevention services to be delivered. In turn, the regional grants awarded from the Department's HIV/AIDS Section require that agencies deliver CDC approved interventions and/or IDPH's approved public health strategies. The PCPG strategic plan timeline included a list of tasks to be completed by the Interventions and Services Committee (ISC) to review, update and better inform the PCPG's process for developing approved interventions for 2012.

### **PCPG / ISC 2011 Process for Approved Interventions for 2012**

In the PCPG's 2010 community planning process, the Intervention and Services Committee (ISC) asked each of the Risk Category workgroups to complete a thorough identification, review and ranking process, by each high risk population (i.e., MSM, HRH, ISU, MSM/IDU), of all of the diffusion of effective behavioral interventions (DEBI) interventions approved by the CDC up to that point for each risk group. In 2011, the approved DEBIs' rankings, previously established in 2010 for the 2011 community planning period, were carried over for 2012, with newly CDC-approved DEBIs added as appropriate and clarifications as to the appropriateness of the intervention(s) for certain target populations made in others.

However, the Department's HIV/AIDS Section Prevention Program staff, the PCPG as a whole, and ISC in particular, had noted that funded agencies using CDC-approved DEBIs were often rather limited, DEBIs were mostly being used by fewer agencies in the higher HIV-incidence regions of the state, due to one or more factors, (e.g., the need for a minimum number of participants for the intervention to be implemented in its intended original form, the cost of implementing DEBIs was relatively high, particularly to agencies with fewer staff, in lower incidence regions of Illinois). For these and other reasons, many agencies were using non-DEBI, homegrown types of interventions, [e.g., Very Informed Brothers Engaged for Survival (VIBES), various types of Group Prevention and Support (GPS)].

### **PCPG/ISC 2011 Provider Survey**

Based on these observations, it was decided for 2011 to focus attention on getting more information from providers about their use of non-DEBI homegrown prevention interventions. Starting in January 2011, the ISC began developing a survey questionnaire and working on identifying a list of targeted participants who will be surveyed about prevention interventions they deliver, focusing less on DEBIs and more on homegrown interventions that work in their particular regions. The survey was designed to answer three broad questions:

1. What homegrown interventions (defined as "agency-developed intervention(s) intended to modify risk behavior") are being delivered in the regions?
2. If and what evaluation components are being conducted during the course of the intervention(s)?
3. What are the training needs of providers?

The Illinois survey was developed by the Interventions and Services Committee with the assistance from the Evaluation Committee, uploaded to an online survey tool (CVENT), and initially

distributed in late February. Recipients were allowed two to three weeks to respond, with periodic reminders given. Technical errors in the tool were discovered in the survey process. These were corrected, and the survey had to be reconstructed and re-uploaded. All previous survey responses had to be deleted and targeted respondents were asked to retake the survey. This may have contributed to a less than optimum survey response rate. The final survey, “Interventions Provider Questionnaire – PCPG Interventions Committee edited draft,” is included in the jurisdictional plan as Attachment 3.

The reconstructed final survey was distributed to the prevention lead agents/subcontractors, Quality of Life (QOL) grantees, Center for Minority Health Services HIV prevention grantees, CTR and HERR prevention service providers funded by the Department with general revenue funds. A total of 27 surveys were completed and returned. The survey results were analyzed and the results presented to the PCPG.

### **PCPG/ISC 2011 Provider Survey Findings**

Most notable among the findings from the ISC survey responses were the following:

1. Agencies delivering any “homegrown interventions”: No = 63 percent, Yes = 37 percent.
  - a. The majority of the homegrown interventions were being delivered to Hispanics, African Americans, IDUs, and some to youth.
2. Evaluation component included the intervention: Yes = 80 percent
  - a. Most reported used some type of pre/post test evaluation questionnaire related to the intervention’s intended purpose, i.e., knowledge or changes in behavior intent or action.
  - b. Data indicated that while some type of evaluation component was often being used, the effectiveness of the evaluation tool or methods may often be less than optimal.
3. Evaluation showed intervention was effective: Majority of respondents said “yes.”
  - a. The most commonly noted evidence of effectiveness was that participants demonstrated an increased knowledge of HIV transmission, HIV testing availability, and linkage to care options.
4. Regarding training, the most frequently requested topics were HIV and Hepatitis prevention interventions.
  - a. Respondents identified several DEBIs they were interested in receiving more training on.
  - b. Many respondents also identified other training needs in key areas, e.g., 53 percent on “outcome measurements” and 42 percent on “adapting DEBIs.”

The data from the surveys and the resulting conclusions yielded information that helped develop considerations for 2012 prevention services and interventions and helped the ISC develop detailed “general” and “additional” recommendations regarding approved interventions, related to actions and/or policies that should be undertaken by the Department, prevention providers and the planning group itself.

Over the course of several months in 2011, the ISC hosted several conference calls to review, add, change, update their recommendations, review and update procedural issues related to overall or specific interventions, e.g., added several recommendations and guidance regarding the use of Group Prevention Support (GPS), to move toward more uniform standardized intervention with measurable outcomes, components that must be included, recommendations on appropriate

populations and content materials to cover for specific populations. Likewise, a whole new section was added to the approved interventions, addressing recommendations and guidance for adapting DEBIs and use of homegrown interventions. Changes were made to the approved interventions list to divide “Approved Public Health Strategies” and “Approved Interventions” into separate categories.

In developing the recommendations and approved interventions, the ISC overall process was structured to be responsive to PS12-1201 guidance and the 2010 NHAS. In addition, decisions regarding interventions and recommendations were informed by several data sets to amplify the committee’s general approved intervention recommendations. These included input from previous intervention presentations, various survey results, and gap analysis data. At the June 2011 PCPG meeting, all these data were used to coordinate risk group breakout sessions to develop the finalized list of Approved Interventions for the designated risks groups and the accompanying recommendations and guidance.

Below are the PCPG’s “Final 2012 Illinois HIV Approved Intervention” recommendations. The recommendations and table showing the complete list of recommendations and table of Approved Interventions is included in the jurisdictional plan in Attachment 4.

### **2012 PCPG Approved Interventions and Services to be Provided - General and Additional Recommendations.**

The Illinois PCPG annually uses an epidemiologically-based process to prioritize high-risk populations that should receive targeted HIV prevention services.

In June 2011, the Department’s HIV/AIDS Section staff and the PCPG Epi/Needs Assessment Committee collaborated on a detailed analysis of 2010 Department-funded HIV counseling, testing, and referral (CTR) and HERR prevention services presentation. It included all data entered into Provide® from: RG providers, STD clinics, Quality of Life/other Department direct-funded grantees, Prison Projects, Minority AIDS Initiative (MAI) projects, the Department’s Laboratory and Illinois Department of Alcohol and Substance Abuse (DASA) CTR providers. Based on the outcomes of these analyses, in July and August 2011, the PCPG Interventions and Services Committee developed a list of approved interventions for 2012 as well as a comprehensive listing of recommendations and guidance on how the prevention public health strategies and interventions should be prioritized, implemented, and evaluated to maximize their effectiveness and ability to reach the hardest hit populations. The approved list of interventions and recommendations was provided to all agencies funded by the Department in 2012 to conduct prevention services and funded agencies are required to adhere to these recommendations.

The “General Recommendations” and “Additional Recommendations” are shown below.

#### **PCPG 2012 Approved Interventions and Services General Recommendations**

1. All prioritized populations shall be defined by serostatus, risk, and race/ethnicity for inclusion in prevention funding documents, including, but not limited to, all requests for proposals (RFP) and scopes of service.

2. Regional prevention funding will be allocated to ensure that total funding is proportional to recent HIV infections (2006-2009) by risk and race/ethnicity, within that region.
3. In order to account for resource distribution, provider scopes should be written by risk, race/ethnicity, gender (if appropriate) and intervention with a value based upon standardized regional unit costs.
4. DEBIs must be used as defined by their core elements.
5. Regional prevention funding must include prevention with HIV-positive individual program(s) that provides linkages to care and treatment, interventions to improve retention in care and treatment, and/or interventions and risk-reduction services for HIV-positive individuals and their sexual or needle-sharing partners.
6. Condom distribution to HIV-positives and those at high risk of infection is a highly recommended structural intervention. Condom distribution must be accompanied by counseling and/or education or incorporated as an element of an approved behavioral intervention.
7. All HIV-positive individuals are prioritized and may be included in appropriate DEBIs.
8. All HIV-positive individuals should be immediately tracked, and referred into CARE services, including ADAP.
9. All newly and ongoing diagnosed HIV positive individuals shall be offered Partner Services. Agencies must follow protocols specific to their status as a health department or a community-based organization (non-health department). Health departments may provide all steps of elicitation and notification associated with providing partner services including cases identified through surveillance records. Community-based organizations shall provide services up to and including partner elicitation, but shall not provide direct notification services unless officially designated by the Department. Community-based organizations do have the authority to be present during a dual notification as requested by the index patient; however, unless officially designated by the Department, the community-based organization's role does not include direct notification of partners of positives identified through testing nor identification and direct notification of partners of positives reported through surveillance records.
10. The Department shall develop comprehensive Partner Services Program guidance, delineating the roles and responsibilities for community-based organizations and for health departments, including roles and responsibilities for select community-based organizations that have received contracted approval to administer partner services, including direct notification services.
11. Any evidence-based, homegrown intervention that is approved by the Department and the regional prevention lead agent may be used.
12. For IDUs, priority in funding decisions shall be given to agencies conducting comprehensive syringe exchange programs on site or with an agency that comes to their site to provide services.
13. Transgender individuals should be included in the appropriate population based on their behavioral risk and current gender identification.
14. Persons who have been victims of sexual assault since their last HIV test or have never been tested for HIV shall be included in all population categories.
15. All funded agencies must demonstrate to the lead agency in the RFP process they have the fiscal/organizational capacity to administer and implement all group and community level interventions via the completion of the Agency Readiness Assessment Tool that will be

provided by the Department to lead agencies for distribution to subcontracted agencies in the RFP process.

16. For GPS:

- a) HIV positive individuals are the highest priority for targeted GPS. The intervention should focus on improving retention in care and treatment, partner safety, and other skills-building topics such as disclosure, coping skills, and condom negotiation.
- b) Agencies must target very high risk prioritized populations to include MSM, HRH, IDU and transgenders who report either condom less anal sex or shared works (syringes and injection drug use paraphernalia) within 12 months or to increase skill sets around treatment adherence, risk reduction, and other skills-building topics.
- c) Agencies must provide an open or closed ended skills-building session to no more than 12 individuals. Agencies should refer to the Department's RFP for a definition of closed and open-ended skills-building sessions.
- d) Agencies must submit a copy of the intended curriculum and pre- and post-test instruments documenting behavioral change measured outcomes to regional lead agent for review and approval.

### **2012 PCPG Approved Interventions and Services Additional Recommendations**

1. In SFY12, for all funded interventions, an agency must first assess the cost effectiveness of the intervention, staff time needed to implement the intervention, sustainability of the intervention, and other available fiscal and in-kind resources. Information on the requirements and expectations of DEBIs can be found at [effectiveinterventions.org](http://effectiveinterventions.org). A copy of the final "Handout 1: A Description of CDC/IDPH Approved Interventions and 2012 Proposals" will be included in the RFP as an attachment for further reference. Additional information should be provided by the Department to lead agencies and their subcontracted agencies in the RFP process.
2. For all funded interventions, each agency must utilize the comprehensive Community Discovery Assessment tool provided by the Department to lead agents and their subcontracted agencies as an attachment in the RFP process along with a plan for monitoring and evaluation which will include the collection of standardized process and outcome measures, as identified by the Department.
3. All funded public health strategies and interventions must include an approved recruitment component (outreach, social marketing, social networking, health communication/public information, Internet, other approved).
4. Youth must be prioritized within all risk, race/ethnicity, and gender populations, in particular young MSMs.
5. Lead agents are responsible for evaluating regional epidemiological data and service delivery (essentially conducting a specific gap analysis) to determine regional unmet need. Using the PCPG 2012 Prevention Priority Population Listing as a guide, the regional gap analysis must be used to further identify and prioritize underserved populations within the respective region(s).
6. HIV positives within each priority population must be prioritized for prevention interventions.
7. All agencies funded to conduct an intervention (DEBI, homegrown, GPS, etc.) must themselves conduct, collaborate with another agency, or have referral agreements in place with other agencies to provide approved public health strategies (CTR, CRCS, STI

- screenings and vaccinations, partner services) to clients receiving the interventions, as needed. This is an example of Program Collaboration and Service Integration (PCSI).
8. All funded interventions must include an evaluation plan that describes the process/outcomes measurement methods that will be used to ensure the intervention is properly conducted and evaluated.
  9. The Department must provide a program guidance evaluation plan for funded interventions.
  10. Prior to the implementation of an intervention and/or public health strategy, agencies must attend a federal or state approved training.
  11. The Department must provide funded agencies with procedural guidance to implement an intervention, providing examples, technical assistance and resources such as requesting CDC capacity building assistance (CBA), as needed.
  12. In 2012, it is recommended that the PCPG Interventions and Services Committee research and develop recommendations on the following promising interventions for possible inclusion in the 2013 Interventions Recommendations: Peer Health Navigation, Antiretroviral Treatment Access Study (ARTAS), Salud, Edicacion, Prevencion y Autocuidado (SEPA), Family Life and Sexual Health (FLASH), CTL (Counsel, Test, Link), and Pre-Exposure Prophylaxis (PrEP).
  13. Funded agencies shall incorporate STI integration into public health strategies/ interventions. The following services are available for provision according to the Morbidity and Mortality Weekly Report (MMWR) 2010 STD Treatment Guidelines at STD clinics outside of the city of Chicago and testing through the Department laboratory: HIV, gonorrhea, chlamydia, and syphilis testing; herpes PCR for clients with symptomatic lesions; hepatitis C testing (for IDUs only); and hepatitis A and B vaccination.

## **2012 Recommendations for Adapting Evidence Based and Developing Homegrown Interventions**

Interventions must be adapted to meet the needs of people/populations that were not part of the studies that showed the interventions' efficacy. Adaptations must be consistent with the intervention and culturally relevance to the population with whom the work is to be done. Retain the intent and internal logic of the intervention's core elements in making the intervention practice culturally relevant. Adapting an intervention for new at-risk populations and new venues must involve formative program evaluation.

### **Adaptation Procedures**

Intervention specific adaptations must engage the following six general procedures in accordance with CDC guidance:

1. Identify intervention components that need adaptation;
2. Collect information to form the procedures and materials;
3. Test the procedures and materials;
4. Document what you have done;
5. Implement, monitor, and evaluate; and
6. Revise implementation materials, as needed.

Intervention specific adaptation must identify the health needs of the persons targeted, as well as their cultural experience. This is a first step to a culturally competent program. Intervention specific adaptation must adhere to the Office of Minority Health (OMH) in the U. S. Department of Health and Human Services published national standards for delivering services that reflect a group's culture and language. This is referred to as culturally and linguistically appropriate services (CLAS). Interventions specific adaptations targeting bisexual men of color must adhere to the CDC adaptation guide (adapting HIV behavior change interventions for gay and bisexual latino and black men).

The Department must provide funded agencies with procedural guidance on adaptations, providing examples, technical assistance and access to CDC CBA providers.

Using a Department-specified format, agencies approved to conduct an adaptation of a DEBI must provide the lead agent and the Department with a summary of the outcomes of the intervention adaptation, to also include a qualitative report.

### **2012 Recommendations for Home Grown Interventions**

The Department must identify, evaluate and approve homegrown interventions used with special concerns populations when appropriate and when home grown interventions have proven behavioral outcome effectiveness.

Agencies choosing to implement a homegrown intervention must assure the following:

- Be feasible, practical, cost-effective, and have good potential for sustainability.
- Have a low potential for adverse short- and long-term individual-level and community-level outcomes that could be attributed to the implementation of the intervention.
- Be acceptable and relevant to the target population.
- Have sufficient time to allow for the collections of data demonstrating the degree to which the intervention works, as well as the impact the intervention has on broader community health.
- Have the potential for additional health or social benefits that could result from its implementation.

Based on a thorough examination of the health behavioral model literature, the CDC's Compendium of Effective Interventions, and the Tiers of Evidence Models, the Illinois PCPG recommends that jurisdictions combine a mix of homegrown and DEBI interventions that best fit its operations and target populations.

When applicable, interventions must address the following HIV-Public Health Strategy related services:

Proposed Approved Services/Strategies	
1.	Counseling, Testing and Referral Services (CTR)
2.	Comprehensive Risk Counseling Services (CRCS)
3.	Partner Services (Community Based Organizations)
4.	Partner Services (Health Departments)
5.	STI Screening
6.	Hepatitis A and B Vaccinations; Hepatitis B and C Testing

## **Other Recent PCPG/IDPH Needs Assessment Activities**

### **HIV Prevention Community Forums**

The PCPG conducted a series of HIV Prevention Community Forums in 2010-2011. Before the 2011 community forums were planned, the PCPG Evaluation Committee reviewed the surveys completed by community members who had attended and participated in the 2010 forums. The comments were taken into consideration and as a result, representatives from regional Care programs were included in the planning and conduct of the 2011 forums, a more general overview of the regional/local level HIV epidemic was provided, and more time was allocated for the risk break-out discussions where the community was encouraged to provide input and feedback into care and prevention services. Review of the forum data identified the need to maintain existing prevention services; provide more prevention for positives and Partner Services programs; utilize peers in the provision of HIV outreach, education and risk reduction services, providing linkage to care and treatment to newly diagnosed clients as well as clients who may have fallen out of care; and provide more HIV awareness and educational information to youth and parents as well as to the general public. The results of the 2009-2010 Illinois Behavioral Risk Youth Survey presented to the PCPG this year emphasized not only the need for more HIV education in the schools but the higher rate of risk behaviors, mental health issues, and bullying among gay, lesbian, and bisexual youth. Results of needs assessment activities such as these were used to help identify areas of need for inclusion in the 2012-2016 Jurisdictional HIV Prevention Plan.

### **PCPG 2012 Prevention Provider Survey**

In 2012, the PCPG Prevention Provider Survey focused on assessment of the knowledge, skills and need for training of regionally-funded prevention providers on prevention for positives interventions and partner services. The responses indicated the following:

1. There remains a need to increase providers' capacity/capability to provide basic HIV skills and prevention services such as condom education, demonstration and distribution. Refresher courses and competency training were recommended.
2. Training for partner services programs, CRCS, ARTAS, and harm reduction was identified as those most needed by staff.

### **PCPG / IDPH HIV/AIDS Section Direct Service Unit Joint Survey, 2012**

In 2012, the PCPG worked with the HIV/AIDS Section Direct Services Unit to develop and conduct a joint survey of Ryan White Part B client to assess care, treatment and prevention needs and gaps. The Direct Services Unit agreed to add prevention questions to their annual Client Satisfaction Survey, which typically produces a 30 to 40 percent response rate. The new questions assessed the awareness, knowledge, utilization, current risk behaviors, and need for prevention services (including Partner Services) among people living with HIV. The survey also assesses utilization of Care services, which is seen as a prevention measure. Some highlights from the responses included the following:

1. 94.3 percent of respondents had seen a doctor in the last 6 months.
2. 97.3 percent of respondents had had a CD4 and 96.9 percent had had a viral load in the last six months.

3. 84 percent of the respondents stated that their case manager has asked them about their partners needing notification and possible testing.
4. 89.8 percent of the respondents felt comfortable talking to their case manager about their sex life and alcohol/drug use.
5. 95.2 percent of the respondents stated they were currently on HIV meds and 99.1 percent of those stated they were taking the medications as prescribed.
6. 90.6 percent of respondents know they should be screened annually for STDs, but only 76.9 percent reported having received screening in the past year.
7. 40.8 percent of respondents stated they would like more information about safer sex and injecting behaviors.
8. 26.6 percent of respondents would like more support groups, 24.2 percent more free condoms, 15.1 percent hepatitis A, B, and C screening, and 13.3 percent hepatitis A and B vaccination.

The PCPG will continue to collaborate with the Department's HIV/AIDS Section Direct Services Unit and other key stakeholders to determine other community services/needs assessments to conduct in 2012 and upcoming years. This might include hosting additional community forums, facilitating focus groups, conducting key informant interviews, or conducting more detailed and targeted surveys. Whatever decision is made, it will be a collaborative effort with representatives from prevention and care being included in the planning, conduct, recruitment, and evaluation of the activities.

## **SECTION IV. 2012 IDPH HIV PREVENTION REGIONAL GRANT PROCESS & GAPS ANALYSIS: TIER THREE**

Section IV describes the several processes used by the Department's HIV/AIDS Section to assure that its HIV Prevention Regional Grant (RG) process for 2012 was consistent with the PCPG 2012 Priority Populations and Approved Interventions; that funding and services closely mirrored the unmet need for prevention services, based on the epidemiology; and that the final steps in the gaps analysis encompassed consideration of all services delivered by other funding streams, to the extent this was possible. The overall goals of these processes were to identify and target those populations with the greatest burden of the epidemic, those at greatest risk for HIV transmission and acquisition and ensure that prevention resources from the CDC grant are allocated and disseminated regionally to the areas and populations with the greatest HIV burden.

Illinois and the U.S. Centers for Disease Control and Prevention (CDC) allocate grant funds to the Department to provide HIV prevention services to Illinois residents at highest risk for transmitting or contracting HIV. Priorities for highest risk populations to be served and interventions to be provided to them are established and updated annually.

Illinois HIV Prevention Regional Grant (RG) funds are contracted to lead agencies chosen to fund and monitor sub-grantees to implement Regional HIV prevention service plans for prioritized highest risk Illinois residents in each region except Region 9, the city of Chicago (see map, Page 32). The Department selects HIV Prevention Regional Grant lead agencies for Regions 1 through 8 through a competitive application process that was last conducted in 2011. Lead agencies then provide fiscal, administrative and program monitoring services to successful sub-grantees that have been selected through an annual competitive award process, who then deliver the contracted HIV prevention services in each of the prevention regions, under guidance of and with cooperation from the Department's HIV/AIDS Section.

Regarding collaboration and coordination of HIV prevention resources between respective jurisdictions, the Department and the Chicago Department of Public Health (CDPH) agreed in letters submitted with the PS12-1201 HIV Prevention application that CDPH would apply for a proportion of the total PS12-1201 funding available for Illinois equal to the city's share of Illinois HIV prevalence cases in 2008, and that the Department would apply for the remainder. Under the agreement, CDPH will provide HIV prevention services for city of Chicago residents while the Department provides these services for Illinois residents outside of the city of Chicago. The Department agreed to "work with CDPH, and other stakeholders as appropriate, annually to ensure that the distribution of all state general revenue funds and state special funds available for HIV prevention services are based on the most current HIV prevalence data for Chicago...and the state of Illinois." The CDC awarded CDPH the full Category A amount it requested under the agreement for the city of Chicago for 2012, but awarded the Department less than the full amount it requested for Category A.

Illinois' 2012 RG guidance is centered around four key elements: 1) service allocation through regional plans; 2) regional (funding) allocation; 3) service class allocation; and 4) epidemiologically-proportioned service allocation to target populations. Built into these processes were the final "Tier Three" steps of the gaps analysis, which is detailed in the following narrative.

**Service Allocation Through Regional Plans**

The regional service plans have been developed to ensure that in Regions 1-8 as a whole, within each region, and in each service class, service units are distributed by target population so that:

- Prevention service resources are distributed between regions proportionately to recent case distribution between those regions
- Service class proportions conform to CDC grant guidelines
- Service units are distributed within regions based upon a gap analysis of other HIV prevention services in accordance to CDC grant guidelines
- Service units are distributed to prioritized populations by risk by race/ethnicity so that the overall services delivered (for this grant plus other HIV prevention resources) in the region will be proportionate to recent case regional distribution between those risk groups

**HIV Prevention and Care Regions – IDPH**

Region	Counties
R1 – Northwestern IL	Jo Davies, Stephenson, Winnebago, Boone, Carroll, Ogle, DeKalb, Whiteside, Lee, Rock Island, Henry, Bureau and Mercer
R2 – NW Central	LaSalle, Putnam, Stark, Knox, Warren, Henderson, Hancock, McDonough, Fulton, Mason, Tazewell, Peoria, Woodford and McLean
R3 – West Central	Adams, Brown, Schuyler, Cass, Menard, Logan, DeWitt, Piatt, Macon, Sangamon, Morgan, Scott, Pike, Greene, Montgomery and Shelby
R4 – Southwestern	Calhoun, Jersey, Macoupin, Madison, Bond, Fayette, Marlon, Clinton, St. Clair, Monroe, Randolph and Washington
R5 – Southern	Jefferson, Wayne, Edwards, Wabash, White, Hamilton, Franklin, Perry, Jackson, Williamson, Saline, Gallatin, Union, Johnson, Pope, Hardin, Alexander, Pulaski and Massac
R6 – East Central	Kankakee, Livingston, Ford, Iroquois, Champaign, Vermillion, Douglas, Edgar, Coles, Cumberland, Clark, Effingham, Jasper, Crawford, Clay, Richland and Lawrence
R7 – Collar Counties	Lake, McHenry, Kane, DuPage, Kendall, Grundy and Will
R8 – Suburban Cook	Cook excluding the city of Chicago

A map of the Department’s (Illinois Jurisdiction) HIV/AIDS Section Regional Implementation Group Jurisdictions is on the following page.

# ILLINOIS DEPARTMENT OF PUBLIC HEALTH - HIV/AIDS SECTION REGIONAL IMPLEMENTATION GROUP (RIG) JURISDICTIONS



## Regions

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8
- Region 9

Effective Date: January 1, 2010

### **Service Allocation Through Gap Analysis (Tier Three, Gaps Analysis)**

Gap analysis attempts to identify in each region those prioritized populations recently *underserved* relative to epidemiologic proportions by HIV prevention services funded by any funding source *other* than the RG for which recent service data is available. It then identifies the numbers of RG service units needed to bring the proportion of *total* services (i.e. for all grants combined including RG) delivered to a given prioritized population into alignment with its proportion of the epi. For the gap analysis conducted in 2011 for the 2012 funding cycle, the recent service data analyzed was for all HIV prevention services documented in Provide® Enterprise from July 1, 2010 through June 30, 2011 for all IDPH and Illinois Department of Human Services (DHS) Department of Alcohol and Substance Abuse (DASA) grant-funded services other than the RG, including Minority AIDS Initiative funding, Quality of Life funding, and other sources for which recent prevention services delivery data was available. While accurately predicting what these other funding streams might accomplish in the coming year would be ideal, in practice, it proved nearly impossible, particularly in fiscally unstable conditions. However, one can accurately complement what other funding streams have just accomplished by applying upcoming RG funds to bring the total service distribution as close a possible to epidemiologic proportions by risk by race/ethnicity (inclusive of any serostatus). Future RG funding cycles will adjust the recent service profile of other grant streams towards an overall epidemiologically proportioned total.

In tiers one and two, the PCPG conducted initial gaps analysis activities, as previously described in Section III, culminating in determining final approved priority populations in July 2011. In June 2011, the PCPG compared the distribution of Illinois' HIV cases to the CTR and HERR services delivery, looking at gender, risk, race/ethnicity, geographic location, age, positivity results, and funding stream and compared positivity rates to distribution of tests and by funding stream. The CTR and HERR data were compared to the trends of new diagnoses in the past five years to determine the extent to which available funding and service that could be identified was meeting the needs of the most impacted at risk populations across Illinois, and where service gaps existed. In Tier Three, the final steps in the gaps analysis, the IDHP HIV/AIDS Section HIV Prevention Program Administrator further examined available resources and services delivered, and compared these to the distribution of the HIV across the state, as evidenced in the most recent epidemiology, incorporating and applying the 90 percent/ 5 percent/ 5 percent formulas for incidence, prevalence, and late diagnoses, respectively, as approved by the PCPG. The narrative and tables below detail the outcomes of Tier Three of the gaps analysis, and show how these were applied to the entire 2012 final Regional Grant awards process and allocation.

The spreadsheet on the following page, "Gaps Analysis, Tier Three, Example: Region 1, Regional HIV Prevention Grant Available Service Units" shows a sample of how the outcomes of this analysis was actually applied in each region. This example spreadsheet shows how, for each region, service category and prioritized population, the number of needed RG service units was calculated to address the region's recent HIV prevention service gaps. For some service categories in some regions, very few service units were delivered by other funding streams, and thus the available RG units are closely proportioned to recent HIV disease cases in that region. In other cases, particularly for HIV testing, other funding streams provided large numbers of tests to some prioritized high risk populations but not others, so the available RG units are proportional to the gaps between an ideal distribution and the actual, bringing those two as close together as resources permit.

Table 3. Gaps Analysis, Tier Three, Example: Region 1, Regional HIV Prevention Grant Available Service Units.

Region 1		Risk Reduction for Positives (P4P)						Surv.-based Linkage to Care	Risk-targeted HIV Counseling & Testing						Partner Services w/ Index & Partner	Risk Reduction Interventions for Negatives					
Services>>	Regional Epi-Share	Recent Non - RG	Ideal: Total Service by Epi-Shares	Gaps: Units Needed to fit Epi	Best Epi-fit	RG 2012 Service Units	% Total	RG 2012 Service Units	Recent Non-RG	Ideal: Total Service by Epi-Shares	Gaps: Units Needed to fit Epi	Best Epi-fit	RG 2012 Service Units	% Total	RG 2012 Service Units	Recent Non-RG	Ideal: Total Service by Epi-Shares	Gaps: Units Needed to fit Epi	Best Epi-fit	RG 2012 Service Units	% Total
Prioritized Populations																					
Black MSM	10.3%	16	26	10	26	10	10.3%	8	53	250	197	165	112	6.8%	8	17	45	28	45	28	10.3%
Black IDU	7.3%	0	18	18	18	18	7.3%	5	112	177	65	149	37	6.1%	5	3	32	29	32	29	7.3%
Black HRH	18.7%	2	46	44	46	44	18.7%	14	516	454	0	516	0	21.3%	14	8	81	73	81	73	18.7%
Black MSM-IDU	1.5%	0	4	4	4	4	1.5%	1	0	37	37	21	21	0.9%	1	4	7	3	7	3	1.5%
White MSM	36.7%	4	91	87	91	87	36.7%	28	58	889	831	529	471	21.8%	28	6	159	153	159	153	36.7%
White IDU	4.7%	0	12	12	12	12	4.7%	4	371	114	0	371	0	15.3%	4	1	20	19	20	19	4.7%
White HRH	5.4%	0	14	14	14	14	5.4%	4	143	132	0	143	0	5.9%	4	13	24	11	24	11	5.4%
White MSM-IDU	2.7%	0	7	7	7	7	2.7%	2	2	66	64	38	36	1.6%	2	0	12	12	12	12	2.7%
Hispanic MSM	4.1%	1	10	9	10	9	4.1%	3	27	99	72	68	41	2.8%	3	2	18	16	18	16	4.1%
Hispanic IDU	1.4%	0	3	3	3	3	1.4%	1	222	33	0	222	0	9.2%	1	0	6	6	6	6	1.4%
Hispanic HRH	4.0%	0	10	10	10	10	4.0%	3	123	96	0	123	0	5.1%	3	1	17	16	17	16	4.0%
Hispanic MSM-IDU	0.0%	0	0	0	0	0	0.0%	0	15	0	0	15	0	0.6%	0	0	0	0	0	0	0.0%
OtherRace MSM	2.5%	0	6	6	6	6	2.5%	2	4	61	57	36	32	1.5%	2	0	11	11	11	11	2.5%
OtherRace IDU	0.0%	0	0	0	0	0	0.0%	0	13	0	0	13	0	0.5%	0	0	0	0	0	0	0.0%
OtherRace HRH	0.6%	0	2	2	2	2	0.6%	0	13	15	2	14	1	0.6%	0	2	3	1	3	1	0.6%
OtherRace MSM-IDU	0.0%	0	0	0	0	0	0.0%	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0.0%
Total	100%	23	248	225	248	225	100%	75	1672	2,423	1325	2423	751	100%	75	57	433	376	433	376	100%
Non-RG Total		23						0	1672						0	57					
RG Total		225						75	751						75	376					
All Service Total		248						75	2423						75	433					
Needed Units for Ideal		225						75	1325						75	376					
% Needed Units available	100.0%							100.0%	56.7%						100.0%	100.0%					

## Regional Grant Funding Award Allocation Based on HIV Epidemiology

Funds are allocated among Regions by a weighted epidemiologic composite of 90% Incident cases, 5% Prevalent cases and 5% Late Diagnosed cases (AIDS diagnoses within 0-12 months of HIV-Infection Diagnosis), a formula recommended by the PCPG to ensure close correspondence between priorities established by PCPG planning processes and RG funding and resource allocation. Sub-grantee Awards for 2012 are supported by a mix of federal and state funds. Table 4, “2012 IDPH Regional Grant Awards by region, based on HIV-disease epidemiology, (18 month funding cycle)” below shows the FY2012 grant program funds by region. This table represents the “unit-based” outcomes of the final “tier three” steps conducted by IDPH for the gaps analysis.

Geographic distribution	2006-2010 IL HIV-Infection (Not AIDS) Diagnoses, excluding Incarcerated cases	2006-2010 IL AIDS Dx's within 0-12 mos of HIV Diagnoses, excluding Incarcerated cases	2010 IL Living HIV Disease Cases, excluding Incarcerated cases	Weighted Epi Composite Value	"Epi-share"	CDC Portion	GRF Portion	LA Awards	Program Awards	Total Regional Awards	Program Funding Allocation Share by Region
Region 1	151	50	884	182.60	7%	\$107,456	\$243,174	\$50,038	\$300,592	\$350,630	7.1%
Region 2	130	42	754	156.80	6%	\$92,273	\$208,815	\$47,065	\$254,023	\$301,088	6.1%
Region 3	115	31	852	147.65	6%	\$86,889	\$196,630	\$46,011	\$237,507	\$283,518	5.8%
Region 4	284	49	1224	319.25	12%	\$187,872	\$425,154	\$65,782	\$547,244	\$613,026	12.4%
Region 5	92	16	442	105.70	4%	\$62,202	\$140,764	\$41,178	\$161,788	\$202,966	4.1%
Region 6	152	35	950	186.05	7%	\$109,486	\$247,768	\$50,435	\$306,819	\$357,254	7.3%
Region 7	478	165	2655	571.20	22%	\$336,138	\$760,683	\$94,809	\$1,002,013	\$1,096,822	22.3%
Region 8	772	267	3757	896.00	35%	\$527,276	\$1,193,229	\$132,230	\$1,588,275	\$1,720,505	34.9%
R1-8 Total	2174	655	11518	2565.25	100%	\$1,509,593	\$3,416,217	\$527,549	\$4,398,261	\$4,925,810	100.0%
Program Award CDC + GRF Funding Amount							\$4,925,810		\$4,925,810		

Note that in the above table, each region’s total award is proportional to within 0.2 percent of the “epi-share” percentage of HIV and AIDS diagnoses for the data analysis period. While there is some regional variation in the proportion of dollars allocated to “Program Awards” (low = 72%, high = 91%), vs. “Total Regional Award,” most of this is attributable to differences the types of services proposed in each of the regions, and “economies of scale” in higher incidence more urban-

centered regions served by agencies who are able to provide more services at lower cost than in lower incidence rural regions.

### Epidemiologically-proportioned Service Allocation to Target Populations

Because 2012 HIV infections are the events that HIV prevention must reach to stop, and because recent HIV disease case distribution is the strongest available predictor of next year’s HIV disease case distribution, aligning the proportions of HIV prevention services as closely as possible to recent HIV infections by risk by race/ethnicity is critical positioning for public health effectiveness. Table 4 above details 2012 RG funding for prevention services by region, based on HIV disease epidemiology for each region in the jurisdiction.

### Service Class Allocation

Within each region, funds are allocated among Service Classes per CDC PS12-1201 Funding Opportunity Announcement requirements and the Department’s 2012 application specifications.

- 10 percent for Prevention For Positives: Risk Reduction Individual Level Intervention (ILI) and Group Level Interventions (GLI) Person-Sessions
- 10 percent for Prevention For Positives: Surveillance-based Linkage to Care
- 40 percent for HIV Counseling, Testing and Referrals with Partner Services
- 15 percent for Surveillance-based Partner Services
- 25 percent for Prevention For HIV-Negatives: Risk Reduction ILI, GLI and CLI (Community Level Intervention) Person-Sessions

Table 5 below details the 2012 RG Award Service Class Allocation funding by region.

Geographic distribution	Service Type	Prevention for Positives (P4P)	Prevention for Positives (P4P)	Risk-Targeted HIV Counseling & Testing	Partner Services (PS) with Index PWHIV	Prevention for Negatives (P4N)	Funding percentage by Geographic Distribution
	Description	Risk Reduction ILI & GLI Person-Sessions	Linkage to Care	Test Sessions	Surveillance-Triggered PWHIV Partner Elicitation, LTC, RRC & Partner Notification Counseling, Testing & Referral	Prevention ILI, GLI and CLI Person-Sessions	
	Unit Cost	\$200	\$200	\$200	\$200	\$200	
% by Service Type		15.0%	5.0%	50.0%	5.0%	25.0%	
<b>Service Funds</b>							
Region 1	\$300,592	\$45,089	\$15,030	\$150,296	\$15,030	\$75,148	6.8%
Region 2	\$254,023	\$38,103	\$12,701	\$127,012	\$12,701	\$63,506	5.8%
Region 3	\$237,507	\$35,626	\$11,875	\$118,754	\$11,875	\$59,377	5.4%
Region 4	\$547,244	\$82,087	\$27,362	\$273,622	\$27,362	\$136,811	12.4%
Region 5	\$161,788	\$24,268	\$8,089	\$80,894	\$8,089	\$40,447	3.7%
Region 6	\$306,819	\$46,023	\$15,341	\$153,410	\$15,341	\$76,705	7.0%
Region 7	\$1,002,013	\$150,302	\$50,101	\$501,006	\$50,101	\$250,503	22.8%
Region 8	\$1,588,275	\$238,241	\$79,414	\$794,137	\$79,414	\$397,069	36.1%
<b>R1-8 Total</b>	<b>\$4,398,261</b>	<b>\$659,739</b>	<b>\$219,913</b>	<b>\$2,199,130</b>	<b>\$219,913</b>	<b>\$1,099,565</b>	<b>100%</b>

**Expected RG Service Units, 2012 IDPH Regional Grant Awards by Service Class and Region**

Table 6 below, “Expected RG Service Units, 2012 IDPH Regional Grant Awards by Service Class and Region (18 month funding cycle),” shows the anticipated number of units of service to be delivered under the 2012 RG awards, by region and service type.

<b>Table 6. Expected RG Service Units, 2012 IDPH Regional Grant Awards by Service Class and Region (18 month funding cycle)</b>							
Geographic distribution	Service Type	Prevention for Positives (P4P)	Prevention for Positives (P4P)	Risk-Targeted HIV Counseling & Testing	Partner Services (PS) with Index PWHIV	Prevention for Negatives (P4N)	
	Description	Risk Reduction ILI & GLI Person-Sessions	Linkage to Care	Test Sessions	Surveillance-Triggered PWHIV Partner Elicitation, LTC, RRC & Partner Notification Counseling, Testing & Referral	Prevention ILI & GLI Person-Sessions	
	Unit Cost	\$200	\$200	\$200	\$200	\$200	
	% by Srvc Type	15.0%	5.0%	50.0%	5.0%	25.0%	
Region 1		225	75	751	75	376	
Region 2		191	64	635	64	318	
Region 3		178	59	594	59	297	
Region 4		410	137	1,368	137	684	
Region 5		121	40	404	40	202	
Region 6		230	77	767	77	384	
Region 7		752	251	2,505	251	1,253	
Region 8		1,191	397	3,971	397	1,985	Grand Total
R1-8 Total		3,299	1,100	10,996	1,100	5,498	21,991
<b>Historical Service Delivery Data</b>							
R1-8 Total	2010	2,901	0	7,171		4,400	14,472
R1-8 Total	2011	1,789	0	5,649		8,351	15,789

**Section V. Description of Existing *Non-RG* Funded Resources for HIV Prevention, Care and Treatment and Key Features on How Prevention Services, Interventions and Strategies are Currently Being Used or Delivered in the Jurisdiction.**

**Existing *NON-RG* Funded HIV Prevention Resources and Services**

Since HIV prevention, care and treatment services are funded by multiple sources from different state and federal agencies, it seems appropriate and necessary to clearly delineate between *existing* HIV prevention resources that are *supported by funding sources other than* the CDC PS-1201 HIV prevention RG process. In this way, the “gaps in HIV prevention services to be addressed and their rationale for selection” and “prevention activities and strategies to be implemented within the jurisdiction” funded under PS12-1201, as detailed in Section VI, can more clearly be discussed. Therefore, Section V describes existing resources and services for HIV prevention, care and treatment in the jurisdiction that are *supported by funding other than* the CDC PS12-1201 Grant and GRF RG awards process. It also outlines key features on how these services are being delivered in the jurisdiction.

**HIV Resource Inventory**

Maintaining a current, comprehensive inventory of HIV prevention, care and treatment resources is a dynamic process, much influenced by factors such as economic shifts, available funding, the changing landscape of providers, and of course, the fluid state of the HIV epidemic itself. Having a reliable HIV resource inventory has been and continues as a weak link in the HIV prevention planning process, having a direct impact on the accuracy and specificity that can be applied to the HIV-prevention need gaps analysis processes.

In 2011, the PCPG Coordinator collaborated with the Illinois HIV-AIDS-STD Hotline to explore the idea of using the hotline to enhance and improve resource inventory data-gathering processes. While it was somewhat productive, it did not result in the comprehensive and robust HIV prevention and care resource inventory the Department was seeking to develop. However, guidance was received from the Department and the regional lead agents about what data fields were most useful and necessary to include in the inventory, and hotline staff exported information from their existing database and a spreadsheet of services was created that can be sorted by region, county and other variables. In July 2011, prevention lead agents were presented with the updated spreadsheet and instructed to distribute it to their funded agencies for their review and update. Additional fields were added on this tool to capture estimates of the proportions of HIV prevention services and funding being delivered to risk/race populations corresponding to our major epidemiologic risk populations by transmission vector (MSM, Heterosexual, IDU, and MSM/IDU transmission). Lead Agents were asked to resubmit these updates to the Department (along with or at the time of their mid-year 2011 progress report) for resubmission to Illinois HIV-AIDS-STD Hotline so the hotline staff could update the database. The total number of agency spreadsheets returned and the data quality and completeness were significantly less than was anticipated. Overall, the results of this process for 2011, while helpful in certain regards, were less than optimal.

In 2012, an intern in the Department’s HIV Section worked with the Department’s PCPG Coordinator to compile a spreadsheet of state and federal fiscal year 2011 jurisdictional HIV

prevention, care, and treatment resources by agency; region(s) served; service types; scopes of services, including specific population groups; and funding amounts. The inventory includes services funded through the Department's federally received Health Resources and Services Administration (HRSA) funds, with federally received Centers for Disease Control and Prevention funds, with State General Revenue funds, and with Red Ribbon Lottery Ticket Quality of Life (QOL) funds. In addition, Part A, C, D, and F funded jurisdictional grantees outside the city of Chicago were contacted and asked to provide information about their FY2011 funding and services. A listing of federally-funded qualified health centers (FQHCs) and community health centers were included as attachments to the resource inventory. The resource inventory was distributed and reviewed with the PCPG at its April 2012 Meeting. It has been reviewed by the Department and the PCPG to determine any need for further assessment and/or analysis of services. The intern is currently working on compilation of the 2012 state and federal fiscal year resource inventory. Future plans include maintaining and updating the inventory on an annual basis and reaching out to other federally funded programs such as the Illinois Department of Alcohol and Substance Abuse to obtain a statewide listing of their funded agencies/services. The resource inventory, updated for 2011 funding, "State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources\_5-30-12" is included as Attachment 5 in the Jurisdictional Plan.

The Department's HIV/AIDS Section Prevention Program Administrator used all data available to him at the time in 2011 to conduct the final Tier Three steps of the gaps analysis to determine what HIV prevention services were already being delivered to whom and where across the jurisdiction, as described in Section IV, above.

The non-RG funded resources that can presently be identified and quantified are described in the Section V narrative below.

**STD Services.** The Department's STD section receives its own federal and state funds to carry out its STD tracking, treatment, education and prevention service functions. All Illinois STD clinics offer testing for STDs and opt-out testing for HIV unless the patient declines. All Department-funded HIV prevention agencies and STD clinics conduct HIV testing and complete thorough risk assessments as required by CDC. Individuals are served by trained clinic staff and prevention counselors. Persons are encouraged to get tested by the best option, including physician referral, STD clinic, a local health department or community clinic. The voluntary nature of HIV and other STD testing is presented during the pre-screening process in STD clinics. Patients are informed orally or in writing that HIV and other testing will be performed unless they decline. All STD DIS, clinic staff and prevention counselors funded through the PS12-1201 prevention grant are trained in accordance with current CDC guidelines and are encouraged to facilitate referrals directly to clinics that can provide STD, HBV, HCV or TB services if necessary.

### **Illinois HIV/AIDS Hotline**

IDPH uses GRF dollars to support a toll-free statewide HIV-AIDS-STD Hotline, operated by the Center on Halsted in Chicago. It is staffed seven days a week and serves as the state's primary HIV information clearinghouse. The hotline maintains a directory of statewide HIV/AIDS and STD service agencies and resources, and refers callers to these resources and agencies as appropriate. The most recent HIV resource inventory shows that the project received more than \$354,000 in GRF dollars for the period July 1, 2010 to June 30, 2011. For the period July 1, 2011 to June 30, 2012, the Department provided 7/1/2011 – 06/30/2012, IDPH provided \$353,748 in grant support (GRF funds) for hotline services.

### **Illinois Department of Corrections (IDOC)**

Recent legislation passed by the Illinois General Assembly (HB 1748), allows for HIV opt-out screening upon entry and/or prior to the release of any inmate in IDOC or juvenile justice facilities. Inmates/detainees will receive HIV/AIDS educational information with the ability to opt-out. In 2011, the Department's HIV/AIDS Section collaborated with IDOC to host several "*Summit of Hope*" community events to assist parolees and previously incarcerated with re-entry back into society. A total of 3,789 ex-offenders/parolees, released this past year, participated in the events. Four were conducted in counties of relatively high HIV prevalence, and 1,374 tested for HIV. Twelve more events are planned for 2012-2013 and targeted HIV testing will occur. Due to anticipated reduced Illinois GRF for HIV prevention, the impact on this program for SFY 2012 and beyond is uncertain at this time.

### **IDHS/DASA HIV Prevention Services**

The Department's HIV prevention resources are complemented by other state agencies that provide HIV testing and/or Ryan White Care services, including the Department of Human Services, Division of Alcohol and Substance Abuse (IDHS/DASA). U.S. Substance and Mental Health Services Administration (SAMSHA)-funded DASA sites offer HIV testing to all clients entering substance abuse treatment. DASA uses 5 percent of its SAMHSA Block Grant (and no Illinois GRF dollars) to fund HIV testing services. In 2011, \$173,705 (5 percent of \$3,474,109) and in 2012, \$170,943 (5% of 3,418,856) respectively were allocated to support HIV testing at 40 sites for persons entering substance abuse treatment. Per data from Provide (the Department's HIV Care & Prevention Services data tracking and reporting system), DASA agencies in 2011 conducted 15,166 tests in test counseling sessions of whom 99.2 percent received their final results. This 2011 DASA testing identified 6 confirmed positives of whom one accepted a referral to case management and two accepted referrals for Partner Services. The confirmed positive cases included one black female who disclosed injection risk, one black and one Hispanic female who disclosed only heterosexual risk, and three black males who disclosed no prioritized high risk behavior. Recent reductions to SAMHSA block-funding have resulted in fewer substance abuse treatment slots being available, and therefore, fewer individuals with potentially high risk behaviors receiving HIV testing through DASA-funded services.

### **Red Ribbon Lottery Ticket Quality of Life Grant Program**

The Red Ribbon Lottery Ticket Quality of Life Grant Program (QOL) was created as a special fund in the Illinois state treasury. Net revenue from the Red Ribbon Lottery Ticket instant scratch-off game is deposited into the special fund for appropriation by the General Assembly. Funds are restricted for HIV/AIDS prevention and support services. Grants are targeted to serve at-risk populations in proportion to the distribution of recent reported Illinois HIV/AIDS cases among risk groups as reported by the Illinois Department of Public Health. Recipient organizations must be engaged in HIV/AIDS prevention education or HIV/AIDS healthcare and support.

Through the Quality of Life Endowment Fund, small, midsize and some large agencies have been given the opportunity to learn and improve grant writing, budget development, and implementation of HIV prevention services. While QOL grant execution and reimbursement processes initially got off to slow start, funds awarded still make resources available to populations at increased risk for HIV infection, and also allowed new HIV service providers to become trained and equipped with tools to implement HIV prevention and support services. Particularly, staff members from small and midsize agencies have been able to build and improve skills in submitting grant applications,

budgets, data reports and quarterly narrative reports. Such skills can be used to obtain funding from other sources. With multiple sources of funding, high risk populations can be reached on a larger scale, therefore attacking the HIV epidemic on multiple fronts.

QOL grantees (8) from regions across the jurisdiction received nearly 41.1 million, the vast majority of these funds coming from the Illinois Red Ribbon Lottery Ticket proceeds, according to the most recently revised HIV resource inventory. Grants covered various periods during between September 1, 2010 and December 31, 2011. Services provided targeted all known HIV risk groups including HIV positive individuals and those at highest risk, varying by agency/region of the state covered. Types of services provided included HIV CTR; comprehensive risk reduction counseling and services (CRCS) sessions; GPS sessions consisting of HIV 101 instruction, healthier relationships, negotiate for safer sex, HIV/STI testing, partner testing, healthy living, education on HIV treatment options and related topics/; community outreach (street/ fixed sites); condoms distribution; HIV/AIDS peer education & outreach; and partner services for HIV positive persons, as well as many DEBI and homegrown prevention interventions.

For the funding period January 1, 2012 to December 31, 2012, a total of \$1.4 million in grants were awarded to 14 Illinois grantees. Approximately 46% of total funding was awarded to agencies for services in the city of Chicago, and the remainder was awarded for services to be delivered outside the city of Chicago and/or statewide.

Populations served by 2012 QOL grantees include: MSM and high risk heterosexual (HRH) Asian Americans; African Americans, White & Other MSM; African American, Hispanic & White MSM/IDU; Hispanic, White, African American & Other HIV positive MSM; Hispanic & African American HIV positive IDU; African American & Hispanic Female HRH; African American Youth HRH; Hispanic, White, African American & other IDU; and black transgender youth.

### **Housing Support for Persons Living with HIV or AIDS (PLWHA)**

Housing services for Illinois PLWHA has included a variety of services and been supported by more than one funding source:

1. Housing-GRF funded: These grants have been awarded to housing facilities to provide housing services to individuals with HIV/AIDS.
2. Housing Opportunities for Persons with AIDS (HOPWA) HIV Care Connect Regions - These grants have been awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
3. HOPWA One Time Awards – These grants have been awarded to housing facilities to provide housing services to individuals with HIV/AIDS.

Housing, GRF-funded. For the period July 1, 2010 to June 30, 2011, the Department awarded \$495,000 in GRF funds to seven agencies in the Illinois jurisdiction to provide various kinds of housing support and related services to Illinois PLWHA. While program scopes of service and number of clients to be served vary from agency to agency, overall this funding provides support for agencies to: establish collaborative partnerships with local agencies, organizations, and medical providers to increase accessibility to critical services for people with HIV; provide supportive services to assist a specified number of PLWHA located in residential housing; provide nutritional meals at each housing site to assist individuals living with HIV; provide comprehensive on-site case management services for a specified number of homeless PLWHA who will be placed in permanent

housing; provide life skills education related to preparing healthy meals to PLWHA; collaborate with local continuum(s) of care to identify permanent housing resources to low income persons living with HIV; provide a specified number of PLWHA with six months subsidies housing with the goal of becoming financially independent through employment; provide a specified number of PLWHA with access to at least two HIV/AIDS medical care providers; skills training sessions for a specified number of PLWHA; provide comprehensive on-site case management services for a specified number of PLWHA who reside in transitional housing; transition a specified number of PLWHA into permanent housing; provide emergency health and housing financial assistance for a specified number of PLWHA. For the period July 1, 2011 to June 30, 2012, available GRF funding was less, and the Department provided \$280,000 grant support in GRF funds to five agencies in four regions for these housing support services for PLWHA.

Housing, HOPWA HIV Care Connect Regional Grants. These grants have been awarded to HIV Care Connect regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease. For the period, January 1, 2011 to December 31, 2011, seven HIV Care Connect lead agencies received nearly \$408,300 in HOPWA funding and HOPWA amendments to the RWP to support these services for PLWHA.

Housing, HOPWA One Time Awards. These grants are awarded to Housing Facilities to provide housing services to individuals living with HIV/AIDS. For the period January 1, 2011 to December 31, 2011, five agencies covering four regions received \$100,000 in HOPWA funding to support these services for PLWHA. For the period January 1, 2012 to December 31, 2012, there was less funding available, and four agencies covering three regions received \$80,000 in HOPWA funding to support these services for PLWHAs.

### **The Illinois Harm Reduction and Syringe Disposal Program**

For the period July 1, 2010 to June 30, 2011, IDPH granted \$520,000 from Illinois GRF funds to support harm reduction and sharps disposal activities across the state. The statewide harm reduction system includes the following services: distribute 6,120 sharps containers and educational material on safe syringe disposal practices throughout Illinois; provide pharmacy access system coordination and promote pharmacy-based syringe access and support the Sharps Container Program through conducting regular outreach and education to pharmacies; provide evidence-based prevention services to at least 2,880 unduplicated IDUs; distribute social marketing materials regarding project services to IDUs within target areas using peers, street mobile outreach in high risk venues and distribute harm reduction educational materials risk reduction supplies and referral information to IDUs; increase number of outreach sites in which IDUS can consistently access HIV prevention education materials and risk reduction supplies, distribute sterile syringes and harm-reduction materials at outreach sites and fixed-project sites.

Recurring annual declines in both federal and state allocations to the Department's HIV Section for HIV prevention services finally prompted the HIV Section in July 2011, to begin to merge the harm reduction grant into the regional grants. These two distinct grants administered by different lead agents each funded many of the same agencies for injection harm reduction services with little coordination in IDU service allocation between the two grants. The Department began the merger by awarding six month continuation grants for the period of July 1, 2011 to December 31, 2011, to five harm reduction sub-grantees through the regional lead agencies. Beginning January 1, 2012,

harm reduction funding, paid for exclusively by Illinois GRF, was fully incorporated into the regional grants, administered through its lead agencies, and subject to its guidance.

The 2012 Regional HIV Prevention Grant includes \$662,200 dedicated to services for persons who inject over its 18 month project period of January 1, 2012 to June 30, 2013. The proportion of funds designated for IDU-specific services in each region is calculated consistently with allocations to other risk populations' services. It is based upon the region's proportion of HIV incidence, prevalence and late diagnosis reported with IDU risk, using a gap analysis to ensure that each region's *total* service delivery across all the funding streams that are documented in Provide (e.g., DASA, CMHS, QOL, Direct, Prison Project) is brought as close as possible to its epi-proportions by risk and race.

The 2012 Regional HIV Prevention Grant guidance includes a *requirement* for a comprehensive harm reduction project including legal research-linked syringe exchange to be funded within *each* region using exclusively state GRF. It also requires funding in each region of a project to engage MSM/IDU in sexual risk reduction and injection harm reduction. The guidance specifies that 90 percent of this IDU-designated intervention funding should be awarded to agencies *directly* providing comprehensive syringe exchange programs on site. (The other 10 percent of the IDU prevention funding is allocated to Surveillance-based Partner Services and Surveillance-based Linkage to Care currently limited to LHDs.) Only if no applicant will agree to serve a municipality with elevated IDU HIV incidence may the lead agency fund a project to serve IDUs at that locale that does not *directly* provide comprehensive harm reduction, and that project must have a linkage agreement with the region's funded harm reduction project(s) to send referrals and receive referral use confirmation from the harm reduction agency.

Additionally, the HIV Section is using state GRF to purchase more than \$800,000 worth of syringes, alcohol pads, tourniquets, antibiotic packs, sterile water, sterile cotton and sharps containers for shipment directly to funded harm reduction projects. Purchases of HCV rapid test kits and HAV/HBV vaccine have also been requisitioned for qualifying funded projects.

In addition to these designated injection-risk-specific funds, harm reduction projects may apply for RG funds to serve non-injecting heterosexual and same-sex sex partners of injectors. Harm reduction projects may also seek funding through Quality of Life or CMHS Community of Color HIV Initiatives grants.

## **FCAN**

For the period July 1, 2010 to June 30, 2011, the Department granted \$125,000 from GRF funds to support the programming of the Families & Children AIDS Network (FCAN) in the Illinois jurisdiction. For the period noted, this funding supported holding two Red Ribbon Trails retreats for HIV infected and HIV affected families at accessible locations throughout Illinois; facilitated six conference calls for the Red Ribbon Alliance to families living with HIV/AIDS by providing therapeutic support and education about HIV/AIDS and parenting, with progress measured through surveys; activities to develop a statewide teen advisory committee of 10 to 12 HIV-positive youth to discuss issues of importance to HIV-positive youth and plan programming to meet identified needs; provided consumers and providers statewide with HIV disclosure counseling, planning, and ongoing support. For the period July 1, 2011 to June 30, 2012, IDPH provided more than \$150,600 in grant support (GRF funds) for FCAN programs and services.

## **HIV Care, Treatment and Prevention Services (Ryan White Program-funded Services).**

The Ryan White Program (RWP), funded by HRSA, is the single largest federal program designed specifically for people with HIV in the United States. It contains several “parts,” each focusing on specific concentration areas of the epidemic and/or specific types of services to PLWHA. Under Parts A through C, 75 percent of funds received must be spent on core services, which include: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low income individuals; home health care; medical nutrition therapy; hospice services; home and community-based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

### **RWP Part A**

Under RWP Part A, funds are provided to “eligible metropolitan areas” (EMAs), those with a cumulative total of more than 2,000 reported AIDS cases over the most recent five-year period, and “transitional grant areas” (TGAs)- those with 1,000-1,999 cumulative reported AIDS cases. Two-thirds of funds are distributed by formula based on an area’s share of living HIV (non-AIDS) and living AIDS cases; the remainder is distributed via competitive, supplemental grants based on “demonstrated need.”

The grantee for the city of St. Louis allocated nearly \$677,600 from its total 2011 Part A award to benefit Illinois PLWHA in Region 4, who reside in the five Illinois counties in the Metro St. Louis area. Services provided under Part A include: outpatient ambulatory care, AIDS pharmaceutical assistance, oral health, medical case management, treatment adherence, and food bank/home delivered meals.

### **RWP Part B**

Under RWP Part B, the Department receives grant monies to support the following services to PLWHA in Illinois: care services, ADAP, ADAP supplemental, and Minority Aids Initiative (MAI) services (under Parts A and B). HRSA guidelines require that services delivered under this funding follow a “75 percent / 25 percent” split, where 75 percent of funds are expended for “core medical services” and 25 percent for “support services”. Because ADAP in Illinois itself requires more than 75 percent of the RWP Part B grant award to deliver services to eligible PLWHAs, Illinois is in compliance with this requirement.

The most recently updated HIV Resource Inventory shows that for the funding period April 1, 2011 to March 31, 2012, for the Illinois jurisdiction outside of Chicago (Regions 1-8), a total of \$4.7 million was received in RWP Part B funding only (not including MAI funding), the vast majority of it coming from federal HRSA funds and a small percentage from Illinois GRF. While the range of services vary a good deal between regions, covered services included: legal services; housing services; medical case management (including treatment adherence); mental health services; food bank/home-delivered meals; substance abuse services - outpatient; outpatient/ambulatory health services; oral health care; and early intervention services.

**ADAP.** Beginning July 1, 2011, ADAP lowered the federal poverty level (FPL) for ADAP eligibility from the 500 percent (\$54,450 for household size of one) to 300 percent (\$32,670 for household size one) for all “**new**” applicants and those previously enrolled clients whose status is classified by ADAP as “**closed**” at the point of enrollment. In federal fiscal year (FFY) 2011, 6309 unduplicated clients were served under the Illinois Part B ADAP. As of 2012, the ADAP formulary includes 82 drugs and therapies; including all the FDA approved antiretroviral treatments from all the classes. Fuzeon, Mepron, and oral Valcyte require prior authorization with limited slots available; however no waiting list was implemented. The formulary also includes an array of treatments and therapies for opportunistic infections, HIV-related diseases and treatment for side effects. ADAP allows up to a maximum of five antiretroviral plus a reduced dosage of Ritonavir (Norvir), treatments for opportunistic diseases up to \$2,000 a month and a limited number of slots for Fuzeon and oral Valcyte. In addition, ADAP requires prior approval for atovaquone (Mepron) for use for more than 21 days, use as prophylaxis (rather than treatment), or more than one prescription per year is written for a patient more approved for use of atovaquone as prophylaxis.

ADAP does not cover psychotropic treatments, which are closely associated with adherence to HIV-related treatments and quality of life. The addition of these agents has been considered on multiple occasions. This category represents a large number of drugs and dosing options, many of which are now available in generic form. The ADAP dispensing cost of \$13 far exceeds the cost of the generic drug. Many of these generics are available through retail pharmacies and discount chains for \$2 to \$4. Therefore, the addition of these agents cannot be justified based on the basis of cost-effectiveness.

On July 1, 2011, Illinois ADAP launched on its new interactive online enrollment application for all ADAP and Continuation of Health Insurance Program (CHIC) applicants. All applicants are required to complete the online application with supporting documentation, i.e., proof of residency, income, CD4 and Viral Load Laboratory results, and third party insurance plans. Since April 1, 2010, the ADAP has required that 100 percent of all applicants submit completed applications with supporting documents to be recertified for continuing ADAP eligibility every six months.

**Core Services.** In addition to ADAP, other “core services” provided under RWP Part B include early intervention services (EIS), medical case management (MCM), medical nutritional therapy (MNT), mental health care (MHC), oral health care (OHC), outpatient/ambulatory health care, (OAHC), and substance abuse outpatient services (SAOS).

**Support Services.** Support services include: emergency financial assistance, housing assistance, legal assistance, linguistic services, medical and support transportation, outreach services, psychosocial support services, and treatment adherence, outside of medical case management or clinical setting.

**Early Identification of Individuals With HIV/AIDS (EIIHA).** Both the Department’s HIV Prevention Program and HIV Care Direct Services Unit have worked together to develop a strategy addressing the identification of persons unaware of their HIV status. This has helped the HIV/AIDS Section to identify subpopulations and outline key activities to address EIIHA.

The Department is implementing the IHAS plan’s focus on increasing the positivity rate identification of HIV-positive individuals, increasing the percent of those who receive their test

results, assuring referrals to care for positive clients and follow-up to confirm positive linkage to HIV care services. One step to increase the ability to follow-up with persons that test positive or negative is limiting anonymous testing at funded testing sites. This strategy increases the number of known clients that could be re-tested at certain intervals due to risk behaviors, followed up by providing Partner Services and referring HIV positive individuals positives to care. In addition, the RWP Part B has developed a process to assure that individuals served in a funded STD site are tracked, offered and provided Partner Services, and referred to care for positive clients and/or their partner that tested positive. The program is also working closely with the Illinois Department of Corrections to assure that those testing positive are referred to an HIV Care Connect office ([www.HIVCareConnect.com](http://www.HIVCareConnect.com)). The specific goals of this programming are to:

1. Assist in building HIV/AIDS Section's capacity for targeted confidential testing to increase identification of individuals unaware of their HIV status.
2. Coordinate with the prevention program in preventing or identifying new infections through provision of Partner Services.
3. Support HIV testing as a routine part of medical care to identify individuals unaware of HIV status.
4. Increase the number of Ryan White case managers trained in HIV testing to increase identification of new positives.
5. Coordinate with prevention in increasing confidential testing leading to increase ability to inform individuals of their HIV status.
6. Refer positive clients to care within 30 days.
7. Link and confirm clients in care within 90 days.

### **RWP Part C**

Under RWP Part C, public and private organizations are funded directly for EIS, to reach people newly diagnosed with HIV with services such as HIV testing, medical case management, and risk reduction counseling. In the 2011 funding period, four agencies covering five regions outside the city of Chicago (Regions 1, 2, 4, 7, 8) received a total of nearly \$1.8 million to provide RWP Part C EIS services across their respective jurisdictions. For the FFY 2012 funding period, RWP Part C grantees were level-funded at their FFY 2011 grant amount to provide RWP Part C EIS services across their respective jurisdictions.

### **RWP Part D**

Under RWP Part D, public and private organizations are funded directly to provide family-centered and community-based services to children, youth, and women living with HIV and their families, including outreach, prevention, primary and specialty medical care, and psychosocial services. Part D also supports activities to improve access to clinical trials and research for these populations. The most updated HIV Resource Inventory shows that for the most recent funding period, one agency, Project ARK (AIDS/HIV Resources and Knowledge), located in St. Louis and a project of Washington University, received a total of \$1,3 million in Part D funding. Project ARK estimates that currently, 13.4 percent of its clients are Illinois residents, and that hence, roughly that same percentage of their Part D funding (\$99,200) is used to meet the needs of ARK's Illinois clients.

Project ARK provides family-centered and community-based services to children, youth and women living with HIV and their families, including outreach, prevention, primary and specialty

medical care, and psychosocial services and supports activities to improve access to clinical trials and research for these populations. Project ARK provides a range of services which are integrated into the delivery of HIV medical care at Part D partner clinics and includes: medical case management, linkage to care services, mental health/substance abuse evaluation, adherence counseling, patient retention activities, support groups, transportation, child care, and HIV prevention education. Project ARK also provides HIV testing, early identification, and HIV prevention services for at-risk women, infant, children, and youth (WICY) populations.

## **RWP, Part F**

RWP Part F includes three major components:

1. *AIDS Education and Training Centers (AETCs)*: national and regional centers that provide education and training for health care providers who treat people with HIV
2. *Dental Programs*: includes the “Dental Reimbursement Program,” which reimburses dental schools/dental care providers and the “Community-based Dental Partnership Program,” which funds programs to increase access to dental care for people with HIV and educate providers.
3. *Minority AIDS Initiative (MAI)*: the MAI, created in 1998 in response to growing concern about the impact of HIV on racial and ethnic minorities in the United States provides funding across several DHHS agencies/programs, including Ryan White, to strengthen organizational capacity and expand HIV-related services in minority communities. The Ryan White component of the MAI was codified in the 2006 reauthorization and the 2009 reauthorization required HRSA to develop a formula for awarding MAI grants under Parts A and B.

## **RWP, Part F, AETC Services**

**The Midwest AIDS Training and Education Center (MATEC)**, located at Jane Addams School of Social Work, University of Illinois, Chicago campus, and primarily serving the Midwest AETC Region, provides education and training for health care providers who treat people with HIV.

**Minority AIDS Initiative (MAI), Funding for Part A Grantees.** Under RWP, Part F, MAI funds are received and used to provide linkage to medical care, and education and outreach services to increase minority access to the Part B, ADAP, and MAI funded services and also to make referrals to ADAP and other Ryan White Care services. In the 2011 funding period, the city of St. Louis allocated \$55,000 of their total MAI, Part A award (all from HRSA dollars) to one agency in Region 4 to benefit Illinois PLWHAs. This funding supports one “linkage to care” case manager, in response to growing concerns about the impact of HIV on racial and ethnic minorities in the service area.

**Minority AIDS Initiative (MAI), Funding for Part B Grantees.** Under RWP, Part F, MAI funds are received and used to provide linkage to medical care, and education and outreach services to increase minority access to the Part B, ADAP, and MAI funded services and also to make referrals to ADAP and other Ryan White Care services.

In the 2011 funding period, the Department’s Center for Minority Health Services received more than \$397,600 from HRSA for MAI funding. There were six agencies funded to provide a variety of HIV related outreach, education, linkage to care, and evaluation services specifically to increase minority access to, and participation in, the ADAP program and other applicable Ryan White Care services. Additionally, the Department’s Center for Minority Health Services received general revenue funding to provide more general HIV outreach, education, screening, and linkage to care

services to HIV positive individuals and those at greatest risk for HIV infection throughout Illinois' communities of color. During this funding period, 19 agencies received a total of more than \$1.9 million.

The FY2011 program goal for linkage to care was that 275 HIV positive individuals from the target population who did not know their status or dropped out of care would be linked into care through an intensive, individual education effort supplemented by a survey tool to track services and treatment adherence. The program goal for outreach activities was for 2,500 minority individuals to receive ADAP and/or other applicable Ryan White Care Service information through a targeted outreach and education effort, and for 500 individuals from the target population to receive information regarding access to ADAP and other applicable Ryan White Care and Treatment Services through an intensive group education effort. A total of 3000 individuals from the target population would be impacted through both methods. The program exceeded all stated program goals for FY2011.

For the 2012 funding period, the Department received nearly \$381,900 from HRSA for MAI funding. This amount includes a base award of approximately \$378,000 and a FY2010 offset of more than \$3,800. The FY2012 granting process has not been completed.

All services are linked to medical outcomes such as HIV/AIDS testing, screenings for other medical conditions and providing services through an elaborate referral system for care of those who are HIV infected. MAI grantees must demonstrate a referral system based on linkages and memorandums of understanding within an extensive statewide Ryan White Care Network directory.

Grantees funded under the MAI may also be funded by the CDC, HRSA and/or SAMHSA. Through these initiatives and federally funded programs, community and faith-based organizations, and organizations specifically serving communities of color, provide innovative and culturally competent outreach services and also implement the Diffusion of Evidence-based Intervention (DEBI) approved by the CDC for those who are HIV positive.

Activities occur in a number of different venues including but not limited to, drug and alcohol treatment centers, homeless shelters, clinics, hospitals, social support groups, and through the Wellness on Wheels Mobile Health Care Initiative. HIV test kits and supplies are supplied to MAI agencies conducting outreach via mobile vans in communities of high risk to identify persons with undiagnosed HIV infection or known HIV positive persons who are not in care.

## **SECTION VI. 2012 – 2016 PREVENTION ACTIVITIES AND STRATEGIES TO BE IMPLEMENTED WITHIN THE JURISDICTION**

Section VI details the services and interventions supported by a combination of CDC's PS12-1201 and GRF funding. The Department's 2012 Prevention RG awards for services and interventions to be delivered in the jurisdiction and the Department's PS12-1201 grant application were based on the PCPG's 2011 review of HIV/AIDS epidemiologic data; the 2012 List of Prioritized Populations and Approved Interventions; the gaps analysis and needs assessment activities, in accordance with CDC PS12-1201 guidance; NHAS goals and objectives and IHAS-identified needs, goals and recommendations, as described in Sections I – IV of this jurisdictional plan.

Section IV described the “quantitative” processes undertaken by the Department to complete the final Tier Three activities of the gaps analysis and the “quantitative” final outcomes of that analysis, in dollars and service units needed to meet identified gaps. Section V described the HIV Prevention and Care activities already being provided in the jurisdiction. Section VI describes the strategy and plan for HIV prevention program services and interventions that will be provided by the Department and Illinois providers in 2012 - 2016, supported by a combination of CDC PS12-1201 and GRF dollars, to address the gaps identified and described in previous sections of the jurisdictional plan.

### **High Impact Prevention and Scalability of Activities**

Illinois' HIV prevention efforts are guided by the Illinois HIV/AIDS Strategy (IHAS), a strategy totally aligned with the National HIV/AIDS Strategy, and an ambitious strategy for combating the epidemic. By using combinations of scientifically proven, cost-effective, and scalable public health strategies and interventions targeted to the right populations and the right geographical regions, Illinois will pursue a high-impact prevention approach to reducing new infections. This approach should increase the impact of HIV prevention efforts in the jurisdiction and assist in achieving the goals of the IHAS/NHAS.

While everyone is potentially at risk and affected by the HIV epidemic, some populations bear an especially heavy burden and account for the greatest number of new infections. Illinois is committed to addressing these hardest hit populations and disparities. The hardest hit and priority populations that have been identified in Illinois include:

- **Gay and bisexual men (MSM) of all races and ethnicities**
- **High risk heterosexuals (HRH)**
- **Injection drug users (IDU)**
- **Both MSM and IDU**

Within the above risk groups, African Americans have been identified as by far the most disproportionately affected racial/ethnic population in Illinois. African Americans represent approximately 14 percent of the Illinois population, yet accounted for approximately 45 percent of new infections in 2009. The HIV infection rate among African Americans was almost 10 times as high as that of whites in 2009 (52.8 among African Americans versus 5.0 among whites), and among African-American women, it was (see Table 16 below) 25 times higher than among white

women. Hispanics/Latinos are also disproportionately impacted, having an infection rate four times as high as that of whites in 2009 (20.2 among Hispanics versus 5.0 among whites).

Rate = Diagnosed cases/Population\*100,000 (Census 2009 population estimates used)

2009 HIV Incidence

White – 455

Black – 991

Hispanic – 309

2009 Census Population Data

White – 9,125,471

Black – 1,876,875

Hispanic – 1,530,262

Table 16: Female HIV/AIDS Incidence Rates by Race/Ethnicity, 2000-2009

	NHWA	NHAA	Hispanic
YEAR	RATE	RATE	RATE
2000	2.0	46.6	12.9
1999	1.9	48.2	12.1
2000	1.7	47.0	9.9
2001	1.7	43.9	8.0
2002	1.6	37.6	6.5
2003	1.6	35.6	7.0
2004	1.9	36.0	6.5
2005	1.6	31.3	4.3
2006	1.6	34.2	6.7
2009	1.2	29.3	5.5

*Note: Data source: 2009 Illinois HIV Epi Profile*

In 2009, among females, the incidence rate per 100,000 population was higher among NHAA (46.6) followed by Hispanics (12.9), and NHWA (2.0). From 2000 through 2009, the incidence rate per 100,000 among NHAA females was 25 times higher compared with NHWA females, and between three and 11 times higher compared with other racial categories.

Special consideration for prioritization of interventions has been recommended for the following populations who fall within any of the above identified risks:

- **HIV positive individuals**
- **Transgender individuals**
- **Young adults**

Experience and research has identified a core set of behavioral, biomedical and structural interventions that are cost-effective and scientifically proven strategies and approaches to reducing the risk of HIV infection. These proven strategies are in place in Illinois and include:

- **HIV testing** identifies people who are infected, links them into care, and prevents transmission to others.

- **Linkage to care** helps ensure people infected with HIV receive medical care and treatment, reducing the risk of transmitting HIV.
- **Antiretroviral treatment** dramatically reduces the risk of HIV transmission for people living with HIV.
- **Access to condoms and sterile syringes**, especially when accompanied by education and behavioral interventions, reduces the risk of HIV transmission.
- **Prevention programs for people living with HIV** reduce risk behaviors among people diagnosed with HIV and reduce the risk of transmitting the virus to others.
- **Partner Services** reduce the spread of HIV by facilitating partner solicitation and notification, providing them with testing, and linking them to testing, prevention, and care services.
- **Prevention programs for people at high risk of HIV infection** still play an important part in a comprehensive prevention program and are essential in reducing risk behaviors.
- **Screening and treatment for other sexually transmitted infections (STIs)** reduce the risk of acquiring and transmitting HIV and other STIs.

To achieve the goals of the IHAS/NHAS, Illinois plans to pursue a High-Impact Prevention approach, using a combination of the above mentioned scientifically proven, cost effective, and scalable interventions targeted to the prioritized populations in the jurisdiction. As recommended by the CDC, the following considerations will be used to guide decisions about prevention efforts:

- **Effectiveness and cost.** High-Impact Prevention prioritizes interventions such as HIV testing, condom distribution, prevention for HIV positives, and others that are the most cost-effective at reaching the populations at highest risk and reducing HIV infections.
- **Scalability of implementation.** Priority will be placed on interventions practical to implement on a large scale when the cost is reasonable. More resource-intensive interventions may be limited and used for populations at the highest risk of HIV infection.

### **Program Collaboration and Service Integration (PCSI)**

With increasing number of HIV-infections and decreasing resources, the Department and the PCPG have long recognized and have acted proactively to address the need for collaboration and service integration, particularly in those settings where undiagnosed highest risk individuals can most likely be found. The Department and the PCPG will continue to collaborate on efforts to increase the number and diversity of state and community agencies and organizations that seamlessly integrate HIV and sexual health services with other related services. This program collaboration and service integration should be done in contexts and settings most likely to reach, diagnose and link to treatment and care those individuals who are at highest risk for HIV and/or other STDs or communicable diseases or who have other HIV/STD-related risks.

**Category A: IDPH Core HIV Prevention Services: Activities and Strategies**

The Department’s 2012 HIV Prevention RG supported services include all CDC core components required under PS12-1201, including HIV testing, comprehensive prevention with positives, condom distribution, and policy initiatives, each of which is described below. All told, about 14,294 core HIV prevention service units will be delivered to high risk populations in Illinois through RG funding in calendar year 2012 (see Table 7 below), including behavioral interventions at both Individual Level Interventions (ILI) and Group Level Interventions (GLI). ILI interventions include HIV testing, Risk Reduction Counseling (RRC), Respect, Comprehensive Risk Counseling Services (CRCS), harm reduction services, Internet Risk Reduction Counseling, and Partner Services (testing-linked and surveillance-triggered). Specific Group Level Interventions include Group Prevention and Support (GPS) and Healthy Relationships. Community Level Interventions include Community Promise, RAPP, Project Start, and MPowerment. Integrated services are provided, such as HAV/HBV Vaccination and Outreach HCV Testing, and Community Discovery in several venues. The number and of types of service units funded and delivered by IDPH funding streams, as well as other available resources, will vary across the 2012 – 2016 planning period, in response to the changing epidemiology of HIV diagnosis, the needs of high-risk populations, and availability of resources.

**Table 7. Illinois Regional Grant Prevention Service Classes / Units to be delivered Regions 1-8, 18 Month Budget Period and Calendar Year 2012**

<b>Service Class / Intervention Type</b>	<b>R1-8, Service Units of all Service Classes (18 months)</b>	<b>R1-8 Service Units of all Service Classes (CY2012)</b>
PWHIV Risk Reduction Interventions	3,299	2,199
Surveillance-based Linkage to Care Interventions	1,100	550
Risk-targeted HIV Counseling and Testing	10,996	7,330
Surveillance-based Partner Services w/ Index or Partner	1,100	550
Risk Reduction Interventions for Negatives	<u>5,498</u>	<u>3,665</u>
All Prevention Service Classes	21,991	14,294

Testing-linked and surveillance-triggered Partner Services have been expanded for 2012. The Department’s STD Program has several mechanisms to maximize the number of candidates for Partner Services. All 33 STD clinics in Illinois (outside the city of Chicago) have Disease Intervention Specialist (DIS) training and counselors to offer Partner Services. The Syphilis Elimination Project is tailored to MSM because that population is disproportionately affected by syphilis infection. In Illinois, among MSM with syphilis, approximately 50 percent are co-infected with HIV. The Department’s STD Section collaborates with Howard Brown Health Center located in Chicago to provide serologic testing, treatment and counseling and Partner Services to MSM residing in suburban Cook County by culturally competent, professional outreach workers (DIS)

that are representative of the community they serve. The Department's STD Section has developed a secure data file in which staff members enter newly diagnosed syphilis cases that are also co-infected with HIV. The data file is securely shared with select Department HIV/AIDS surveillance and counseling and testing personnel. The creation and use of the file ensures active HIV cases identified through syphilis testing and treatment have been reported to eHARS surveillance data system and linked to HIV Care for on-going Partner Services (PS). All Department CTR sites funded under PS12-1201 also offer PS at the post-testing counseling session. HIV Care Connect case managers serving PLWHA will provide ongoing PS to HIV positive persons and their partners during 2012, once they have completed the necessary program training.

**Targeted HIV Testing.** Under PS12-1201, approximately 50 HIV prevention RG-funded sites will conduct risk-targeted HIV-testing in 2012. For Calendar Year 2012, 7330 risk-targeted HIV Counseling and Testing Program service units are projected to be conducted with RG funding (see Table 7, Page 52).

### **Community-based Organizations Under Regional Lead Agents in Category A**

CBOs funded through the Department's RG provide HIV testing in non-healthcare settings and are required to conduct a community discovery assessment process. Through this and the use of social networking strategies, CBOs can identify high risk persons of the proposed target populations. Each CBO chooses their target population based on the PCPG's priority populations and the epidemiology of their local jurisdiction or geographical region and set testing scopes to reach the high-risk target populations. Settings include local LGBT bars, house parties, hotels, ball parties/events, streets, bathhouses, strip clubs, Gay Pride parades, and other sites.

All agencies have identified formal and informal gatekeepers within their respective communities that serve as a liaison to the agency that reach out and visit the settings and multiple venues and community events. Gatekeepers dialogue while blending into the settings and are often recognized as safe, approachable persons. They are often not recognized as being staff from an agency and can therefore create an atmosphere of safety and "approachableness" and making it more conducive for persons to test, particularly adolescents and teens.

Each CBO has tools and resources to reach and engage members of the target population they serve. In 2010-2011, a series of community forums were hosted by the Department's HIV/AIDS Section Prevention Program to hear from community members on the epidemic in their regions. Participants shared how they promote HIV testing and prevention through the community forum channels. This assists agencies serving the target populations and community stakeholders on how to better engage hard to reach individuals and to tailor program services to reach the community at large. All CBOs will be encouraged to attend a PCPG meeting when hosted in the region to share about their program and services.

Many CBOs have established gatekeepers within the communities and implement DEBI evidence-based interventions designed to recruit high risk individuals. Agencies that can partner and offer Partner Services to persons testing positive will also be successful in reaching individuals who do not know their current HIV status.

Prevention funded agencies including CBOs must obtain informed consent for testing as specified by current Illinois law. All individuals who give informed consent have the right to receive their test

results, whether negative or positive, in person. No test results are to be provided over the phone but directly to the person for laws pertaining to confidentiality of HIV testing.

Most sites now are required to use rapid, “point of care” screening tests before using an OraSure or confirmatory test. All preliminary positives are to have a confirmatory test completed via oral swab or blood draw and sent to the lab. Previous PS10-10138 provided incentives to all participating expanded testing sites with monetary reimbursement for all tests conducted and successful linkages to care and receipt of Partner Services. Limitations of Category B funding will prohibit incentives in the form of reimbursements for this project. Sites hope to identify other non-monetary incentives to maximize the proportion of persons testing receiving their test results.

Prevention funded CBO sites as well as expanded testing sites will be monitored by testing data collection whether through the Provide® system or Excel spread sheets and all information is then entered into an Access database for required CDC reporting. All sites are responsible to keep testing data up-to-date. The Department’s HIV/AIDS Section program will work with PHIMC and the Department’s STD Program to assure all sites have been trained and through quality assurance monitoring and site reports, determine mechanisms and supports for sites to achieve a 2 percent rate of newly identified positive test results. This will require direct TA to each individual site as well as a proposed site training to explore strategies to reach this target 2 percent rate.

Corrective action plans can be done site specific. All prevention funded agencies currently use a template at sites visits for correction action plans. This template will be utilized and each site that is not reaching the 2 percent will complete and participate in a corrective action plan process with the contractor, agency, lead agent or the Department’s HIV/AIDS Section and/or STD Program staff. Alternative testing strategies will be explored and implemented to work towards the 2 percent standard.

All sites are trained in current recommendations, best practices and guidelines for HIV testing as specified by the CDC. The guidelines are covered in HIV testing trainings and also will be provided in the newly revised Counseling and Testing and Partner Services manual that is currently undergoing revision and update. All agencies will receive a hard and electronic copy of the revised and updated manual guidance document.

The Department continues to work with CBOs and other service organizations by providing required and recommended trainings. Required trainings include the HIV Fundamentals of Counseling and Testing, Partner Services, Skills Building and Provide® database training. All agencies are to attend a Partner Services training specific to the agency’s role in providing Partner Services. CBOs are specifically trained on elicitation only and local health department staffs are trained on both elicitation and notification. CBOs work directly with their local health department to assure Partner Services are offered for all HIV positive persons and partners named are notified by a LDH disease intervention specialist (DIS). CTR and Partner Services Programs offer a forms webinar training which was developed for all agencies to learn how to complete the necessary forms and enter data into the Provide® database. The Department’s CTR and Partner Services Program staff personnel also provide direct phone technical assistance for any agency to assure Partner Services are offered according to Department protocols, procedures and policy. Provide® quality assurance reports are run monthly to monitor and identify which agencies have been

conducting Partner Services. If an agency has no records, Department staff members follow up to identify barriers or challenges and find solutions for agencies to assure Partner Services are offered.

Plans for 2012 are to continue to deliver services in a culturally and linguistically appropriate manner and to support prevention funded CBOs that provide HIV testing in venues outside the agency site. All staff are trained through the Department's training unit and are encouraged to attend cultural sensitivity trainings as needed and related to the target populations they serve. PHIMC along with the Department's HIV/AIDS Section and the TB Program will contract with Heartland Alliance for Human Need and Human Rights to develop a training curriculum for agency health care providers who work directly with the homeless and immigrant population. The curriculum and webinar development will be made available as a resource for all agencies when delivering services with certain target populations or those most vulnerable to contracting HIV.

### **Comprehensive Prevention With Positives.**

The Illinois RWP Part B Program links HIV positive persons into comprehensive medical care and support services throughout the state. Early Identification of Individuals with HIV/AIDS (EIIHA) guidelines set by the Health Resources and Service Administration (HRSA) are used by the RWP to develop the following implementation process in coordination with prevention. As a person learns their HIV positive status, a referral is made to one of the eight regional HIV Care Connect offices ([www.HIVCareconnect.com](http://www.HIVCareconnect.com)). When a CTR site newly diagnoses someone they arrange to have a RW case manager on site, with client acceptance, to learn about the available services. All Care Connect regions have a close relationship with prevention services in their region. Often, programs share the same office space. Trained peer navigators assist newly diagnosed persons with acceptance of their diagnosis; understanding HIV self care and navigating service systems.

The RWP Part B has an established outreach approach delivered through the Illinois Public Health Association (IPHA), that educates health care providers statewide on making timely linkages to care and other services available for patients they identify as HIV positive. This is accomplished through promotion of the HIV Care Connect website and through promotional work with medical professionals by MATEC at their sponsored medical seminars and other training events. Linkage-to-care systems are also in place for any HIV positive person released from any IDOC facility or Illinois county jail.

Each RWP Part B client is closely monitored according to their risk assessment. Those considered high risk must see a case manager every three months to assure needs are being met and care plans followed as regular contact leads to better retention rates. Clients that do not show for scheduled appointments with case managers are contacted by phone or in person by case finders as needed to reschedule or to determine barriers. Peer navigators provide additional client support as well.

RWP Part B clients are referred to specific providers based on their needs and risks. They are assessed for types of services needed and other risk factors, with re-assessment at minimum every six months. Each Care Connect region has many services, including: mental health and substance abuse treatment, transportation and housing assistance, nutritional support and domestic violence interventions and more. Regional prevention agencies, when identifying an HIV positive person, can record client risk factors and current needs. These agencies identified 124 persons with confirmed HIV infection, with 97 accepting referrals to case management and 78 accepting Partner Services in 2010.

**Specific Prevention Intervention Approaches for HIV Positive People**

The Department funds 41 HIV prevention providers in Illinois, outside the city of Chicago, to implement risk reduction interventions specifically for or inclusive of HIV positive persons. All individuals are screened for PCPG-prioritized sexual and injection risk behaviors in the past 12 months prior to service delivery for standard XPEM client risk variables. Interventions serving PWHIV are many: RRC, CRCS, Harm Reduction/Syringe Disposal, Healthy Relationships, Internet Risk Reduction Counseling, Many Men Many Voices, Mpowerment, Popular Opinion Leader, Respect, SISTA, and linkages to partner services, medical care and case management. Provider service objectives are written for PWHIV-specific and for PWHIV-inclusive interventions. For CY2009, the latest year for which service data is compiled by serostatus, 23 percent (7,069/31,158) of all HIV education/risk reduction service units delivered were delivered to HIV positive clients.

Most RWP Part B programs throughout Illinois integrate RRC, CRCS and GPS interventions with their patients. Many RWP Part B programs currently receive a Prevention grant in addition to their Care funding so that their own agency staff can provide risk assessment and individual and group risk reduction services. Other RWP Part B programs permit Prevention-funded agency staff to serve their Care site during HIV clinic sessions. Patients are referred after a clinical identification of a subsequent STI, pregnancy confirmation or behavior risk disclosure occurs. Patients receive individualized risk reduction plans; condoms and other tools with instruction on effective use.

**Behavioral Interventions for PWHIV**— About 23 percent of Department Core HIV Prevention-funded Behavioral Interventions were delivered to PWHIV in recent years. In 2012, 25 percent of HIV Prevention program support will focus on PWHIV including 10 percent of for PWHIV Risk Reduction Behavioral Interventions, 10 percent for Linkage to Care (LTC) (see Table 8 below). Behavioral and clinical risk assessments are part of the overall Ryan White program. When the assessments are completed, clients are offered services to meet their needs.

<b>Intervention Category</b>	<b>% Program Funding</b>	<b># Service Units</b>
Prevention for Positives (P4P)-Risk Reduction ILI & GLI Person-Sessions	10.0%	4,968
Prevention for Positives (P4P)-Linkage to Care	10.0%	2,981
Risk-Targeted HIV Counseling & Testing Sessions	40.0%	18,628
Partner Services (PS) with Index PWHIV-Surveillance- Triggered PWHIV Partner Elicitation, LTC, RRC	5.0%	466
Partner Services (PS) with Partners-Surveillance- Triggered Partner Notification Counseling, Testing, Referral	10.0%	466
Prevention for Negatives (P4N)-Prevention ILI & GLI Person-Sessions	25.0%	11,819
<b>Total</b>	<b>100.0%</b>	<b>39,327</b>

**Biomedical Interventions for PWHIV**-Ten percent of the Department's HIV prevention funds will support the PWHIV biomedical intervention of Linkage to Care targeting diagnosed, surveillance reported PWHIV with no evidence of being in care. No evidence of care will be defined as one or more care indicators being absent: HIV Viral Load, CD4 Counts received through required laboratory electronic reporting, RW documented service appointments or, ADAP utilization.

**Adherence Counseling** is routinely provided through RW providers, prevention programs that serve HIV positive persons, case managers and trained peer leaders.

**PrEP and nPEP Cost Effectiveness Analysis.** As part of preparations for the PS12-1201 application, the Department and the PCPG considered the cost effectiveness of funding interventions, including PrEP and nPEP.

The cost estimate analysis for these two interventions compared sero-conversions in 3 hypothetical conditions among 1,000 black MSM within the the Department's jurisdiction over a one year interval: (1) without any intervention; (2) with PrEP or nPEP; or (3) with HIV testing. PrEP is demonstrated to be *most* cost effective among the highest sero-incidence populations, hence the example uses black MSM. The HIV incidence among the example risk population used for the analysis is estimated to be 3 percent, based upon the sero-positivity rate among black MSM tested within the Department's jurisdiction by RG providers in CY2011.

For 1,000 BMSM without any intervention, at a 3 percent annual sero-conversion rate, there would be approximately 30 new HIV infections over a 12 month period. Research on PrEP indicates a 40 percent overall program success rate. Based on this, for the 1,000 BMSM on anti-retroviral therapy (ART) medications for 12 months, 18 infections would occur (60% of 30), but 12 more infections (40% of 30) that would have occurred are averted. For PrEP, the 12-month cost of ART medications and the required counseling sessions result in a "cost per infection averted" of \$1,050,000. For nPEP, the costs of the intervention result in a "cost per infection averted" of \$344,828. For the "HIV Testing only" intervention, the "cost per infection averted" among the example population is \$104,167.

Given Illinois' HIV ART medication prices and using a 3 percent rough estimate of the annual sero-conversion rate for black MSM, the analysis suggested that the estimated "cost per infection averted" for PrEP or nPEP was not at all cost effective for the Illinois jurisdiction outside Chicago, relative to "cost per infection averted" of HIV testing. If PrEP and nPEP are too expensive to be cost effective for Illinois' *highest* incident rate population, the "cost per infection averted" is even more prohibitive for other prioritized risk populations in the jurisdiction.

Another major factor considered is that CDC funds cannot be used to provide PrEP or nPEP medications for high risk or even for HIV-exposed persons. So, if PrEP or nPEP were selected as an Approved Intervention by the PCPG, Illinois would have to successfully secure other funding to actually implement them. Based on the Department's analyses of PrEP cost effectiveness, plus Illinois epi and cost conditions, the best estimates indicate that 10 times or 3 ½ times more HIV infections can be averted per dollar spent on HIV testing than on PrEP or nPEP, respectively. Using all these data, the PCPG and IDPH determined that PrEP and nPEP are not cost-effective intervention investments of scarce CDC prevention dollars for the Illinois jurisdiction outside

Chicago, even if private or grant funding could be obtained to actually offer them. Therefore, neither PrEP nor nPEP were identified by the PCPG as an Approved Intervention for the Illinois jurisdiction.

**Post-Exposure Prophylaxis**— The Department’s HIV/STD/AIDS Hotline will selectively provide PrEP and nPEP information and free or affordable primary care referrals to individuals who report HIV exposures through the very highest risk behaviors (shared injection equipment or receptive anal sex) with known HIV-positive partners.

**Pre-Exposure Prophylaxis**— The Department will collaborate with the IPHA's HIV Prevention Committee to develop and disseminate information about the efficacy and cost-effectiveness of PrEP for interested health care providers and community members.

**Circumcision**—The Department will make information about the efficacy of circumcision to reduce heterosexual HIV transmission from females to males available through its HIVCareConnect.com Website and the Illinois Statewide Perinatal HIV Network.

**Structural Interventions for PWHIV**—Illinois law and programming *currently* offers the following structural resources for behavioral and biomedical risk reduction supports for PWHIV.

- HIV-impacted Family Reunification (support for family stabilization, including legal custody services and retention in care)
- Legal Syringe Purchase—increased access to sterile syringes for HIV+ IDU
- Legal Research-linked Syringe Exchange—increased access to a range of safer injection tools with overdose reversal medication and harm reduction counseling for HIV+ IDU
- Good Samaritan Law-protects physicians from liability who prescribe naloxone for injectors without charging for the service; protects individuals who report overdoses from drug prosecutions or assist in reversing them
- Same-sex Partners Civil Union Law
- Modification of AIDS Confidentiality Law to support routine testing
- Laboratory Reporting – facilitates finding PWHIV diagnosed but not yet reported for linkage to care and Partner Services

**Evidence-based Interventions for HIV-negative persons at highest risk of acquiring HIV**

The Department has placed emphasis on these highest risk populations for HIV: MSM, IDUs, MSM/IDU and HRH. Providers in Region 4 (East St. Louis region – defined by the PCPG as having the highest HIV incidence outside of the Chicago MSA), are implementing RESPECT and Project Start, two interventions designed to support clients with repeat STIs, or formerly incarcerated and returning to society and at-risk for STIs, HIV and hepatitis C. Both interventions are tailored to meet the needs of HIV-Sero-discordant couples. In 2012, IDPH will develop an enhanced framework of incremental risk reduction, focusing on increasing client awareness of HIV, STD and hepatitis risk behaviors and provide them with tools and resources to reduce their risk. HERR risk assessment measures for risk frequency and latency will be added to Provide® for HIV positive and high risk negative participants.

The Department’s providers implement interventions for HIV-negative persons at highest risk of acquiring HIV previously named in the prevention with positives section; these include social networking strategies with MSM and bisexual men, GPS for IDUs, including harm reduction, and

for previously incarcerated males and their partners; and CRCS for very high-risk clients. The Department's providers use a client assessment tool to screen for program eligibility and determine HIV risk.

**The Illinois Harm Reduction and Syringe Disposal** program was previously detailed in Section V. It has been successful, as a noticeable decline in new infections among IDUs has been consistent for several years in Illinois. In 2012, the Department required regional lead agency applicants to assure that at least one harm reduction program will be identified and funded in each region, as now GRF and federal funds can be co-mingled to implement this proven prevention strategy.

**Condom Distribution.** All Department providers are required to be aligned with the PCPG prioritized highest risk populations. Funded providers encounter HIV positive persons at highest risk for acquiring HIV infection in their work due to self-disclosure or test positive. The Department's providers incorporate condom distribution into all aspects of its HIV/STI prevention and RW programs. A variety of condoms and lubricant are distributed at the individual level (HIV/STD testing, RRC, GPS Sessions, health education). Clients can select from a wide variety of condoms and lubricants, health information materials, and safer sex kits. Condoms are made available to clients in all kinds of settings in high prevalence communities, clinical sites serving HIV positive persons, all STD clinics and for high risk individuals across Illinois. The Department's providers are required by the PCPG to target HIV positive persons and high risk populations. Condoms and lubricant are distributed to HIV positive clients and high risk populations in traditional and non-traditional settings. Clients are assessed during CT and Risk Reduction sessions and condoms and other risk reduction supplies are distributed. All eight RW regional programs regularly distribute condoms in their clinical settings where patients are medically seen, as well as case management offices. All Harm Reduction programs distribute condoms. Agencies will be required to report on their condom distribution activities. Condoms are distributed in clinics, community outreach settings, bars, beauty and barber shops, liquor stores and other venues where HIV positive and highest risk populations congregate. No state or local laws regulate condom distribution, except as in correctional setting policies. IDPH distributed more than 1.1 million male and 42,000 female condoms in 2010. In combination with the services to be provided under the Category C proposed PS12-1201 application, IDPH plans to increase that amount by 50 percent in 2012.

**Policy Initiatives.** Policy initiative elements targeted to be addressed under PS12-1201 in 2012 include addressing several current structural needs, as identified below.

- Appointment of agencies to conduct culturally competent HIV Partner Services
- Comprehensive School Sexuality Education inclusive of STI/HIV risk behaviors and risk reduction for LGBT adolescents.
- Medicaid reimbursement for HIV testing
- Condom availability and access in correctional settings
- Third trimester HIV testing for pregnant women in Illinois
- Completion of lining up all administrative rules to compliment implementation of newer, revised Illinois laws that facilitate ease in HIV routine opt-out testing, including in correctional settings. Facilitate confidential use of surveillance data in real time to inform action to prevent HIV infection; linkage or reengagement in care services.

Several other strategy actions are underway with more planned. The two Category C proposals detailed later in the jurisdictional plan are designed, in part, to help us innovatively address the delivery of culturally competent Partner Services in the community with very high risk persons including MSM and transgender persons of color and correctional populations, in collaboration with IDOC, community based agencies and key local health departments to address risk reduction strategies, routine and targeted HIV testing for these populations with disproportionate disease burden. An existing HIV Testing Workgroup meets quarterly to address issues of sustainability for ongoing routine opt-out HIV testing in Illinois. A meeting date is set that will include participants from the Department's HIV/AIDS and STD Sections and Division of Laboratories together with the Illinois Department of Healthcare and Family Services, the agency that administers the state Medicaid program, to explore the issue of Medicaid support for HIV testing in Illinois. A statewide campaign is planned for all prenatal care providers and institutions that serve pregnant women to make third trimester HIV testing a routine standard of care. Finally, an active workgroup is in place, assembled by the Department's HIV/AIDS Section which includes representatives from the IL State Board of Education and the Chicago Public Schools to address the issue of K-12 health/sex education for youth, including specific content for LGBTQ youth. Finally, extensive participation of HIV prevention and care service providers, consumers, activists and academics from across Illinois have contributed to the development of an Illinois HIV/AIDS strategy that is scheduled to be finalized and approved for distribution in mid 2012, with added policy priorities expected to emerge.

**Perinatal Prevention.** The Illinois Perinatal Prevention Program is comprised of interventions at several different levels and is supported by a mix of funding sources. In 2012, funding sources included: \$191,683 (100% GRF) for the PACPI Pediatric Hotline for the period July 1, 201 to June 30, 2012 and \$687,737 for PACPI-Enhanced Case Management (\$50,000 Fetal Infant Mortality Review [FIMR], \$107,666 in federal HIV prevention funds, and \$530,071 in Illinois GRF). The various Perinatal Prevention Program interventions supported in Illinois using GRF and/or federal prevention funds are detailed below.

The Illinois HIV Perinatal Prevention Act mandates all prenatal care providers to offer routine opt-out HIV testing to all pregnant women as early in their pregnancy as possible. Women in labor and delivery with an undocumented status **must** be offered a rapid HIV test. Last year, two cases of third trimester transmission were reported. Advocacy efforts have begun for routine third trimester testing in Illinois. Ten regional perinatal networks exist across the state, consisting of 128 birthing and non-birthing hospitals. All of these conduct rapid HIV testing and report preliminary and confirmed positive results to the Illinois 24/7 Perinatal Hotline (1-800-439-4079) for follow-up with HIV positive mothers and infants. The Department's Perinatal Prevention Program is one of the best HIV prevention success stories in recent years, and offers strong support for Illinois' goal of reducing perinatally transmitted HIV to zero.

The Illinois perinatal HIV safety net anchors the interventions and services necessary to prevent perinatal transmission. Several different programs are funded to reduce perinatally transmitted HIV, including Rapid Testing and Reporting, Linkage to Care/Enhanced Case Management, Reproductive Health Counseling and Prevention Strategies for Discordant Couples, Disclosure and Therapeutic Group Support, and Reproductive Health Screening and Linkage to Care through Case Management.

The Illinois perinatal programs and initiatives supported through GRF and/or Federal HIV prevention funds include: the Pediatric AIDS Chicago Prevention Initiative (PACPI), Rapid Testing Initiative, Enhanced Perinatal Surveillance (EPS), Families and Children AIDS Network (FCAN), 24/7 Illinois Perinatal HIV Hotline, and St. Clair County Health Department, East St. Louis – Project ARK, enhanced Case Management. These programs are summarized below.

**Pediatric AIDS Chicago Prevention Initiative (PACPI).** PACPI is an intensive case management program. Five case managers, two of whom are bilingual/bicultural Spanish speakers, serve clients in Chicago and the nine collar county region. They work exclusively with HIV-positive pregnant women and their families from the time they are identified until approximately six months postpartum when they are transitioned to regular HIV case management services. The PECCM's provide an array of intensive services ensuring that HIV-positive pregnant women are linked to specialty HIV/OB care. These services include stabilizing families, supporting medication adherence during pregnancy, assistance with transportation, benefits, food and emergency assistance, helping with disclosure and confidentiality issues, and arranging linkage to postpartum care for mothers and pediatric ID follow-up for infants. PACPI also assists families with access to support for baby items and facilitates emergency family grants for families in need statewide. PACPI case managers are available to consult with Ryan White case managers (Parts A and B) statewide on any case of a pregnant HIV-positive woman, a positive woman seeking pregnancy or sero-discordant couples seeking pregnancy.

**Rapid Testing Initiative, formerly known as Perinatal Rapid Testing Implementation Initiative in Illinois (PRTII<sup>2</sup>).** Due to reduced available funding, the Department decided that it made fiscal sense to transition PRTII<sup>2</sup> out of the FY 2012 budget and to merge the remainder of the program's necessary activities into the grant with PACPI. PACPI is now responsible for implementing rapid HIV testing in all hospital labor and delivery units in Illinois. PACPI currently works training nurses, physicians and support staff about the Illinois Perinatal HIV Prevention Act and Safety Net as well as providing resources to clinicians such as the services of the 24/7 Hotline and the perinatal enhanced case management program.

**Enhanced Perinatal Surveillance (EPS).** In 2011, the Department learned that the CDC would no longer support EPS across the nation. In the past, though Illinois was not funded to conduct EPS, the Department relied on our partnership with PRTII<sup>2</sup> and the Chicago Department of Public Health to ensure that relevant perinatal data was collected from across the state. Because the Department values this work, we applied for funds to support EPS as part of our federal application. The Department then amended PACPI's current contract to allow the Department to subcontract these services. A standard protocol is followed by an abstractor who visits hospitals where HIV-positive women have delivered in order to collect all relevant data. This data is tracked by the Department to examine overall trends and identify area of improvement.

**The Children's Place (TCP).** TCP was not funded for SFY2012 due to a smaller budget.

**Fetal and Infant Mortality Review/HIV (FIMR/HIV).** Since October 2009, the Department has been a site for the CDC/CityMatCH/ACOG funded FIMR/HIV project. This project has allowed us to bring together a formal committee, the Case Review Team (CRT) of 29 professionals, from 13 institutions and organizations to review cases of perinatal transmission, maternal deaths and fetal losses amongst HIV-positive pregnant women or missed opportunities for prevention. Based on

their reviews, the team makes recommendations to improve gaps in our perinatal system and passes those results to the Community Action Team (CAT), which works to implement solutions based on those recommendations.

**Families and Children AIDS Network (FCAN).** FCAN's mission is to provide coordinated, family-centered services to meet the unique needs of families with children who are from homes impacted by HIV/AIDS. FCAN professional providers and peer advisors offer intensive, home-based interventions with families living in Chicago and its surrounding suburbs; and therapeutic programming for HIV-affected families in all areas of the state. FCAN provides legal/policy and social work/mental health consultation statewide about issues for HIV-affected families with children. FCAN is a leader in policy development, consumer education and professional training affecting the quality of life of families affected by HIV/AIDS on local, state and national levels. FCAN has been providing supportive services for families affected by HIV since 1985. Their target populations consist of families where at least one parent or guardian of a minor child is HIV-positive; families where a minor child is HIV-positive; or children who have been orphaned by HIV/AIDS and their new caregivers. The Department funds FCAN's four primary programs, Family Options, Red Ribbon Trails, the Disclosure Project, and their policy education efforts, including the Red Ribbon Alliance and the Teen Advisory Committee, that all address the needs of the HIV-affected families that we serve.

**24/7 Illinois Perinatal HIV Hotline.** The Illinois Perinatal HIV Hotline is a statewide resource for medical and social service providers caring for pregnant HIV-positive women. The Hotline provides up-to-date treatment recommendations for pregnant women and their HIV-exposed infants. It also links mothers and infants to an ongoing network of specialty care during and after pregnancy including enhanced case management services. Additionally, the hotline is the official reporting mechanism for positive rapid HIV tests performed on mothers and infants and it initiates follow-up and support for hospital rapid test reports. It is staffed by medical, public health and social service professionals from Northwestern Memorial Hospital, Children's Memorial Hospital and the Pediatric AIDS Chicago Prevention Initiative.

**St. Clair County Health Department, East St. Louis – Project ARK, Enhanced Case Management.** St. Clair County Health Department in the East St. Louis region, partners with Washington University's Project ARK to deliver enhanced case management to HIV positive pregnant women, similar to the services that PAPCI provides. Each year we expect reports of about 10-15 women and infants served in this area.

## **Category B. IDPH HIV Prevention Activities and Strategies, IDPH Expanded HIV Testing for Disproportionately Affected Populations**

### **Routine Opt-Out HIV Testing**

In 2012, under PS12-1201 Category B, the Department will continue implementing routine opt-out HIV testing in at least 29 of 33 STD clinics that participated in PS10-10138. The Department's STD Program and the HIV/AIDS Section have agreed to the expansion of HIV testing in all STD clinic settings to assure HIV testing is made available for all persons visiting an STD clinic for services and treatment of reoccurring STD infections. A combination of conventional serological and rapid HIV testing methods will be utilized to maximize the proportion of STD clinic clients who receive their HIV test results and are immediately linked to care, case management any other services if they are HIV positive.

For community health centers (CHCs) originally funded under PS10-10138, routine opt-out HIV testing will continue to be supported in the CHC sites originally funded under PS10-10138, including:

- Family Christian Health Center (FCHC) in Harvey (South Suburban Cook County – Region 8)
- Crusader Community Health in Rockford (Northwest Illinois, Winnebago County – Region 1)
- Lake County Health Department in Waukegan (Northeast Illinois —Collar County, adjacent to Cook County – Region 7)
- PCC Community Wellness Center in Oak Park (West Suburban Cook County – Region 8)
- Southern Illinois Regional Wellness Centers, two locations: East Saint Louis and Washington Park
- (Southwest Illinois; Saint Clair County – Region 4)

In addition, the Department will expand routine opt-out HIV testing in community health centers at several new sites that were added in 2011 or will be added in 2012 including:

- Lake County Health Department and Community Health Center, three 3 locations: North Chicago Community Health Center, Mid-Lakes Community Health Center, and Northeast Satellite Community Health Center (Northwest Illinois; Lake County – Region 7)
- Loyola University Medical Center, Emergency Department (West Suburban Cook County – Region 8)
- Cook County Ambulatory Care Network, four locations (in planning stages): Cottage Grove Health Center, Oak Forest Specialty Health Center, Robbins Health Center and Woody Winston Health Center, all in South Suburban Cook County – Region 8)
- Southern Illinois Healthcare Foundation will offer routine opt-out testing at two sites in St. Clair County and East St. Louis, both high incidence areas. These new sites are Belleville Family Health Center and Adult Care Center (Southwest Illinois; Saint Clair County – Region 4).
- The STD and CHC routine opt-out HIV testing programs are considered health care setting. The goal for 2012 is to conduct 15,000 HIV tests in participating STD clinics, and 5,000 in CHCs for a total of 20,000 HIV tests. This includes additional sites targeted for expansion.

CDC Performance Standards for this intervention include:

- For targeted HIV testing in non-health care settings or venues, achieve at least a 2.0 percent rate of newly-identified HIV-positive tests annually.
- Achieve a testing positivity rate of 1.0 in health care settings
- At least 85 percent of persons who test positive for HIV receive their test results.
- At least 80 percent of persons who receive their HIV-positive test results are linked to medical care and attend their first appointment (within 90 days of the HIV positive test).
- At least 80 percent of persons who receive their HIV-positive test results are referred to and interviewed for Partner Services (within 30 days of having received a positive test result).
- At least 80 percent of persons who receive their HIV-positive test results receive prevention counseling or are referred to prevention services.
- Over the course of the project, increase the number of health care facilities that have implemented sustainable, routine HIV testing programs consistent with CDC's 2006 guidelines.

**In Health Care Settings.** Public Health Institute of Metropolitan Chicago (PHIMC) along with MATEC provided on-going training and technical assistance as part of PS 10-10138 and PS 07-768 project activities (funded in previous years through the CDC) for expanded routine opt-out testing. For PS12-1201 and this project we will reach individuals seeking care at Community Health Centers (CHC)s in high-incidence areas, outside the city of Chicago, including Loyola University, a large medical center/emergency department, and four clinics in an ambulatory care network in south suburban Cook County. CHCs are nonprofit, community-based health care providers serving low income people in medically underserved communities. More than 50 percent of Illinois CHC patients are enrolled in Medicaid, Family Care or the All Kids programs; 32 percent have no health insurance; and 77 percent are at or below the federal poverty level (FPL) which is \$22,050 per year for a family of four. Additionally, all 33 STD clinics will continue routine HIV screening under PS12-1201. STD clinic target populations are HRH and MSM of all races. It is not uncommon for individuals accessing services to be co- infected with other STIs. Several STD clinics have higher volume testing because of being located in areas of HIV incidence and prevalence. Winnebago, Peoria, Champaign, DuPage and Lake counties are STD clinics located in geographical regions with a significantly higher portion of the population at risk. Past projects have demonstrated that these clinics have identified a larger number of newly infected HIV positive persons and have overall higher seropositivity rates.

**In Non-healthcare settings.** The Department's TB program participated in PS10-10138 for expanded testing for integration of TB testing with HIV testing to foster program collaboration and services integration (PCSI). Kane County Health Department worked with the Hesed Homeless Shelter in Aurora and the Open Door Clinic to conduct a TB/HIV testing event in June 2011 targeting homeless and immigrant populations in Kane County. The decision to engage this population was based on data showing an increase in active TB cases co-infected with HIV between 2007 and 2011. Of 29 homeless clients, four (14%) were identified as co-infected with HIV. For the event, to maximize the number of homeless persons getting tested for TB, an alternative HIV testing flow was utilized. A pre-test screening for HIV was given to each client

by trained Open Door Clinic staff throughout the month prior to and after the actual TB screening event. Open Door Clinic was selected to offer HIV testing services because of its stellar reputation as an HIV testing provider in the community. Open Door is (regionally) funded to conduct targeted testing of high risk individuals. PS12-1201 will continue offer routine opt out screening for the homeless substance abusing populations.

## Category C: IDPH HIV Prevention Activities and Strategies

### **MSM and Transgender of Color Project - Illinois Department of Public Health**

The MSM and Transgender of Color Project will target black and Latino men and transgendered persons who have sex with men (BLTMSM) in Illinois counties outside Chicago that have the greatest HIV prevalence and incidence for these populations. Analysis of incident cases for BLMSM reported in 2010 surveillance data, and through geo-mapping (for black and Latino MSM only) by zip code to identify communities with the greatest population HIV disease burden. (TSM cases were not mapped due to low case numbers as Illinois HIV surveillance reports only became transgender-inclusive in June, 2009.) Most impacted municipalities were Cicero, Harvey, Maywood in suburban Cook County; Waukegan, Joliet, West Chicago, Elgin and Aurora in the collar counties; Rockford in northeast IL, Pontiac, Peoria, Springfield, and Champaign in Central Illinois; and East St. Louis and Madison in Southern Illinois.

1. The program is a collaboration of the Department's HIV/AIDS Section, target-focused CBOs, LHDs, and health care providers. These agencies will collaborate to: Generate recruitment events such a house balls to engage BLMTSM per year in HIV/STI testing, linkage to HIV/STI treatment, risk reduction, and Partner Services.
2. Cross-reference monthly HIV and STI surveillance data to identify diagnosed HIV+ BLMTSM who are later STI-infected to provide linkage to STI and HIV treatment, partner services, and culturally appropriate risk reduction services.
3. Provide intensive training annually to 5 percent (173/3,454) of reported HIV+ BLMTSM to strengthen clients' care-engagement skills and to promote peer norms for establishing and routinely using primary care homes for HIV/STI screening, treatment, and medication adherence.

The targeted Illinois counties are suburban Cook (excluding the city of Chicago), Lake, Will, DuPage, Kane, Winnebago, St. Clair, Madison, Sangamon, and Champaign.

The program includes four elements:

1. **Test and Treat** - Sponsoring 20 peer-generated events very popular with BLMTSM (mini and glam balls, fiestas, dances, hair/fashion shows, speed dating, house parties) for which an admission ticket is provided upon completion of routine confidential screens for HIV, HC, syphilis, GC and CT, either through Illinois mobile vans onsite that night or in the past month at a collaborating LHD STD clinic or FQHC. Peer recruiters will receive stipends per participant screened. Self-identified diagnosed PWHIV will be assessed for care engagement and medication adherence. All participants will be offered linkage to an FQHC local primary health care home. The goal is to link 90 percent of individuals with positive HIV or STI results to treatment, Partner Services, and prevention.
2. **Enhanced Disease Investigation Services (EDIS)** - Monthly HIV and STI surveillance data cross-referencing is projected (applying subsequent STI HIV co-infection rates from a CCDPH pilot study) to annually identify 203 per year HIV-diagnosed BLMTSM with later STI-infection for intervention. Enhanced DIS will include the standard linkage to STI treatment and Partner Services augmented with linkage/reengagement to HIV care, adherence counseling, and the RESPECT intervention. The Department will refer EDIS cases to targeted county LHD STD departments and to three CBOs: Brothers' Health Collective (BHC), Renz and Southern Illinois

Healthcare Foundation, to be legally designated to deliver peer-delivered surveillance-triggered partner elicitation and notification services.

3. **Public Health Professional Capacity Building**--Training will be provided to DIS and case managers in the target counties with intended outcomes of strengthening their: (a) cultural competency to work with BLMTSM, (b) grasp of psychological, sociological, health care access and epidemiologic determinants *beyond* risk behavior (detailed above in Background) driving high BLMTSM HIV incidence, (c) linkage/re-engagement to care counseling skills (d) adherence counseling skills (e) Partner Services elicitation skills and (f) RESPECT intervention skills.
4. **Community-level Treatment Engagement Intervention**--A homegrown, *Prevention for Positives* initiative known as Black Oasis Institute (BOI) developed, implemented and evaluated by BHC will be culturally adapted by BHC and Renz for Latino MSM and for TSM. BOI intervention integrates individual, group, and Community Level components into a 2½ day peer-led intensive training retreat. Sessions address: mental health (resolving internalized stigma), assertive communication, substance use and decision-making, diagnosis acceptance and disclosure to past, current, and future sex and injection partners; relationship challenges, risk reduction, establishing a primary care home for life-long sexual health care, and informally promoting community sexual health norms within social networks. Individual treatment engagement and adherence planning sessions are included. All workshop participants will receive individual one hour telephone sessions at three months and six months to evaluate goal behaviors and boost future goal attainment. By training 5 percent of HIV positive BLMTSM in NC-IL per year to reach 15% of this population, the goal is to strengthen not only individual outcomes, but community-level behavioral norms among HIV positive BLMTSM to reduce community HIV viral load and STD prevalence. In year two, the goal is to reinforce gains from year one and build peer leadership, promising Institute graduates will be trained, mentored and stipend to work as testing and institute assistants, peer counselors, and community planners.

Each of the collaborating agencies and partners involved in the project has distinct roles and responsibilities. BHC and Renz will be responsible for African-American and Latino testing and recruitment events, respectively. BHC will provide the BOI retreats and Renz will provide the Latino version. The Department will cross-reference HIV and STI records monthly for co-infections. IDPH will designate BHC, Renz and SIHCF as Partner Notification providers. They with the LHDs of Winnebago, Peoria, Sangamon, Champaign, suburban Cook and East St. Louis will conduct Enhanced DIS for HIV/STI Co-infected BLMTSM.

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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**PCPG Goal 1: Community planning supports broad-based community participation in HIV prevention planning.**

**IAS Goal 4: Achieve a more coordinated response to HIV by engaging key community stakeholders and increase collaboration and coordination among HIV programs.**

Objectives:

Epi/NA 1.1. Enhance ability of membership to effectively participate in the community prevention planning process.

Strategies/Activities:

Epi/NA 1.1.1. By January 2012, provide a basic overview of epidemiology methodologies used to analyze HIV and how data is used in prevention planning. This will be presented at the January PCPG meeting.

Epi/NA 1.1.2. By February 2012, provide a more in-depth presentation on “Using Data for Prevention Planning,” focusing on analyzing data to determine priority populations to the PCPG. This will be presented at the February PCPG meeting.

Eval 1.1. Monitor and evaluate the community planning process to ensure it is based on accomplishment of CDC community planning goals and objectives.

Strategies/Activities:

Eval 1.1.1. By January 2012, review and assess the 2011 retreat evaluation results and provide recommendations to the PIR/TA Committee and the PCPG on membership TA needs for the 2012 planning retreat. There will be further group discussion at the January PCPG meeting.

Eval 1.1.2. Ongoing, throughout 2012, conduct a monthly member feedback/evaluation of PCPG meetings, compile results, and provide a summary of results to the PCPG at the following PCPG meeting.

Eval 1.1.3. By February 2012, develop a tool to be used by the committee to track actions and changes that have occurred to the community planning process based on member input from the meeting and PCPG member surveys.

Eval 1.1.4. By September 2012, formally survey PCPG members to determine PCPG meeting effectiveness and progress toward meeting community planning attributes. The analysis should measure the following community planning indicator: “Proportion of key attributes of an HIV prevention community planning process that CPG membership agreed have occurred.” Present the analysis of the results of these surveys to the PCPG at the October PCPG meeting with recommendations for improving the community planning process that can be incorporated into the Interim Progress Report and grant narrative.

Eval 1.2. Plan for the conduct and evaluation of four (4) 2012 targeted community focus group discussions to be held in March, April, May, and June 2012. The objectives of the community focus groups will be: 1. to solicit input on innovative approaches to reduce HIV related stigma and homophobia; 2. to assess risk behavior practices in areas/populations hardest hit by HIV; 3. to assess knowledge and utilization of

## **Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11**

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HIV prevention, care, and treatment services among representatives of at risk communities; and 4. to identify facilitators and inhibitors of HIV risk and risk reduction.

Strategies/Activities:

Eval 1.2.1. In collaboration with the Training Unit, provide an overview/training on “Facilitating Focus Groups” at the February PCPG meeting.

Eval 1.2.2. Ongoing, throughout 2012, engage sero-positive community representatives in the community focus groups.

Eval 1.2.3. Ongoing, throughout 2012, use youth/LGBT social networks and community HIV prevention and care networks to engage participants in the community focus groups.

Eval. 1.2.4. Evaluate and present results of community focus groups to the PCPG at the August 2012 meeting.

Eval 1.3. Plan for the conduct and evaluation of three (3) 2012 community engagement meetings to be held in July, August and September. Two of the objectives of the community engagement meetings will be: 1. to increase coordination and collaboration among HIV programs in the areas/populations hardest hit by HIV and 2. to enhance the engagement of representatives of at risk communities, local health departments, and HIV prevention, care, and treatment service providers in HIV prevention planning.

Strategies/Activities:

Eval 1.3.1. Ongoing, throughout 2012, include regional care and prevention lead agents and local health departments in planning and conduct of community engagement meetings.

Eval 1.3.2. Ongoing, throughout 2012, engage local HIV prevention, care/treatment and support service CBOs and youth/LGBT group providers in the community engagement meetings.

Eval 1.3.3. Ongoing, throughout 2012, engage sero-positive community leaders in the community engagement meetings.

Eval. 1.3.4. Evaluate and present results of community engagement meetings to the PCPG at the October 2012 meeting.

Exec. 1.1. Ensure PCPG meetings and committee conference calls/meetings foster the community planning process and encourage inclusion and parity.

Strategies/Activities:

Exec. 1.1.1. Ongoing, throughout 2012, develop PCPG meeting agendas and arrange for meeting presentations from committees, Department subject matter experts, and other sources, to support the jurisdictional plan, collaborative HIV prevention planning, engagement plan, and concurrence processes.

Exec. 1.1.2. Ongoing, throughout 2012, develop PCPG meeting agendas and arrange for technical assistance opportunities that promote capacity building of members needed to fulfill their community planning roles on the PCPG.

## **Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11**

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Exec. 1.1.3. Ongoing, throughout 2012, in collaboration with the committee co-chairs, track monthly attendance at PCPG meetings and participation on committee conference calls and implement appropriate member follow-up in accordance with the PCPG bylaws and policies.

Exec 1.2. Include an appropriate representative of the Illinois Department of Corrections to be a state agency liaison on the PCPG.

Exec 1.3. Ongoing, throughout 2012, in scheduling and determining agendas of all 2012 PCPG meetings, include prevention, care, and treatment service providers so they might share best practices, communicate gaps, and provide guidance on existing referral/linkage agreements and prevention with positives initiatives.

### Strategies/Activities:

Exec. 1.3.1. Ongoing, throughout 2012, the Department PCPG Co-chair will establish communications with HIV prevention and care lead agents and continue to invite them to provide presentations or invite regional service providers to do so at PCPG meetings held in their region.

Exec 1.3.2. Ongoing, throughout 2012, the Department PCPG Co-chair will establish communications with regional HIV prevention and care service providers and stakeholders, including Part A, B, C, D, and F planning bodies and service providers and ensure they are invited to attend the meetings when held in their area.

Exec 1.3.3. Ongoing, throughout 2012, the Department PCPG Co-chair will provide all meeting participants with meeting information, materials, and minutes from the meetings to keep the community engaged.

Exec. 1.3.4. Ongoing, throughout 2012, stakeholders will be provided a schedule of PCPG meetings throughout the calendar year and information regarding the PCPG website and encouraged to attend meetings when possible and keep abreast of materials posted on the website.

Exec 1.4. Ongoing, throughout 2012, assigned members of the executive committee and other PCPG members, as needed, will participate in meetings of the Interagency AIDS Task Force, the Statewide Coordinated Statement of Need Workgroup, the Ryan White Advisory Group, Chicago and St. Louis Planning Councils, identifying opportunities for collaboration/coordination.

### Strategies/Activities:

Exec 1.4.1. Ongoing, throughout 2012, the PCPG Co-chairs shall participate in meetings of the IATF, sharing information and identifying opportunities for collaboration/coordination.

Exec 1.4.2. Ongoing, throughout 2012, assigned members of the executive committee shall participate in meetings of the Statewide Coordinated Statement of Need Workgroup, sharing information and identifying opportunities for collaboration/coordination.

Exec 1.4.3. Ongoing, throughout 2012, the Department PCPG Co-chair and any members who are consumer reps shall participate in Ryan White Advisory Group meetings, sharing information and identifying opportunities for collaboration/coordination.

## **Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11**

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Exec 1.4.4. Ongoing, throughout 2012, the Department PCPG Co-chair will consult monthly with the HIV/AIDS Section administrators to determine if there are any opportunities for collaboration/coordination with the PCPG.

MR 1.1. Ensure members are educated and updated on PCPG Conflict of Interest Policy and have completed and signed Disclosure of Interest/Code of Ethics Statements on file.

Strategies/Activities:

MR 1.1.1. By January 2012, ensure all current and new members have been educated and updated on the PCPG Conflict of Interest Policy.

MR 1.1.2. By February 2012, ensure all current and new members have completed and signed 2012 Disclosure of Interest/Code of Ethics statements on file.

MR 1.2. Coordinate the update and development of applicable PCPG policies and bylaws.

Strategies/Activities:

MR 1.2.1. By January 2012, review current policies to ensure consistency with PCPG bylaws and identify any discrepancies or areas needing further clarification/update. Survey all PCPG committees for their input. Provide recommendations and assignments to appropriate committees during the January PCPG meeting.

MR 1.2.2. By April 2012, collect all bylaws and policy revisions from appropriate subcommittees, edit/format as needed; draft new policies, where applicable; review with the executive committee; and present them to the PCPG for vote at the April meeting.

MR 1.3. Maintain updated PCPG documents on PCPG website.

Strategies/Activities:

MR 1.3.1 Ongoing, throughout 2012, collaborate with the Department PCPG Co-chair to obtain and post the annual PCPG meeting schedule and all meeting notices and agendas of the full PCPG on the PCPG website prior to the meetings.

MR 1.3.2. Ongoing, throughout 2012, collaborate with the Department PCPG Co-chair to obtain PCPG meeting materials, minutes, updated bylaws/policies, blank membership application, and community planning documents for posting on the PCPG website.

PIR/TA 1.1. Ensure PCPG membership is representative of the diversity of community characteristics, populations most at risk for HIV infection, and includes key professional expertise and representatives from community, governmental and non-governmental agencies.

Strategies/Activities:

PIR/TA 1.1.1. By March 2011, in collaboration with the Department PCPG Coordinator, conduct an annual survey of current voting and non-voting PCPG members, collecting data on demographic and risk representation as well as professional expertise and skills. Use the survey responses to maintain an updated spreadsheet of current members and for community planning reporting purposes to CDC.

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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PIR/TA 1.1.2. By June 2012, in collaboration with the Department's PCPG Coordinator, prepare an analysis of current PCPG membership by gender, race/ethnicity, region, and transmission risk representation, including a comparison to the current HIV epidemic in Illinois, for use in identifying gaps in membership, targeting 2012 new member recruitment, and prioritizing new member selection. The analysis should measure the following community planning indicator: "Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one CPG member that reflects the perspective of that population." The analysis and recruitment needs will be presented to the full PCPG at the June meeting.

PIR/TA 1.2. Plan and implement an open recruitment and selection process (outreach, applications, and selection) for 2013 membership.

Strategies/Activities:

PIR/TA 1.2.1. Ongoing, June through September 2012, following the "PCPG New Member Recruitment and Selection Policy," plan, organize, and conduct the recruitment, interviewing, and selection of new members for 2013. Present a summary of the process, the committee recommendations for new members to the PCPG, and a ballot for voting at the October PCPG meeting.

PIR/TA 1.2.3. Coordinate the development and staffing of a PCPG exhibit at the 2012 HIV/STD Conference.

PIR/TA 1.3. Develop, update and implement new member orientation.

Strategies/Activities:

PIR/TA 1.3.1. By December 2012, in conjunction with the Department PCPG Co-chair and training unit staff, as available, plan, organize, and conduct an orientation for new PCPG membership.

PIR/TA 1.4. Provide community planning technical assistance support to the PCPG.

Strategies/Activities:

PIR/TA 1.4.1. By January 2012, in collaboration with the Evaluation Committee, review 2011 meeting survey results to determine member TA needs that would facilitate the community planning process. If needed, conduct a separate survey to solicit TA needs. Provide a report on the results of this review/survey at the January PCPG meeting.

PIR/TA 1.4.2. Collaborate with the parliamentarian and the HIV/AIDS Section Training Unit Coordinator to provide an instructional and creative training on Use of Robert's Rules of Order at the May 2012 PCPG meeting.

<b>PCPG Goal 2: Community planning identifies priority HIV prevention needs.</b>
<b>IAS Goal 1: Reduce new HIV infections in hardest hit areas/populations</b>
<b>IAS Goal 5: Reduce HIV-related health disparities and inequities.</b>
<b>IAS Goal 3 : Reduce stigma and discrimination against people living with HIV.</b>

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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### IAS Goal 2: Increase/facilitate linkage and access to care and improve health outcomes

#### Objectives:

Epi/NA 2.1. In collaboration with the Evaluation Committee, identify community service assessment activities that are needed in 2012 to identify the priority populations, social determinant factors, needs, and gaps in prevention, care, and treatment services.

#### Strategies/Activities:

Epi/NA 2.1.1. At the November 2011 strategic planning meeting, in conjunction with the Executive Committee, finalize topics and data collection points for epi analyses and needs assessment activities (forums, focus groups, surveys).

Epi/NA 2.2. Coordinate the compilation and review of HIV prevention, care, and treatment resources.

#### Strategies/Activities:

Epi/NA 2.2.1. By April 2012, in coordination with the Department, IATF, and the SCSN Workgroup, compile a listing and mapping of Department funded and other CDC and HRSA direct-funded HIV prevention, care, and treatment resources across the state to identify resource gaps. Delineate the HIV prevention services funded by the Department and entered into the Provide® system. Provide this presentation to the PCPG at the April PCPG meeting.

Epi/NA 2.3. Review service delivery data and make recommendations to the PCPG for the 2013 HIV jurisdiction plan update.

#### Strategies/Activities:

Epi/NA 2.3.1. By April 2012, in collaboration with the Evaluation Committee and the HIV Evaluation Unit Coordinator, review, analyze, and make presentations to the PCPG on 2011 Department- funded and other, as appropriate, service delivery data in Illinois, focusing on the identification of any HIV-related health disparities and inequities. Provide this presentation at the April PCPG meeting.

Epi/NA 2.4. Review updated data in the Epidemiologic Profile and make recommendations to the PCPG for updating the priority populations to be identified in the 2013 HIV jurisdiction plan update.

#### Strategies/Activities:

Epi/NA 2.4.1. By May 2012, in collaboration with the HIV/STD Section Surveillance Unit, review, analyze, and make presentations to the PCPG on the current epidemiologic profile in Illinois (incidence, prevalence, late diagnoses, etc.) to determine and make recommendations/updates on 1. the areas and populations hardest hit by HIV/AIDS in Illinois and 2. the identification of any HIV-related health disparities and inequities, focusing on the jurisdiction outside the city of Chicago. Provide this presentation at the May PCPG meeting.

Epi/NA 2.5. Coordinate the gap analysis process, as needed, ensuring a logical, evidence-based process is used to determine the highest priority populations and gaps in their prevention, care, and treatment needs.

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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### Strategies/Activities:

Epi/NA 2.5.1. In July-August 2012, in collaboration with the Executive Committee, develop and conduct gap analysis activities, as needed, based on updated epi and service delivery data (including information about services not funded by Regional Implementation Groups), identifying populations hardest hit and most at risk for HIV infection, prevention needs, gaps to be addressed, rationale for selection, and strategies to address the gaps. This gap analysis process will be conducted at the July-August PCPG meetings.

Epi/NA 2.6. Review and assess aggregate client level data to determine if prevention services are resulting in improved health outcomes.

### Strategies/Activities:

Epi/NA 2.6.1 By October 2012, in collaboration with the HIV/STD Section Surveillance and Prevention Program Administrators, review and assess aggregate client level data from Provide® and eHARS for indicators of care (CD4 counts, viral loads, referrals made, referrals kept, etc.) to determine if PLWHA clients receiving prevention and care services are active, in care, compliant with care, retained in care, and receiving secondary prevention services. Provide a presentation on this at the October PCPG meeting.

Eval 2.1. Increase the capacity of community planning group to understand and apply behavioral science and evaluation methodologies in HIV prevention priority setting and needs assessment activities.

### Strategies/Activities:

Eval 2.1.1. Provide an instructional presentation to the PCPG on the role of behavioral science and evaluation in HIV prevention planning at the May 2012 PCPG meeting.

Eval 2.2. Coordinate the planning, conduct, and analysis of the 2012 community focus groups and engagement meetings.

### Strategies/Activities:

Eval 2.2.1. By January 2012, work with the Department's HIV Section Evaluation Unit Coordinator and the Epi/Needs Assessment Committee, as needed, to develop standardized format, discussion questions, data collection tools, etc., to coordinate the conduct and data collection/evaluation of the 2012 Community focus group discussions (using existing prevention-funded support groups) to be held in March, April, May, and June 2012. The objectives of the community focus groups will be: 1. to solicit input on innovative approaches to reduce HIV related stigma and homophobia, 2. To assess risk behavior practices in areas/populations hardest hit by HIV, 3. To assess knowledge and utilization of HIV prevention, care, and treatment services among representatives of at risk communities, and 4. To identify facilitators and inhibitors of HIV risk and risk reduction.

Eval 2.2.2. By May 2012, work with the IDPH Evaluation Unit Coordinator and the Epi/Needs Assessment Committee, as needed, to develop standardized format, content, engagement strategy, discussion questions, and data collection tools, to coordinate the conduct and data collection/evaluation of the 2012 community engagement meetings to be held in July, August, and September 2012. Two of the objectives of the community engagement meetings will be: 1. to increase coordination and collaboration among HIV programs in

## **Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11**

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the areas/populations hardest hit by HIV and 2. to enhance the engagement of representatives of at risk communities and HIV prevention, care, and treatment service providers in HIV prevention planning.

Eval 2.2.3. By August 2012, develop a summary of the results of the 2012 community focus groups, combined and broken out by individual region to the PCPG. The results of the evaluation will be posted on the PCPG website and shared with the regional lead agents, all Department HIV funded service providers, the IATF, and the Ryan White Advisory Group, including the consumer representative group. The results will be presented at the August PCPG meeting.

Eval 2.2.4. By October 2012, develop a summary of the results of the 2012 Community Engagement Meetings, combined and broken out by individual region to the PCPG. The results of the evaluation will be posted on the PCPG website and shared with the Regional Lead Agents, all IDPH funded service providers, the IATF, and the Ryan White Advisory Group, including the Consumer Representative group. The results will be presented at the October PCPG meeting.

Exec. 2.1. Ensure that the community planning process supports awareness, education, and advocacy on issues pertaining to HIV anti-stigma and anti-discrimination.

Strategies/Activities:

Exec 2.1.1. Ongoing, throughout 2012, in scheduling meetings and agenda, the Executive Committee will invite AIDS Foundation of Chicago to provide an annual update to the group on HIV-related policies and legislation, including those that pertain to anti-stigma and anti-discrimination of PLWHA.

Exec 2.1.2. By October 2012, the PCPG Executive Committee will collaborate with the HIV Prevention and Care Units to co-host a Legislators Reception during the 2012 HIV-STD Conference to meet and inform legislators about HIV transmission, prevention, and care/treatment issues and about laws and policies that encourage stigma and discrimination.

Exec 2.2. Collaborate with the Interagency AIDS Task Force, the Ryan White Advisory Group, the AIDS Foundation of Chicago, and HIV/AIDS Section leadership to support HIV related policy initiatives.

Strategies/Activities:

Exec 2.2.1 Ongoing, throughout 2012, the PCPG Co-chairs shall participate in meetings of the IATF, sharing information re: prevention planning and bringing information back to the PCPG.

Exec 2.2.2. Ongoing, throughout 2012, the Department PCPG Coordinator and any members who are consumer reps shall participate in Ryan White Advisory Group meetings, sharing information re: prevention planning and bringing information back to the PCPG.

Exec 2.2.3. Ongoing, throughout 2012, the Department PCPG Coordinator will coordinate monthly with the HIV/AIDS Section administrators to determine if there are any policy initiatives in which the PCPG could provide support.

Exec 2.2.4. The Executive Committee will invite AFC to provide an annual update to the group and facilitate a discussion on HIV-related policies and legislation.

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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Exec 2.3. Ensure that the community planning process facilitates linkage to care.

Strategies/Activities:

Exec 2.3.1. Ongoing, throughout 2012, in scheduling and determining agendas of all 2012 PCPG meetings, include prevention, care, and treatment service providers and ask that they share best practices, communicate gaps, and provide guidance on existing referral/linkage agreements and Prevention with positives initiatives that might facilitate linkage to care.

I&S 2.1. Conduct client and provider surveys to identify HIV prevention, care, and treatment needs.

Strategies/Activities:

I&S 2.1.1. By Feb 2012, in collaboration with the Department's HIV Section Direct Services Unit liaison and the Executive Committee, develop a series of questions that can be incorporated into the Annual Ryan White Program Client Satisfaction Survey, to ascertain gaps in prevention services, access to services, referral to care, access to care services (if applicable), and access to Partner Services (if applicable). The presentation should include any committee recommendations gleaned from the results for consideration in the 2013 Jurisdictional HIV Prevention Plan. Provide the survey results to the PCPG at the March PCPG meeting.

I&S 2.1.2. By Feb 2012, collaborate with the Department's HIV Section Evaluation Program Administrator and Evaluation Committee, to develop and conduct a survey of prevention service providers to ascertain the providers' capacity and capability and technical assistance needs to provide prevention services, refer newly tested clients into care services, and provide secondary prevention to PLWHA and their partners. The survey will be implemented through the Department and the prevention lead agents. The results of the survey should be assessed by the committee and presented to the PCPG at the April PCPG meeting. The presentation should include any committee recommendations gleaned from the results for consideration in the 2013 Jurisdictional HIV Prevention Plan.

I&S 2.2. Provide recommendations to the Department about HIV prevention strategies, interventions, and considerations to include in the 2013 jurisdictional plan update.

Strategies/Activities:

I&S 2.3.1. By July 2012, thoroughly review and assess the current listing of approved interventions, researching new and promising interventions, focusing on interventions that provide linkage to and support retention in care. Provide recommendations to the PCPG for input and vote at the July PCPG meeting.

I&S 2.3.2. By July 2012, thoroughly review and assess the current listing of approved interventions and recommendations, focusing on interventions, strategies, and approaches that reduce stigma and homophobia in the hardest hit areas/populations. Provide recommendations to the PCPG for input and vote at the July 2012 meeting.

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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I&S 2.3.3. By July 2012, thoroughly review and assess the current listing of approved interventions and recommendations, and determine if stronger recommendations regarding the provision of culturally appropriate services and assuring the cultural competency of service providers is suggested. Provide recommendations to the PCPG at the June 2012 meeting.

I&S 2.3.4. By July 2012, to increase collaboration among service providers, develop a policy/recommendation to the Department to require the Department's HIV-funded service agencies to have active linkage agreements between prevention, care, and treatment service providers, regardless of funding type. Provide recommendations to the PCPG at the July 2012 meeting.

I&S 2.3.5. By July 2012, thoroughly review and assess the current listing of approved interventions and recommendations, research other peer based models, and facilitate a group discussion to develop recommendations on peer-based interventions that facilitate linkage to and retention in care. Provide recommendations to the PCPG at the July 2012 meeting.

I&S 2.3.6. By July 2012, thoroughly review and assess the current listing of approved interventions and recommendations, use input from previous intervention presentations and research, and facilitate a group discussion to develop recommendations on “scalability of activities”: “Interventions or combinations of interventions that can reach a significant portion of those in need, in a cost-efficient manner, and demonstrate population-level impact.” The group discussion will occur at the May PCPG two-day workshop. Provide recommendations to the PCPG at the July 2012 meeting.

I&S 2.3.7. By July 2012, thoroughly review and assess the current listing of approved interventions and recommendations, use input from previous intervention presentations and research, and facilitate a group discussion to develop recommendations on “high impact interventions”: “using programs and other scalable interventions that have demonstrated the potential to reduce new HIV infections in the right populations in order to yield a greater impact on the HIV epidemic”. The group discussion will occur at the May PCPG two-day workshop. Provide recommendations to the PCPG at the July 2012 meeting.

I&S 2.3.8. By July 2012, using input from previous intervention presentations, research, survey results, group discussion, gap analysis data, and breakout discussions as needed, provide a list of appropriate prevention strategies and recommendations to the PCPG for vote.

MR 2.1. Assess how the PCPG website and other social networking methods could be used by the PCPG to reduce HIV stigma and homophobia.

Strategies/Activities:

MR 2.1.1. By February 2012, work with the PCPG website administrator to develop recommendations on how the PCPG website and other social networking methods could be utilized by the PCPG to provide education aimed at reducing HIV stigma and homophobia. Present these recommendations at the February PCPG meeting.

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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MR 2.1.2. By June 2012, develop a plan for implementing the recommendations referenced in MR 1.2. as approved by the PCPG at the February PCPG meeting.

MR 2.2. Assess how the PCPG website could be used to link users to information about HIV prevention, care, and treatment resources.

Strategies/Activities:

MR 2.2.1. By February 2012, work with the PCPG website administrator to develop recommendations on how the PCPG website can be used to link users to a directory of HIV prevention, care, and treatment services, including links to the regional lead agents, HIV Care Connect and HIV/AIDS and STD hotline searchable database. Present these recommendations at the February PCPG meeting.

MR 2.2.2. By June 2012, implement the recommendations referenced in MR 2.2.1., as approved by the PCPG at the February PCPG meeting.

<b>PCPG Goal 3: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the jurisdictional plan.</b>
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<b>IAS Goal 1: Reduce new HIV infections in hardest hit areas/populations</b>
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<b>IAS Goal 5: Reduce HIV-related health disparities and inequities.</b>
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Objectives:

Epi 3.1. Demonstrate the relationship between the priority populations and approved strategies/interventions in the jurisdictional HIV prevention plan and funded interventions

Strategies/Activities:

Epi 3.1.1. By April 2012, in collaboration with the IDPH HIV Prevention Program Administrator and Evaluation Coordinator, review, analyze, and make a presentation to the PCPG assessing the linkage between the 2012 priority populations and interventions and the funded interventions. The analysis should measure the following community planning performance indicator: “Percent of health department funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive prevention plan”. This presentation should include geo-mapping of statewide incidence data and priority population data compared to CTR and HERR funded service data. Provide this presentation at the April PCPG meeting.

Exec 3.1. Demonstrate the relationship between the jurisdictional HIV prevention plan and the 2012 IDPH Application for federal prevention funding.

Strategies/Activities:

Exec. 3.1.1. By June 2012, work with the Department’s PCPG Coordinator and HIV Prevention Program Administrator to demonstrate to the PCPG an assessment of the linkages between the 2012 priority populations and interventions in the Jurisdictional HIV Prevention Plan and the IDPH Application for federal HIV prevention funding. Provide this presentation at the June PCPG

## Attachment 1. PCPG 2012 Strategic Plan -finalized 11-16-11

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meeting. (Note: This presentation was provided at the September 2011 PCPG Meeting, but should be reviewed with the PCPG again in preparation for the concurrence process).

Exec. 3.1.2. By June 30, 2012, in collaboration with the Department's PCPG Co-chair, submit the IDPH HIV Prevention Jurisdictional Plan 2012-2016 to CDC.

Exec. 3.1.3. By September 2012, work with the Department's PCPG Coordinator and HIV Prevention Program Administrator to demonstrate to the PCPG an assessment of the linkages between the 2013 priority populations and interventions in the 2013 jurisdictional HIV prevention plan update and the Department's application for federal HIV prevention funding. The analysis should measure the following community planning performance indicator: "Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan". Provide this presentation at the September PCPG meeting.

Exec 3.2. Ensure the concurrence process is conducted.

Strategies/Activities:

Exec. 3.2.1. By June 2012, under the direction of the PCPG Co-chairs, facilitate the annual concurrence discussion and concurrence vote process by the full PCPG. Upon vote by the PCPG, the co-chairs shall draft, sign, and submit a letter of concurrence, concurrence with reservations, or non-concurrence to CDC.

### **Program Description:**

The Illinois Department of Public Health (Department) Engagement Plan identifies strategies for increasing coordination across HIV care, treatment, and prevention programs across the state, jurisdiction, and localities to strengthen and enhance the relationships across governments and communities and ultimately, to reduce rates of new HIV infection. The plan recommends bringing people with HIV, community stakeholders, and service providers together for collaboration and coordination in program planning, delivery, evaluation, and assessment; and to identify and address gaps, deficiencies, and barriers to accessing HIV care, treatment, and prevention services.

### **Program Goals:**

The overarching goal of the engagement plan is to:

**Achieve a more coordinated response to HIV by engaging key community stakeholders and leaders and increasing collaboration and coordination among HIV programs.**

This goal aligns with one of the goals of the Illinois AIDS Strategy. Four additional, more specific goals have been developed and include:

- Goal 1: Increase community stakeholders' awareness and understanding of HIV care, treatment, housing, and prevention programs.
- Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.
- Goal 3: Increase access and linkage to HIV services, including housing opportunities where available and as needed..
- Goal 4: Mitigate the impact of stigma and discrimination on HIV care, treatment and prevention.

**Key Stakeholders:**

**Key stakeholders will include:**

- Networks of HIV positive people and their sex and/or needle sharing partners
- Networks of at-risk populations including youth, LGBT, and areas/populations hardest hit by HIV
- Networks of marginalized groups (IDUs/other substance users, sex workers, current/former incarcerated/detained persons and advocates)
- Networks of groups with language and cultural barriers
- HIV prevention, care, and treatment planners, including governmental and non-governmental agencies and planning/advisory groups
- HIV prevention, care, and treatment providers, including mental health program leaders
- STD/hepatitis prevention, disease intervention and clinical program leaders
- Community and youth leaders; women's health/reproductive health/transgender health advocates and program leaders
- Legislators and decision makers
- Governmental and non-governmental program leaders implementing health care reform, including patient-centered medical homes
- Affordable and specialized housing advocates, policy makers and program leaders

**Engagement and Retention Strategies:**

Specific, measurable, achievable, realistic, and time-measured objectives and key strategies/activities needed to accomplish the objectives have been developed to engage new and previous partners, maintain current partner relationships, and retain those partners in HIV prevention, care, and treatment coordination and collaboration processes. The Department's Prevention Community Planning Group (PCPG) Coordinator will set up and maintain two-way communication with all identified key stakeholders and participants in engagement activities as well as maintain a record of documents, reports and notes developed throughout all engagement activities. This documentation record will not only provide key stakeholders with easy access to information for program coordination and decision-making but will uphold the continuity of the process should staff change roles and enhance retention of new and previous partners through the sharing of information and the transparency of the engagement process.

**Guiding Principles for Engagement will be based on the following factors:**

- Mutual respect and understanding
- Engagement and participation will be beneficial and of interest to all
- Communication will be open and involve balanced and objective information-sharing and discussion as well as solicitation of feedback that will promote understanding of the issues, coordination across programs, and informed decision-making

The following implementation plan identifies the activities that have been prioritized to occur in 2012. Progress will be monitored regularly by the Department's PCPG Coordinator utilizing the evaluation indicators identified for each activity. A feedback loop will be established to ensure all stakeholders who participated in the engagement plan activities are provided with follow up information, reports and documents.

## Attachment 2. 2012 Illinois Department of Public Health HIV Engagement Plan - Final August 2012

**Overall Program Goal: Achieve a more coordinated response to HIV by engaging key community stakeholders and increasing collaboration and coordination among HIV programs.**

**Goal 1: Increase community stakeholders' awareness and understanding of HIV care, treatment, housing, and prevention programs.**

**Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.**

**Objective:** Plan for, conduct and evaluate four (4) 2012 targeted community focus group discussions to be held in March (East St. Louis), April (Berwyn), May (Peoria), and June (Joliet) 2012. The objectives of the community focus groups will be: 1. to solicit input on innovative approaches to reduce HIV related stigma and homophobia; 2. to assess risk behavior practices in areas/populations hardest hit by HIV; 3. to assess knowledge and utilization of HIV prevention, care, and treatment services among representatives of at risk communities; and 4. to identify facilitators and inhibitors of HIV risk and risk reduction.

2012 Key Strategies and Activities	Target Group	Lead Role	Timeline				Evaluation Indicator(s)
			Q1	Q2	Q3	Q4	
1. In collaboration with the Training Unit, provide an overview/training on "Facilitating Focus Groups" at the February PCPG meeting.	PCPG	PCPG Evaluation Committee and Training Unit	X				Training provided
2. Ongoing, throughout 2012, engage sero-positive community representatives in the community focus groups.	PLWHA	PCPG Evaluation Committee	X	X			Participation in focus groups
3. Ongoing, throughout 2012, use youth/LGBTQ social networks and community HIV prevention and care networks to engage participants in the community focus groups.	HIV prevention and care support groups	PCPG Evaluation Committee and PCPG Coordinator	X	X			Participation in focus groups
4. Evaluate and present results of community focus groups to the PCPG at the August 2012 meeting.	PCPG	PCPG Evaluation Committee				X	Focus group results analyzed and presented.
5. Post the results and reports from the community focus groups on the PCPG website and share with the regional lead agents, HIV care and prevention service providers, the IATF, and the Ryan White Advisory Group, including the consumer representative group. Disseminate to other interested parties, as appropriate.	HIV prevention and care community stakeholders	Department PCPG Coordinator				X	Focus group results posted on website and disseminated to community stakeholders.

## Attachment 2. 2012 Illinois Department of Public Health HIV Engagement Plan - Final August 2012

**Overall Program Goal: Achieve a more coordinated response to HIV by engaging key community stakeholders and increase collaboration and coordination among HIV programs.**

**Goal 1: Increase community stakeholders' awareness and understanding of HIV care, treatment, housing, and prevention programs.**

**Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.**

Objective: Plan for, conduct, and evaluate three (3) 2012 community engagement meetings to be held in July (Champaign), August (Rockford), and September (Collinsville) 2012. Two of the objectives of the community engagement meetings will be: 1. to increase coordination and collaboration among HIV programs in the areas/populations hardest hit by HIV, and 2. to enhance the engagement of representatives of at risk communities and HIV prevention, care, housing, and treatment service providers in HIV prevention planning.

2012 Key Strategies and Activities	Target Group	Lead Role	Timeline				Evaluation Indicator(s)
			Q1	Q2	Q3	Q4	
6. Ongoing, throughout 2012, include regional care and prevention lead agents and local health departments in planning, participation, and conduct of community engagement meetings.	Regional Prevention and Care Lead Agents; LHDs	PCPG Coordinator and Evaluation Committee		X	X	X	Plans developed for Community engagement meetings. Meetings conducted.
7. Ongoing, throughout 2012, engage local health departments, local HIV prevention, care/treatment and support service CBOs and youth/LGBTQ groups in the community engagement mtgs.	HIV prevention & care providers and youth/LGBTQ groups	PCPG Coordinator and Evaluation Committee		X	X	X	Targeted participants engaged.
8. Ongoing, throughout 2012, engage sero-positive community leaders in the community engagement mtgs.	Sero-positive community leaders and Ryan White Program	PCPG Coordinator and Evaluation Committee		X	X	X	Meetings held and content developed for webinar.
9. Evaluate and present results of community engagement meetings to the PCPG at the October 2012 meeting.	PCPG	PCPG Evaluation Committee				X	Community engagement meeting results analyzed and presented.
10. Post the results of the community focus groups on the PCPG website and share with the regional lead agents, HIV care and prevention service providers, the IATF, and the Ryan White Advisory Group, including the consumer representative group.	HIV prevention and care community stakeholders	Department PCPG Coordinator				X	Focus group results posted on website and disseminated to community stakeholders.

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<b>Overall Program Goal: Achieve a more coordinated response to HIV by engaging key community stakeholders and increasing collaboration and coordination among HIV programs.</b>							
<b>Goal 1: Increase community stakeholders' awareness and understanding of HIV care, treatment, housing, and prevention programs.</b>							
<b>Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.</b>							
Objective: Ongoing, throughout 2012, in scheduling and determining agendas of all 2012 PCPG meetings, include prevention, care, and treatment service providers so they might share best practices, communicate gaps, and provide guidance on existing referral/linkage agreements and prevention with positives initiatives.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
11. Include an appropriate representative of the Illinois Department of Corrections (IDOC) to be a state agency liaison on the PCPG.	Department of Corrections representative	Department PCPG Co-chair	Q1 X	Q2	Q3	Q4	IDOC representative added to PCPG
12. Ongoing, throughout 2012, establish communications with HIV prevention and care lead agents and continue to invite them to provide presentations or invite regional service providers to do so at PCPG meetings held in their region.	HIV Care and Prevention Lead Agents	Department PCPG Co-chair	X	X	X	X	Lead agents participation in PCPG meetings
13. Ongoing, throughout 2012, establish communications with regional HIV prevention and care service providers and stakeholders, including Part A, B, C, D, and F planning bodies and service providers and ensure they are invited to attend the meetings when held in their area.	HIV Care and Prevention regional service providers and stakeholders	Department PCPG Co-chair	X	X	X	X	Regional HIV prevention and care service providers participation in PCPG meetings
14. Ongoing, throughout 2012, provide all PCPG meeting participants with information, materials, and minutes from the meetings to keep the community engaged.	PCPG Meeting participants	Department PCPG Co-chair	X	X	X	X	Meeting information, materials, and minutes provided to meeting participants
15. Ongoing, throughout 2012, stakeholders will be provided a schedule of PCPG meetings throughout the calendar year and information re: the PCPG website and encouraged to attend meetings when possible and keep abreast of materials posted on the website.	HIV care and prevention community stakeholders.	PCPG Materials Review Committee and the Department PCPG Co-chair	X	X	X	X	Meeting schedule and meeting materials posted on PCPG website.

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<b>Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.</b>							
Objective: Ongoing, throughout 2012, assigned members of the Executive Committee and other PCPG members, as needed, will participate in meetings of the Interagency AIDS Task Force, the Statewide Coordinated Statement of Need Workgroup, the Ryan White Advisory Group, Chicago and St. Louis Planning Councils, identifying opportunities for collaboration/coordination.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
16. Ongoing, throughout 2012, the PCPG co-chairs shall participate in meetings of the IATF, sharing information and identifying opportunities for collaboration/coordination.	IATF	PCPG Co-chairs	Q1 X	Q2 X	Q3 X	Q4 X	Meeting participation
17. Ongoing, throughout 2012, assigned members of the Executive Committee shall participate in statewide and regional meetings of the Statewide Coordinated Statement of Need Workgroup, sharing information and identifying opportunities for collaboration/coordination.	Statewide Coordinated Statement of Need Workgroup	PCPG Executive Committee	X	X			Meeting participation
18. Ongoing, throughout 2012, the Department's PCPG co-chair and any members who are consumer reps shall participate in Ryan White Advisory Group meetings, sharing information and identifying opportunities for collaboration/coordination.	Ryan White Advisory Group	Department PCPG Co-chair and consumer reps	X	X	X	X	Meeting participation
19. Ongoing, throughout 2012, the Department's PCPG Co-chair will consult monthly with the HIV/AIDS Section administrators to determine if there are any opportunities for collaboration/coordination with the PCPG, including the identification and recruitment of affordable/specialized housing expert(s) as participants.	HIV/AIDS Section Administrators	Department PCPG Coordinator	X	X	X	X	Opportunities for collaboration identified

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<b>Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.</b>							
Objective: Ensure PCPG membership is representative of the diversity of community characteristics, populations most at risk for HIV infection, and includes key professional expertise and representatives from community, governmental and non-governmental agencies.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
			<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	
20. By March 2011, in collaboration with the Department's PCPG Coordinator, conduct an annual survey of current voting and non-voting PCPG members, collecting data on demographic and risk representation as well as professional expertise and skills. Use the survey responses to maintain an updated spreadsheet of current members and for community planning membership recruitment purposes.	PCPG Membership	PCPG PIR/TA Committee and IDPH PCPG Co-chair	X				Survey conducted and data collected.
21. By June 2012, in collaboration with the Department's PCPG Coordinator, prepare an analysis of current PCPG membership by gender, race/ethnicity, region, and transmission risk representation, including a comparison to the current HIV epidemic in Illinois, for use in identifying gaps in membership, targeting 2012 new member recruitment, and prioritizing new member selection. The analysis should measure the following community planning indicator: "Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one CPG member that reflects the perspective of that population." The analysis and recruitment needs will be presented to the full PCPG at the June meeting.	PCPG Membership	PCPG PIR/TA Committee and IDPH PCPG Co-chair		X			Survey results analyzed and compared to the HIV epidemic in Illinois and presented to the PCPG to guide 2013 new member recruitment and selection.

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Objective: Ensure PCPG membership is representative of the diversity of community characteristics, populations most at risk for HIV infection, and includes key professional expertise and representatives from community, governmental and non-governmental agencies.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
22. Plan and implement an open recruitment and selection process (outreach, applications, and selection) for 2013 new PCPG membership.	HIV community stakeholders	PCPG PIR/TA Committee and IDPH PCPG Co-chair	Q1	Q2 X	Q3 X	Q4 X	Survey conducted and data collected.
23. Develop, update and implement new member orientation.	Newly selected PCPG Members	PCPG PIR/TA Committee; Executive Committee; and IDPH PCPG Co-chair				X	Orientation provided and evaluations received
24. By January 2012, in collaboration with the Evaluation Committee, review 2011 meeting survey results to determine member TA needs that would facilitate the community planning process. If needed, conduct a separate survey to solicit TA needs. <u>Provide a report on the results of this review/survey at the January PCPG meeting.</u>	PCPG Membership	PCPG PIR/TA Committee and Evaluation Committee	X				Technical assistance needs of the PCPG membership determined

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<b>Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.</b>							
<b>Goal 3: Increase access and linkage to HIV services, including housing opportunities where available and as needed.</b>							
<b>Goal 4: Mitigate the impact of stigma and discrimination on HIV care, treatment, and prevention.</b>							
Objective: Ensure that the community planning process supports awareness, education, and advocacy on issues pertaining to HIV anti-stigma and anti-discrimination.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
25. Ongoing, throughout 2012, in scheduling meetings and agenda, the Executive Committee will invite AIDS Foundation of Chicago to provide an annual update to the group on HIV-related policies and legislation, including those that pertain to anti-stigma and anti-discrimination of PLWHA.	PCPG	AIDS Foundation of Chicago Policy Coordinator	Q1	Q2 X	Q3	Q4 X	Policy and legislative updates provided
26. By October 2012, the PCPG Executive Committee will collaborate with the HIV Prevention and Care Units to co-host a Legislators Reception during the 2012 HIV-STD Conference to meet and inform legislators about HIV transmission, prevention, and care/treatment issues and about laws and policies that encourage stigma and discrimination.	Illinois Legislators	HIV/AIDS Section Administrators; PCPG Executive Committee			X	X	Legislators' Reception held and positive feedback received
27. In 2012, the Department's HIV and the STD Sections will form a workgroup to discuss and develop strategies to address the alarming trends of HIV and STD co-infection among young African-American MSM.	Young African-American MSMS	HIV and STD Section Chiefs		X	X	X	Workgroup formed; strategy developed; the PCPG and other entities will be involved and asked for input, as needed.

Attachment 2. 2012 Illinois Department of Public Health HIV Engagement Plan - Final August 2012

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<b>Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.</b>							
<b>Goal 3: Increase access and linkage to HIV services, including housing opportunities where available and as needed.</b>							
<b>Goal 4: Mitigate the impact of stigma and discrimination on HIV care, treatment and prevention.</b>							
Objective: Collaborate with the Interagency AIDS Task Force, the Ryan White Advisory Group, the AIDS Foundation of Chicago (AFC), Housing Coalition advocates, and HIV/AIDS Section leadership to support HIV related policy initiatives.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
28. Ongoing, throughout 2012, PCPG Co-chairs shall participate in meetings of the IATF, sharing information re: prevention planning and bringing information back to the PCPG.	Interagency AIDS Task Force (IATF)	AIDS Foundation of Chicago	Q1 X	Q2 X	Q3 X	Q4 X	Meeting participation and meeting notes showing information provided and received
29. Ongoing, throughout 2012, the Department PCPG Coordinator and any members who are consumer reps shall participate in Ryan White Advisory Group meetings, sharing information regarding prevention planning and bringing information back to the PCPG.	Ryan White Advisory Group	IDPH PCPG Coordinator and members who are consumer reps	X	X	X	X	Meeting participation and meeting notes showing information provided and received
30. Ongoing, throughout 2012, the IDPH PCPG Coordinator will coordinate monthly with the HIV/AIDS Section administrators to determine if there are any policy initiatives in which the PCPG could provide support.	HIV/AIDS Section Administrators	IDPH PCPG Coordinator	X	X	X	X	Policy initiatives and areas for PCPG support identified
31. The Executive Committee will invite AFC and other health policy experts to provide an annual update to the PCPG and facilitate a discussion on HIV-related policies and legislation. The Executive Committee will also seek to have an annual overview and update on HIV housing policy issues and updates as needed on health care reform (Affordable Care Act), including Illinois-specific Medicaid and insurance policies.	PCPG	AFC Policy Coordinator; HIV Section Housing Coordinator; DSU Administrator		X		X	Policy and legislative areas for PCPG support/collaboration identified

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<b>Goal 2: Identify opportunities for collaboration and coordination across all HIV programs, statewide and local.</b>							
<b>Goal 3: Increase access and linkage to HIV services, including housing opportunities where available and as needed.</b>							
<b>Goal 4: Mitigate the impact of stigma and discrimination on HIV care, treatment and prevention.</b>							
Objective: Identify HIV prevention, care, and treatment needs; ensure that the community prevention planning process facilitates linkage to care.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
			<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	
32. Ongoing, throughout 2012, in scheduling and determining agendas of all 2012 PCPG meetings, include HIV and STD prevention, care, and treatment service providers and ask that they share best practices, communicate gaps, and provide guidance on existing referral/linkage agreements and prevention with positive initiatives that might facilitate linkage to care.	HIV prevention and care service providers	IDPH PCPG Coordinator	X	X	X	X	Meeting participation and meeting notes showing information shared
33. By Feb 2012, in collaboration with the Department's HIV Section Direct Services Unit liaison and the Executive Committee, develop a series of questions that can be incorporated into the Annual Ryan White Program Client Satisfaction Survey, to ascertain gaps in prevention services, access to services, referral to care, access to care services (if applicable), and access to Partner Services (if applicable). <u>Provide the survey results to the PCPG at the March PCPG meeting.</u>	Ryan White Program clients	IDPH Direct Services Unit, PCPG Interventions and Services Committee; PCPG Executive Committee	X				Prevention questions developed and added to survey and survey conducted and analyzed
34. By Feb 2012, collaborate with the HIV Section Evaluation Program Administrator and Evaluation Committee, to develop and conduct a survey of prevention service providers to ascertain the providers' capacity and capability and technical assistance needs to provide prevention services, refer newly tested clients into care services, and provide secondary prevention to PLWHA and their partners. The survey will be implemented through the Department and the prevention lead agents. <u>The results of the survey should be assessed by the committee and presented at the April PCPG meeting.</u>	HIV Prevention Service providers	PCPG Interventions and Services Committee; PCPG Evaluation Committee	X	X			Prevention providers' survey developed, conducted and analyzed

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<b>Goal 4: Mitigate the impact of stigma and discrimination on HIV care, treatment and prevention.</b>							
Objective: Assess how the PCPG website and other social networking methods could be better used to link users to information about HIV prevention, care, and treatment resources and to reduce HIV stigma and homophobia.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
35. By February 2012, work with the PCPG website administrator to develop recommendations on how the PCPG website can be used to link users to a directory of HIV prevention, care, and treatment services, including links to the regional lead agents, HIV Care Connect and HIV/AIDS and STD hotline searchable database. <u>Present these recommendations at the February PCPG meeting.</u>	PCPG Website Administrator	Materials Review Committee	Q1 X	Q2	Q3	Q4	Assessment conducted and recommendations made
36. By February 2012, work with the PCPG website administrator to develop recommendations on how the PCPG website and other social networking methods could be utilized by the PCPG to provide education aimed at reducing HIV stigma and homophobia. <u>Present these recommendations at the February PCPG meeting.</u>	PCPG Website Administrator	Materials Review Committee	X				Assessment conducted and recommendations made
37. By June 2012, develop a plan for implementing the recommendations for enhancing the PCPG website and using other social networking methods to inform the community about HIV prevention, care, and treatment resources, and to reduce HIV stigma and homophobia.	PCPG Website Administrator	Materials Review Committee		X			Implementation plan developed
38. Ongoing in 2012, solicit input from the PCPG in the development of the jurisdictional HIV prevention plan.	PCPG Executive Committee and full PCPG	PCPG Coordinator	X	X	X		PCPG meeting minutes; draft and final jurisdictional plan

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Objective: Assess how the PCPG website and other social networking methods could be better used to link users to information about HIV prevention, care, and treatment resources and to reduce HIV stigma and homophobia.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
			<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	
39. Ongoing in 2012, solicit input from the PCPG in the development of the HIV engagement plan.	PCPG Executive Committee and full PCPG	PCPG Coordinator	X	X	X		PCPG meeting minutes; draft and final engagement plan
40. At the November 2012 PCPG strategic planning meeting for 2013, review and assess the completion of the strategies and activities identified in the 2012 engagement plan.	PCPG Executive Committee and full PCPG	PCPG Coordinator				X	PCPG strategic plan meeting agenda and minutes.
41. At the November 2012 PCPG strategic planning meeting for 2013, begin drafting the 2013 engagement plan.	PCPG Executive Committee and full PCPG	PCPG Coordinator				X	Draft 2013 Engagement Plan
42. By July 15, 2012 develop and train on curricula to include protocols and Provide ® data system procedures for Partner Services to be implemented in the HIV Care Connect regions.	Ryan White case managers	Direct Services and Training Units			X	X	Developed training curriculum and attendee evaluations

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Objective: Assess how the PCPG website and other social networking methods could be better used to link users to information about HIV prevention, care, and treatment resources and to reduce HIV stigma and homophobia.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
			<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	
43. By November 1, 2012, develop a multidiscipline program for implementing the 21 <sup>st</sup> Annual HIV/STD Conference that will address issues surrounding prevention, care, and clinical HIV and STD services that will build skills and enhance knowledge of those attending the conference.	HIV Section funded grantees, state and local health departments staff, nurses, counselors, social workers, public health professionals, case managers, social service and other community-based agency staff, HIV/STD educators, mental health and substance abuse counselors	HIV/STD Conference Planning Committee		X	X	X	Participant evaluations conducted - input is taken into consideration for future conference planning

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<b>Goal 4: Mitigate the impact of stigma and discrimination on HIV care, treatment and prevention.</b>							
Objective: Assess how the PCPG website and other social networking methods could be better used to link users to information about HIV prevention, care, and treatment resources and to reduce HIV stigma and homophobia.							
<b>2012 Key Strategies and Activities</b>	<b>Target Group</b>	<b>Lead Role</b>	<b>Timeline</b>				<b>Evaluation Indicator(s)</b>
			<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	
<b>44.</b> Ongoing, throughout 2012, the Illinois AIDS Drug Assistance Program (ADAP) has established the Illinois ADAP Medical Issues Advisor Board (AMIAB), which meets quarterly (4 times per year). The board is comprised of medical care providers; case managers; advocates; and Department staff. The intent of the meetings is to gather comprehensive feedback from a cross section of community providers and consumers in the guidance of policies and procedures being implemented by the program. The meeting is governed through the Illinois Open Meeting Act, and welcomes community representatives to participate in strategic planning. Meeting notices, agendas, meeting minutes, and other supporting documents are provided ahead of meetings to ensure informed collaboration participation. The advisory board influence ADAP formulary decisions, eligibility guidelines; legislative policies and procedures governing the program. The meetings are also used as a medium to network information across the state to providers and consumers.	HIV care and prevention service providers; medical care providers, HIV consumers; Ryan White Care statewide staff; legislative/governmental bodies; and pharmaceutical manufacturers	IDPH ADAP/CHIC Administrator	X	X	X	X	Meeting participation, meeting minutes, subcommittee reports, progress on action steps defined at board meetings, and provider/consumer feedback.

**Interventions Provider Questionnaire**  
**PCPG Interventions and Services Committee (edited draft)**

**This questionnaire is intended to collect data to provide a more in-depth understanding of non-DEBI HIV prevention services being delivered in the state of Illinois through Department funded programs. For the intent of this program; the definition of a homegrown intervention is “an agency-developed intervention intended to modify risk behavior.”**

**1) Not including DEBIs, is your agency delivering any homegrown interventions?**

Yes\_\_\_ No\_\_\_

**a. If yes, what specific risk/race group(s) (if any) do the interventions target? If more than one, select all that apply:**

- i. \_\_\_MSM**
- ii. \_\_\_HRH-F**
- iii. \_\_\_HRH-M**
- iv. \_\_\_IDU**
- v. \_\_\_African American**
- vi. \_\_\_Hispanic**
- vii. \_\_\_youth**
- viii. \_\_\_other \_\_\_\_\_**

**b. If yes, what is the name of the intervention(s)?**

\_\_\_\_\_

**c. Is there an evaluation component to the intervention?      Yes\_\_\_      No\_\_\_**

**i. If yes, what type of evaluation tools do you use (i.e. pre/post test)?**

\_\_\_\_\_

**ii. Did the evaluation results show that the intervention was effective?**

Yes\_\_\_ No\_\_\_

**iii. If yes, please briefly explain how.**

\_\_\_\_\_

**iv. Would you be willing to share your evaluation tool with the PCPG?**

Yes\_\_\_ No\_\_\_

**2) Are there any non-DEBI interventions you would like to deliver but need staff trained on? If so, please identify: \_\_\_\_\_**

**3) Are there any DEBIs you are interested in being training for and implementing? If so, please identify: \_\_\_\_\_**

**4) Are there any other areas related to the intervention(s) you need staff trained on (select all that apply):**

- a. \_\_\_ **Adapting DEBIs**
- b. \_\_\_ **Program implementation**
- c. \_\_\_ **Program evaluation**
- d. \_\_\_ **Outcome measurements**
- e. \_\_\_ **Other** \_\_\_\_\_

### PCPG 2012 Approved Interventions and Services General Recommendations

1. All prioritized populations shall be defined by *serostatus, risk and race/ethnicity* for inclusion in prevention funding documents, including, but not limited to, all requests for proposals (RFP) and scopes of service.
2. **Regional** prevention funding will be allocated to ensure that **total** funding is proportional to recent HIV infections (2006-2009) by risk and race/ethnicity, within that region.
3. In order to account for resource distribution, provider scopes should be written by risk, race/ethnicity, gender (if appropriate) and intervention with a value based upon *standardized regional unit costs*.
4. DEBIs (Diffusion of Effective Behavioral Interventions) must be used as defined by their core elements.
5. Regional prevention funding must include *prevention with HIV-positive* individual program(s) that provides *linkages to care and treatment*, interventions to improve *retention in care and treatment*, and/or interventions and *risk-reduction services* for HIV-positive individuals and their sexual or needle-sharing partners.
6. **Condom distribution** to HIV-positives and those at high risk of infection is a highly recommended structural intervention. Condom distribution must be accompanied by counseling and/or education or incorporated as an element of an approved behavioral intervention.
7. All HIV-positive individuals are prioritized and may be included in appropriate DEBIs.
8. All HIV-positive individuals should be immediately tracked, and referred into CARE services, including the AIDS Drug Assistance Program (ADAP).
9. All newly and ongoing diagnosed HIV positive individuals shall be offered *partner services*. Agencies must follow protocols specific to their status as a health department or a community-based organization (non-health department). Health departments may provide all steps of elicitation and notification associated with providing partner services including cases identified through surveillance records. Community-based organizations shall provide services up to and including partner elicitation, but shall not provide direct notification services unless officially designated by the Illinois Department of Public Health. Community-based organizations do have the authority to be present during a dual notification as requested by the index patient; however, unless officially designated by the Department, the community-based organization's role does not include direct notification of partners of positives identified through testing nor identification and direct notification of partners of positives reported through surveillance records.
10. The Department shall develop comprehensive Partner Services Program guidance, delineating the roles and responsibilities for community-based organizations and for health departments, including roles and responsibilities for select community-based organizations that have received contracted approval to administer partner services, including direct notification services.
11. Any *evidence-based, homegrown intervention* that is approved by the Department and the regional prevention lead agent may be used.
12. For IDUs, priority in funding decisions shall be given to agencies conducting comprehensive syringe exchange programs on site or with an agency that comes to their site to provide services.
13. **Transgender** individuals should be included in the appropriate population based on their behavioral risk and current gender identification.
14. Persons who have been victims of sexual assault since their last HIV test or have never been tested for HIV shall be included in all population categories.
15. All funded agencies must demonstrate to the lead agency in the RFP process they have the fiscal/organizational capacity to administer and implement all group and community level interventions via the completion of the Agency Readiness Assessment Tool that will be provided by IDPH to Lead Agencies for distribution to subcontracted agencies in the RFP process.

## Attachment 4. 2012 PCPG Priority Population Approved Interventions

### 16. For Group Prevention Support (GPS):

- a) HIV- positive individuals are the highest priority for targeted GPS. The intervention should focus on improving retention in care and treatment, partner safety, and other skills-building topics such as disclosure, coping skills, and condom negotiation.
- b) Agencies must target very high risk prioritized populations to include MSM, HRH, IDU and TG who report either condom less anal sex or shared works (syringes and injection drug use paraphernalia) within 12 months or to increase skill sets around treatment adherence, risk reduction, and other skills-building topics.
- c) Agencies must provide an open- or closed-ended skills building session to no more than 12 individuals. Agencies should refer to the Department's RFP for a definition of closed- and open-ended skills-building sessions.
- d) Agencies must submit a copy of the intended curriculum and pre- and post-test instruments documenting behavioral change measured outcomes to regional lead agent for review and approval.

### **2012 PCPG Approved Interventions and Services Additional Recommendations**

1. In SFY12, for all funded interventions, an agency must first assess the cost effectiveness of the intervention, staff time needed to implement the intervention, sustainability of the intervention, and other available fiscal and in-kind resources. Information on the requirements and expectations of DEBIs can be found at [effectiveinterventions.org](http://effectiveinterventions.org). A copy of the final "Handout 1: A Description of CDC/IDPH Approved Interventions and 2012 Proposals" will be included in the RFP as an attachment for further reference. Additional information should be provided by the Department to lead agencies and their subcontracted agencies in the RFP process.
2. For all funded interventions, each agency must utilize the comprehensive Community Discovery Assessment tool provided by the Department to lead agents and their subcontracted agencies as an attachment in the RFP process along with a plan for monitoring and evaluation which will include the collection of standardized process and outcome measures, as identified by the Department.
3. All funded public health strategies and interventions must include an approved recruitment component (outreach, social marketing, social networking, health communication/public information, internet, other approved).
4. Youth must be prioritized within all risk, race/ethnicity, and gender populations, in particular young MSMs.
5. Lead agents are responsible for evaluating regional epidemiological data and service delivery (essentially conducting a specific gap analysis) to determine regional unmet need. Using the PCPG 2012 Prevention Priority Population Listing as a guide, the regional gap analysis must be used to further identify and prioritize underserved populations within the respective region(s).
6. HIV positives within each priority population must be prioritized for prevention interventions.
7. All agencies funded to conduct an intervention (DEBI, homegrown, GPS) must themselves conduct, collaborate with another agency, or have referral agreements in place with other agencies to provide approved public health strategies (CTR, CRCS, STI screenings and vaccinations, partner services) to clients receiving the interventions, as needed. This is an example of Program Collaboration and Service Integration (PCSI).
8. All funded interventions must include an evaluation plan that describes the process/outcomes measurement methods that will be used to ensure the intervention is properly conducted and evaluated.
9. The Department must provide a program guidance evaluation plan for funded interventions.
10. Prior to the implementation of an intervention and/or public health strategy, agencies must attend a federal or state approved training.

#### Attachment 4. 2012 PCPG Priority Population Approved Interventions

11. The Department must provide funded agencies with procedural guidance to implement an intervention, providing examples, technical assistance and resources such as requesting CDC capacity building assistance (CBA), as needed.
12. In 2012, it is recommended that the PCPG Interventions and Services Committee research and develop recommendations on the following promising interventions for possible inclusion in the 2013 Interventions Recommendations: Peer Health Navigation , Antiretroviral Treatment Access Study (ARTAS), Salud, Edicacion, Prevencion y Autocuidado (SEPA), Family Life and Sexual Health (FLASH), CTL (Counsel, Test, Link), and Pre-Exposure Prophylaxis (PrEP).
13. Funded agencies shall incorporate *STI integration* into public health strategies/ interventions. The following services are available for provision according to MMWR 2010 STD Treatment Guidelines at STD Clinics outside of the city of Chicago and testing through the Department laboratory: HIV, gonorrhea, chlamydia, and syphilis testing; herpes PCR for clients with symptomatic lesions; hepatitis C testing (for IDUs only); and hepatitis A &B vaccination.

#### **2012 Recommendations for Adapting Evidence Based and Developing Homegrown Interventions**

Interventions must be adapted to meet the needs of people/populations that were not part of the studies that showed the interventions' efficacy. Adaptations must be consistent with the intervention and culturally relevance to the population with whom the work is to be done. Retain the intent and internal logic of the intervention's core elements in making the intervention practice culturally relevant. Adapting an intervention for new at-risk populations and new venues must involve formative program evaluation.

##### Adaptation procedures

Intervention specific adaptation, must engage the following six general procedures in accordance with CDC guidance:

1. Identify intervention components that need adaptation;
2. Collect information to form the procedures and materials;
3. Test the procedures and materials;
4. Document what you have done;
5. Implement, monitor and evaluate; and
6. Revise implementation materials, as needed.

Intervention specific adaptation must identify the health needs of the persons targeted, as well as their cultural experience. This is a first step to a culturally competent program. Intervention specific adaptation must adhere to the Office of Minority Health (OMH) in the Department of Health and Human Services published national standards for delivering services that reflect a group's culture and language. This is referred to as culturally and linguistically appropriate services (CLAS). Interventions specific adaptations targeting bisexual men of color must adhere to the CDC adaptation guide (adapting HIV behavior change interventions for gay and bisexual latino and black men).

The Department must provide funded agencies with procedural guidance on adaptations, providing examples, technical assistance and access to CDC CBA providers.

## Attachment 4. 2012 PCPG Priority Population Approved Interventions

Using an IDPH-specified format, agencies approved to conduct an adaptation of a DEBI must provide the lead agent and the Department with a summary of the outcomes of the intervention adaptation, to also include a qualitative report.

### **2012 Recommendations for Home Grown Interventions**

The Department must identify, evaluate and approve homegrown interventions used with special concerns populations when appropriate and when home grown interventions have proven behavioral outcome effectiveness.

Agencies choosing to implement a homegrown intervention must assure the following:

- Be feasible, practical, cost-effective, and have good potential for sustainability
- Have a low potential for adverse short- and long-term, individual-level and community-level outcomes that could be attributed to the implementation of the intervention
- Be acceptable and relevant to the target population
- Have sufficient time to allow for the collection of data demonstrating the degree to which the intervention works, as well as the impact the intervention has on broader community health
- Have the potential for additional health or social benefits that could result from its implementation

Based on a thorough examination of the health behavioral model literature, the CDC's Compendium of Effective Interventions, and the Tiers of Evidence Models, the Illinois PCPG recommends that jurisdictions combine a mix of homegrown and DEBI interventions that best fit its operations and target populations.

When applicable, interventions must address the following HIV-Public Health Strategy related services:

Proposed Approved Services/Strategies	
1.	Counseling, Testing and Referral Services (CTR)
2.	Comprehensive Risk Counseling Services (CRCS)
3.	Partner Services (Community-based Organizations)
4.	Partner Services (Health Departments)
5.	STI Screening
6.	Hepatitis A and B Vaccinations; Hepatitis B & C testing

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Key to Reading Priority Population Approved Interventions Tables

1. \* A dot indicates the intervention can be used with the specified risk population.
2. Specific age, race or gender requirements for an intervention are noted.

**1. HIV positive and HIV negative men who have sex with men (MSM): A high-risk MSM is defined as a) any male or transgender individual who has had condomless anal sex with a male or transgender individual in the past 12 months, or b) any male or transgender individual who has had condomless anal sex with a male since his last HIV test. A high-risk MSM youth is defined as any male or transgender individual, age 13-19 years, who reports ever having had anal or oral sex with a male or transgender individual, or who states he is sexually attracted to males or transgender individuals (for Health Education/Risk Reduction services only).**

Strategies and Interventions for Men Who Have Sex with Men (MSM) (subpopulations in no ranked order)									
Populations >	HIV positive MSM, all races and ages	African-American; age 25+	White; age 25+	Hispanic age 25+	African-American; ages 13-24	White, ages 13-24	Hispanic ages 13-24	Other races age 24+	Other races ages 13-24
<b>Approved Public Health Strategies</b> ▼									
Comprehensive Risk Counseling and Services (CRCS)	*	*	*	*	*	*	*	*	*
Counseling, Testing and Referral (CTR)		*	*	*	*	*	*	*	*
Partner Services (Community Based Organizations)	*	*	*	*	*	*	*	*	*
Partner Services (Health Departments)	*	*	*	*	*	*	*	*	*
Hepatitis A&B vaccination; Hep B testing	*	*	*	*	*	*	*	*	*
STI Screenings (gonorrhea, Chlamydia, and syphilis)	*	*	*	*	*	*	*	*	*
<b>Approved Interventions</b> ▼									
CLEAR (age 16 and above)	*	*	*	*	*	*	*	*	*
Community PROMISE	*	*	*	*	*	*	*	*	*
Cuídate!							*		
d-up: Defend Yourself!		*			*				
Focus on Youth (FOY) with ImPACT					*				
Group Prevention and Support (GPS)	*	*	*	*	*	*	*	*	*

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for Men Who Have Sex with Men (MSM) (subpopulations in no ranked order)									
Populations ➤	HIV positive MSM, all races and ages	African-American; age 25+	White; age 25+	Hispanic age 25+	African-American; ages 13-24	White, ages 13-24	Hispanic ages 13-24	Other races age 24+	Other races ages 13-24
<b>Healthy Relationships (age 18 and above)</b>	✱								
<b>Internet Risk Reduction Counseling (IRRC)</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Many Men, Many Voices (3MV)</b>		✱		✱	✱		✱		
<b>Mpowerment (ages 18-29)</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Partnership for Health (PFH)</b>	✱								
<b>Personal Cognitive Counseling (PCC)</b>		✱	✱	✱	✱	✱	✱	✱	✱
<b>Popular Opinion Leader (POL)</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Project START</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Respect</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Risk Reduction Counseling</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Safe in the City</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Shield</b>	✱	✱	✱	✱	✱	✱	✱	✱	✱
<b>Street Smart (ages 11-18)</b>	✱				✱	✱	✱		✱
<b>Together Learning Choices (ages 13-29)</b>	✱								
<b>VIBES</b>					✱		✱		

Attachment 4. 2012 PCPG Priority Population Approved Interventions

**2. HIV positive and HIV negative high risk heterosexuals (HRH): Females and males (including transgender individuals not included as MSM) engaging in condomless vaginal and/or anal sex with partners of the opposite sex, defined as any of the following:**

- HIV positive individuals
- Persons with HIV positive partner(s) of the opposite sex
- Persons with IDU partner(s) of the opposite sex
- Female partners of MSM
- Heterosexual males and females with two or more STDs in 12 months
- Persons who have had sex with six or more partners in the past month
- Females who have had unprotected sex with a male(s) released within the past year from an incarceration of one year or longer in any county, state or federal correctional facility

Points of Consideration for HRH individuals only:

The positivity rate of HRH increases as age increases. Blacks and Hispanics are more likely to test positive than whites. Women are less likely to test HIV positive if they report using condoms, but males who reported condom use were not less likely to test positive. Oral sex with someone of the opposite gender was not found to be a predictor of new positive tests. Females who reported having sex with known HIV positive individuals, MSM or IDU are more likely to test positive than the heterosexual population tested.

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations >	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Approved Public Health Strategies v														
Counseling, Testing and Referral (CTR)		*	*	*	*	*	*	*	*	*	*	*	*	*
Comprehensive Risk Counseling and Services (CRCS)	*	*	*	*	*	*	*	*	*	*	*	*	*	*

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations ►	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Partner Services (Community-based Organizations)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Partner Services (Health Departments)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Hepatitis A&B Vaccination; Hep B testing	*	*	*	*	*	*	*	*	*	*	*	*	*	*
STI Screenings (gonorrhea, Chlamydia, syphilis)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Approved Interventions ▼														
CLEAR ( age 16 and above)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Community PROMISE	*	*	*	*	*	*	*	*	*	*	*	*	*	*
CONNECT (age 16 and above)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cuídate!							*				*			
Focus on Youth (FOY) with ImPACT	*(African American, ages 12-15)		*(ages 12-15)						*(ages 12-15)					
Group Prevention and Support (GPS)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Healthy Relationships	*(age 18 or >)													

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations >	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Internet Risk Reduction Counseling (IRRC)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
NIA	*(African American, M 18 and up)			*(ages 18 and above)					*(ages 18 and above)					
Partnership for Health (PfH)	*													
Platicas de Comadres	* Hispanic F				*(Hispanic)		*							
Popular Opinion Leader (POL)	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Project AIM			*		*		*		*		*	*	*	*
Project START	*	*	*	*	*	*	*	*	*	*	*	*	*	*
RAPP	*(female only)	*	*		*		*			*(female only)			*	*
Respect	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Safe in the City	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Shield	*	*	*	*	*	*	*	*	*	*	*	*	*	*
SIHLE			*(ages 14- 18)				*(ages 14- 18) - with approved adaptation							
SISTA		*	*(age 18 and above)											
SISTA adaptation for Latinos age 18+ )					*(Hispanic F)		*							

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for High Risk Heterosexuals (subpopulations in no ranked order)														
Populations ➤	HIV positive HRH, all races, genders and ages	African-American F age 25+	African-American F ages 13-24	African-American M age 25+	White F age 25+ Hispanic F; age 25+ White, F; ages 13-24	Hispanic M, age 25+	Hispanic F, ages 13-24	White M, age 25+	African-American M ages 13-24	Other M, age 25 + Other F, age 25+	Hispanic M, ages 13-24	White M, ages 13-24	Other F, ages 13-24	Other M, ages 13-24
Sister to Sister		✱ (ages 18-45)	✱ (ages 18-45)											
Street Smart (ages 11-18)	✱		✱		✱		✱		✱		✱	✱	✱	✱
Together Learning Choices	✱ (ages 13- 29)													
VOICES/ VOCES (age 18 and above)	✱(African-American & Hispanic)	✱	✱	✱	✱ (Hispanic)	✱	✱		✱		✱			
WILLOW	✱(Females , ages 18-50)													

Attachment 4. 2012 PCPG Priority Population Approved Interventions

3. HIV positive and HIV negative injection drug user (IDU): A high-risk IDU is defined as a person who:
- Discloses sharing injection equipment or supplies in the last 12 months or since his or her last HIV test; or
  - Does not disclose injection risk, but displays visible signs of recent non-prescribed drug injection (specifically, fresh injection sites, injection abscesses, nodding off).

Strategies and Interventions for Injection Drug Users (IDU) (subpopulations in no ranked order)																	
Populations ▼	HIV positive IDUs, all races, genders and ages	African- American, M age 25+	African- American, F age 25+	White, M, age 25+	Hispanic, M, age 25+	White, F, age 25+	Hispanic, F, age 25+	African-American, F, ages 13-24	African-American, M, ages 13-24	White, F, ages 13-24	Hispanic, M, ages 13-24	White, M, ages 13-24	Hispanic, F, ages 13-24	Other races, M, ages 13-24	Other races, F, ages 13-24	Other races, F, age 25+	Other races, M, age 25+
Approved Public Health Strategies ▼																	
Comprehensive Risk Counseling and Services (CRCS)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Counseling, Testing and Referral (CTR)		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Partner Services (Community Based Organizations)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Partner Services (Health Departments)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Hepatitis A & B vaccination; Hepatitis B testing; Hepatitis C testing	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
STI Screenings (gonorrhea, Chlamydia, syphilis)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Approved Interventions ▼																	
CLEAR (age 16 and above)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Group Prevention and Support (GPS)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Healthy Relationships	* (age 18 and above)																

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for Injection Drug Users (IDU) (subpopulations in no ranked order)																	
Populations ➤	HIV positive IDUs, all races, genders and ages	African- American, M age 25+	African- American, F age 25+	White, M, age 25+	Hispanic, M, age 25+	White, F, age 25+	Hispanic, F, age 25+	African-American, F, ages 13-24	African-American, M, ages 13-24	White, F, ages 13-24	Hispanic, M, ages 13-24	White, M, ages 13-24	Hispanic, F, ages 13-24	Other races, M, ages 13-24	Other races, F, ages 13-24	Other races, F, age 25+	Other races, M, age 25+
Holistic Health Recovery Program (HHRP)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
IDU Harm Reduction Counseling	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Modelo de Intervencion Psicomédica (MIP) (age 18 and above)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Naloxone (in combination with syringe exchange)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Partnership for Health	*																
Popular Opinion Leader (POL)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Project START	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Respect	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Safety Counts	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Shield (age 18 and above)	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Together Learning Choices	* (ages 13- 29)																
WILLOW	* (Females, ages 18-50)																

Attachment 4. 2012 PCPG Priority Population Approved Interventions

**4. HIV positive and HIV negative MSM/IDU: Defined as any male who meets the combined definitions of MSM and IDU (#1 and 3 above), in this document.**

Strategies and Interventions for Men Who Have Sex with Men/Injection Drug User (MSM/IDU) (subpopulations in no ranked order)									
Populations >	HIV positive MSM/IDU, all races and ages	African-American age 25+	White age 25+	Hispanic age 25+	African-American ages 13-24	White, ages 13-24	Other races age 24+	Hispanic ages 13-24	Other races ages 13-24
Approved Public Health Strategies and Interventions▼									
All Public Health strategies and interventions approved for MSM or IDU populations are approved for MSM/IDU. See Tables 1 and 3 above for specific interventions.									

**Other Important points of consideration:**

Prevention with HIV positive individuals falling within any of the risks identified above should be a top priority within each subpopulation category and specific strategies to engage this population should be developed, including linkage to care and treatment. Prevention with positives should include reproductive health education for females and their partners, including linkage to perinatal care.

Transgender individuals are considered priority within each of the priority populations due to the alarming national HIV prevalence rates in this population and the severe social determinants impacting this population. Transgender identity does not mean an individual engages in risk behaviors and transgender individuals should be prioritized within each of the risk groups based on risk history and current gender identity.

**Transgender**

Strategies and Interventions for Transgender									
Populations >	HIV positive transgender individuals, all races and ages;	Male to female transgender individuals, female to male transgender individuals.							
Approved Public Health Strategies▼									
Comprehensive Risk Counseling and Services (CRCS)	*	*	*	*	*	*	*	*	*
Counseling, Testing and Referral (CTR)		*	*	*	*	*	*	*	*

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for Transgender									
Populations >	HIV+ transgender individuals, all races and ages;	Male to female transgender individuals, female to male transgender individuals.							
Approved Public Health Strategies v									
Partner Services (Community Based Organizations)	*	*	*	*	*	*	*	*	*
Partner Services (Health Departments)	*	*	*	*	*	*	*	*	*
Hepatitis A&B vaccination; Hep B testing	*	*	*	*	*	*	*	*	*
STI Screenings (gonorrhea, Chlamydia, syphilis)	*	*	*	*	*	*	*	*	*
Approved Interventions v	*	*	*	*	*	*	*	*	*
CLEAR (age 16 and above)	*	*	*	*	*	*	*	*	*
Group Prevention and Support (GPS)	*	*	*	*	*	*	*	*	*
Healthy Relationships	* HIV+ (age 18+)								
IDU Harm Reduction	*	*	*	*	*	*	*	*	*
Internet Risk Reduction Counseling (IRRC)	*	*	*	*	*	*	*	*	*
Partnership for Health (PFH)	*								
Personal Cognitive Counseling (PCC)	*	*	*	*	*	*	*	*	*
Popular Opinion Leader (POL)	*	*	*	*	*	*	*	*	*
Project START	*	*	*	*	*	*	*	*	*
Respect	*	*	*	*	*	*	*	*	*
Risk Reduction Counseling	*	*	*	*	*	*	*	*	*
Safe in the City	*	*	*	*	*	*	*	*	*

Attachment 4. 2012 PCPG Priority Population Approved Interventions

Strategies and Interventions for Transgender									
Populations ➤	HIV positive transgender individuals, all races and ages;	Male to female transgender individuals, female to male transgender individuals.							
Shield	*	*	*	*	*	*	*	*	*
Street Smart (ages 11-18)	*	*	*	*	*	*	*	*	*
TWISTA	*	*	*	*	*	*	*	*	*
WILLOW	*(Females, ages 18-50)								

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Care, Treatment, Housing, and Prevention Grant Resources							
Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Prevention Counseling and Testing (GRF)	Center on Halsted		07/01/2010-06/30/2011	\$250,000	\$250,000		Provide HIV rapid testing, confirmatory testing, prevention counseling, STD & hepatitis education & statewide referrals for medical, case management, substance abuse & mental health for individuals at risk for HIV infection; provide a minimum of 1,000 extended HIV counseling sessions which will include information about enhanced risk reduction, referrals & prevention counseling; All HIV + clients will receive support & information about partner notification; Provide group education cohorts for HIV positive individuals; Provide active linkage & referral to prevention case management or care case management services for newly diagnosed HIV positive individuals; Reach out to Latino affinity groups & engage their members in raising awareness, promoting programs, translating materials & referring members of the social networks to services including HIV CT & RR.
	Chicago Department of Public Health	8	01/01/2011-12/31/2011	\$455,000	\$455,000	CDPH clinics & other venues, coordinating with multiple HIV prevention community based agencies within the city of Chicago	Provide HIV CTR services with 16,000 people in CDPH clinic sites; Provide PS & linkage to care with at least 80% of all persons who test positive for HIV infection, including HIV testing with 20% of identified partners of index clients who test positive for HIV; Distribute 10 million condoms in a variety of HIV prevention efforts; Distribute 100,000 HIV prevention/education public information messages in print & other media forms; Conduct capacity building & training activities with community-based HIV prevention agencies
	Douglas County	6	07/01/2010-06/30/2011	\$60,000	\$60,000		Provide confidential HIV CTR services through outreach; Provide RR counseling, distribution of condoms, sexual responsibility kits, & educational materials to at least 80 at-risk Hispanic/Latino individuals; Provide individual level interventions through HED including assessing HIV risk behaviors & developing risk reduction plans with clients to 100 at-risk Hispanic/Latino individuals; Active linkage & referral to prevention case management or care case management services for all newly diagnosed HIV positive individuals identified through services funded under this agreement.
(Non-GRF)	PHIMC Routine Testing Amendment #1		10/01/2010-09/30/2011 12/31/2011	\$680,260 \$134,470 <hr/> \$814,730	\$0	Work with Midwest AIDS Treatment & Education Center (MATEC) for additional training and technical assistance for sites implementing routine opt-out HIV testing.	Continue routine HIV testing with seven community health centers & replicate the model with four additional clinical sites; Develop & maintain a fee-for-service reimbursement system with the Department to support HIV testing, PS & linkages to care for newly identified HIV-positive persons; Ensure at least 90% of persons receiving a positive HIV test in an STD clinic receives counseling & PS & referral to an HIV care case manager & attends first appointment with documented evidence; Ensure 90% of newly diagnosed HIV-positive persons are referred to care with documented evidence of attendance, with 85% receiving appropriate STD, Hepatitis, & STD & TB screenings during the initial visit.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Prevention Education (GRF)	AFC- Harm Reduction/ Sharps Disposal	1, 3, 4, 6, 7, 8,	07/01/2010-06/30/2011	\$520,000	\$520,000	Chicago Recovery Alliance, Community Outreach Interventions Project at University of Illinois-Chicago, Total Health Awareness Team, Sisters and Brothers Helping Each Other, Care Point, Test Positive Aware Network, Champaign Urbana Public Health District, Bethany Place, Young Women's Empowerment Project, & The Phoenix Center	Statewide harm reduction system (distribute 6,120 sharps containers & educational material on safe syringe disposal practices throughout Illinois, provide pharmacy access system coordination, & promote pharmacy-based syringe access & the Sharps Container Program through conducting regular outreach & education to pharmacies). Provide evidence-based prevention services to at least 2,880 unduplicated IDUs (distribute social marketing materials regarding project services to IDUs within target areas using peers, street mobile outreach in high risk venues & distribute harm reduction educational materials risk reduction supplies & referral information to IDUs, increase number of outreach sites in which IDUS can consistently access HIV prevention education materials & risk reduction supplies, distribute sterile syringes & harm-reduction materials at outreach sites & fixed-project sites).
	Salud Latina		07/01/2010-06/30/2011	\$75,000	\$75,000		Assess the participation of new high risk Latinos/Hispanics in CTR & other HIV prevention & treatment services in IL; Deliver capacity building assistance (CBA), long distance training on Latino issues, resources linkage & treatment adherence (TA) to increase professional proficiency in addressing the needs of Latino at-risk groups; Conduct four forums in representative geographic regions of Illinois identifying challenges & assets that impact utilization of HIV prevention & care services by Latinos in Illinois.
	The Children's Place Assoc.		07/01/2010-06/30/2011	\$60,000	\$60,000		
	Chicago Child Care Society		07/01/2010-06/30/2011	\$60,000	\$60,000	Collaborate with Chicago Public High Schools, alternative high schools, Juvenile justice settings, & other community service organizations & institutions through the Grantee's Safe Life/HIV Prevention Program	Implement five HIV/AIDS prevention interventions: 1) single –session Safe Life HIV/AIDS, STD Prevention group presentations presented in both English and Spanish; 2) Focus on Youth with ImPact HIV/AIDS prevention intervention groups (8- week small group intervention, with single session parent-child intervention); 3) HIV rapid testing with pre-& post- test counseling & referral; 4) Safe Life presentation will be offered as part of a regular activity or group in which youth participate; 5) Parents of those youth who give signed consent for participation in Focus on Youth with be recruited to participate in ImPact; Maintain & establish HIV/AIDS prevention education/counseling & testing services to the adolescent high-risk heterosexual, gay, bi-sexual, African-American, & Latino populations in Chicago communities; Facilitate condom information & testing site information; Active linkage & referral to prevention case management or care case management services for all newly diagnosed HIV positive individuals identified through services funded under this agreement.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Prevention for Positives (GRF)	Test Positive Awareness Network		07/01/2010-06/30/2011	\$75,000	\$75,000		Provide Treatment, Education, Advocacy, & Management (TEAM) core training to 75 HIV-positive individuals; Conduct an 18-hour peer education workshop to 75 HIV-positive individuals; Conduct three 3-hour TEAM educational update sessions to 50 HIV-positive individuals; Provide one-to-one peer counseling sessions to five HIV positive individuals.
	FCAN		07/01/2010-06/30/2011	\$125,000	\$125,000		Hold 2 Red Ribbon Trails retreat for HIV infected and HIV affected families at accessible locations throughout Illinois; Facilitate six conference calls for the Red Ribbon Alliance to families living with HIV/AIDS by providing therapeutic support & education about HIV/AIDS and parenting, with progress measured through surveys; Develop a statewide teen advisory committee of 10 to 12 HIV-positive youth to discuss issues of importance to HIV-positive youth & plan programming to meet identified needs; Provide consumers and providers statewide with HIV disclosure counseling, planning, & ongoing support.
Prevention Lead Agencies (GRF)	Sangamon County	3	01/01/2011-12/31/2011	\$182,950	\$105,402		Serve as the Department's regional HIV prevention lead agency for Region 3; Provide monitoring & oversight of regional provision of HIV prevention services funded via sub-grants derived from this grant agreement; Conduct sub-grantee administration, monitoring, quality assurance, & evaluation processes; Monitor & observe in person the actual delivery of HIV prevention services; Provide technical assistance & develop corrective action plans based upon sub-grantee assessment.
	Champaign/Urbana Amendment #1	6	01/01/2011-12/31/2011	\$241,434	\$236,184.00 \$5,250.00		Serve as the Department's regional HIV prevention lead agency for Region 6. Conduct sub-grantee administration, monitoring, quality assurance, and evaluation processes; Ensure that sub-grantees providing HIV counseling and testing offer partner services to all newly-identified, HIV-positive persons; Ensure that sub-grantees conducting counseling & testing link all HIV- positive clients to Ryan White Case Management within 48 hours of a confirmed positive result; Assist with the development of the Department HIV prevention plan by providing information on regional HIV prevention services, service needs, community forums, & focus group activities in the region as requested.
	Illinois Public Health Association Amendment #1	1, 2, 4, 5, 7, 8,	01/01/2011-12/31/2011	\$3,096,307	\$1,698,984.00 \$144,750.00		Serve as the Department's Regional HIV Prevention Lead Agency for regions one, two, four, five, seven, and eight.
Misc. (GRF)	Center on Halsted Renewal #1		07/01/2010-06/30/2011	\$354,748	\$354,748		Toll-free statewide STD/HIV/AIDS Hotline operated seven days a week, a state AIDS information clearinghouse, & maintains a directory of statewide HIV/AIDS & STD service agencies & resources
	Pediatric AIDS Chicago Prevention Initiative		07/01/2010-06/30/2011	\$191,863	\$191,863	Northwestern Memorial Hospital Perinatal Center	Hotline services include real-time 24/7 English and Spanish HIV medical consultation for perinatal care providers and social service consultation for immediate linkage of newly diagnosed pregnant women to HIV/OB care. Hotline vendor must: Assist providers seeking guidance related to appropriate HIV treatment guidelines for HIV positive pregnant women and their newborn infants, link preliminary positive mothers and their newborn infants to intensive case management, link HIV positive pregnant women to HIV/OB care and other services necessary to ensure optimal treatment, refer HIV positive women who deliver in hospitals that do not provide HIV primary care and link them to the appropriate expert HIV provider, provide callers with information on medical & social service resources in their specific geographic area.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Ryan White Lead Agencies (GRF)	AFC- Cook	8	04/01/2011-03/31/2012	\$1,423,290	\$260,000	AIDS Legal Council of Chicago; Alexian Brothers/Bonaventure House; Catholic Charities of Chicago & Lake Co.; Cermak Health Services; Chicago House & Social Service Agency; Chicago Womens' AIDS Project; Children's Place Association; Christian Community Health Center; Erie Family Health Center; Haymarket Center/McDermott Center; Healthcare Alternative Systems; Heartland Human Care Services; Hektoen Institute/Austin Health Center; Hektoen Institute/Provident Hospital of Cook Co.; Hektoen Institute/The CORE Center; Howard Brown Health Center; Interfaith House; Lawndale Christian Health Center; Near North Health Service Corporation; Test Positive Aware Network; UIC; Vital Bridges.	Legal services; Housing services; Medical case management (including treatment adherence); Mental health services; Food bank/Home-delivered meals; Substance abuse services - outpatient; Outpatient/Ambulatory health services; Oral health care; Early intervention services
	AFC- Cook Amendment #1	8	04/01/2011-03/31/2012	\$2,694,321	\$260,000		
	AFC- Collar	7	04/01/2011-03/31/2012	\$240,415	\$80,000	Agape Missions; Alexian Brothers The Harbor; DuPage CHD (EIS); DuPage CHD (MH); Lake CHD; Open Door Clinic; Peoples Resource Center; Regional Care Association	Emergency financial assistance; Housing services; Medical case management (including treatment adherence); Early intervention services; Mental health services; Outpatient/Ambulatory health services; Oral health care; Food bank/Home-delivered meals; Substance abuse services-outpatient

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
	AFC- Collar Amendment #1	7	04/01/2011-03/31/2012	\$420,679	\$80,000		
	Champaign	6	04/01/2011-03/31/2012	\$460,285	\$120,000	Carle Foundation Hospital; Carle Foundation Physician Services, LLC; Carle Healthcare Inc.; Carle Physician Group; Danville Poly Clinic; GCAP Harvest to Home; Hellen McDonald Counseling; Improving Smiles PC; Infectious Disease Specialists Ltd.; Kevin Elliott Counseling; Provena St. Mary's Hospital; Raffi K. Leblebiiian, DDS, LLC; Tim Shea, LCSW	Outpatient/Ambulatory health services; Food bank/Home-delivered meals; Mental health services; Oral health care
	Champaign Amendment #1	6	04/01/2011-03/31/2012	\$460,285	\$120,000		

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
	Winnebago	1	04/01/2011-03/31/2012	\$455,391	\$120,000	Action Taxi Service; Ben Gordon Center; Community Health Care; Community Kitchen Inc.; Crusader Community Health; DeKalb CHD; Dental Dreams; Katherine Shaw Bethea Hospital; Prairie State Legal Services Winnebago; Rock River Valley Pantry; Rockford Infectious Disease Clinic; Sinnissippi Centers Dixon; Southpark Psychology; Sterling Rock Falls Clinic; SwedishAmerican Reference Laboratory; The Project of the Quad Cities; Tri-County Community Health Center; Troy J. Roeder; Voluntary Action Center; Whiteside CHD	Medical transportation services; Mental health services; Oral health care; Outpatient/Ambulatory health services; Food bank/Home-delivered meals; Medical case management (including treatment adherence); Legal services; Psychosocial support services; Treatment adherence counseling (non-medical)
	Winnebago Amendment #1		04/01/2011-03/31/2012	\$818,732	\$120,000		
	Jackson	5	04/01/2011-03/31/2012	\$210,393	\$80,000	Ace Taxi; Cape Radiology Group; Center for Medical Arts (SIMS); CHESI; Crosstown Cab; Dr. Cynthia Clark; Dr. Frederick Gustave; Heartland CARES Inc.; Laboratory Corporation of America; Shawnee Health Services; SIH/Memorial Hospital of Carbondale; SMART Transportation	Medical transportation services; Outpatient/Ambulatory health services; Mental health services; Oral health care
	Jackson Amendment #1	5	04/01/2011-03/31/2012	\$351,654	\$80,000		

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
	Board of Trustees of the University of Illinois (Peoria)		04/01/2011-03/31/2012	\$354,497	\$100,000		
	Board of Trustees of the University of Illinois (Peoria) Amendment #1		04/01/2011-03/31/2012	\$630,203	\$100,000		
	SIU School of Medicine	3	04/01/2011-03/31/2012	\$472,643	\$120,000	A & E Behavioral Health Care Association P.C.; Adams CHD; Adams Co. Retired & Senior Volunteer Program RSVP; CHELP Inc.; DMH Decatur Memorial Hospital; DMH Decatur Memorial Group; DOVE Inc.; Get a Life Coaching & Counseling Services; Homestyle Inn & Suites; JMJ Dental Inc.; Land of Lincoln Legal Assistance Foundation; Memorial Medical Center; Personal Counseling Services; Quincy Medical Group; Ruth Kathryn Pearson; Springfield Clinic; Tabb Dental Lab	Mental health services; Medical case management (including treatment adherence); Oral health care; Medical transportation services; Outpatient/Ambulatory health services; Emergency financial assistance; Housing services; Legal services; Substance abuse services-outpatient
	SIU School of Medicine Amendment #1	3	04/01/2011-03/31/2012	\$854,674	\$120,000		

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
	St. Clair	4	04/01/2011-03/31/2012	\$499,509	\$148,500	Behavioral Health Alternatives; Catholic Social Services; Coordinated Youth and Human Services; Densel Jines, DMD; Duane Davis, DMD; East Side Health District; Food Outreach, Inc.; Helping Hands; Interfaith Residence; Land of Lincoln Legal Assistance Foundation, Inc.; New Day Family Dental; Smile Team Dental; Southern Illinois Healthcare Foundation; Timothy Case, DMD; Washington University School of Medicine	Psychosocial support services; Mental health services; Emergency financial assistance; Medical transportation services; Food bank/Home-delivered meals; Medical case management (including treatment adherence); Treatment adherence counseling (non-medical); Oral health care; Outreach services; Medical nutrition therapy; Housing services; Legal services; Outpatient/Ambulatory health services; Special projects funded with state GRF
	St. Clair Amendment #1	4	04/01/2011-03/31/2012	\$879,769	\$148,500		
Ryan White Amendments (Non-GRF)	St. Clair HD	4	04/01/2010-3/31/2011	\$77,000	\$0		
	UIC Peoria	2	04/01/2010-3/31/2011	\$60,701	\$0	Central Illinois Friends of PWA Inc.; OSF System Laboratory; Peoria City County Health Department	Medical transportation services; Housing services; Outpatient/Ambulatory health services; Oral health care
	Winnebago HD	1	04/01/2010-3/31/2011	\$99,800	\$0		
Ryan White Care Connect-Other (Non-GRF)	Central Illinois FRIENDS		04/01/2011-03/31/2012	\$85,000	\$0		
Ryan White Part A (Hard Hit Urban Areas)	City of St. Louis			\$677,579	Missouri (Illinois allocation)	St. Clair CHD	Outpatient /Ambulatory care, AIDS pharmaceutical assistance, Oral health care, Medical case management, Treatment adherence, Food bank/Home-delivered meals; Funds provided to "eligible metropolitan areas" (EMAs), those with a cumulative total of more than 2,000 reported AIDS cases over the most recent 5 year period, and "transitional grant areas" (TGAs), those with 1,000-1,999 cumulative reported AIDS cases

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Ryan White Part C (Community Based Early Intervention)	Crusaders Central Clinic Association	1 (Also provide services across the regional lines)		\$410,197			Early intervention services (EIS): to reach people newly diagnosed with HIV with services such as HIV testing, Case management, and RR counseling; Core Medical Services: Outpatient/ ambulatory health services, Medications, Pharmaceutical assistance, Oral health care, Health insurance premium & cost sharing assistance for low-income individuals, Home health care, Medical nutrition therapy, Hospice services, Home & community-based health services, Mental health services, Substance abuse outpatient care, & Medical case management including treatment adherence services
	Open Door Clinic of Greater Elgin	7 & 8		\$243,750			Early intervention services (EIS): to reach people newly diagnosed with HIV with services such as HIV testing, Case management, and RR counseling; Core Medical Services: Outpatient/ ambulatory health services, Medications, Pharmaceutical assistance, Oral health care, Health insurance premium & cost sharing assistance for low-income individuals, Home health care, Medical nutrition therapy, Hospice services, Home & community-based health services, Mental health services, Substance abuse outpatient care, & Medical case management including treatment adherence services
	Southern Illinois Healthcare Foundation	4		\$590,738			Early intervention services (EIS): to reach people newly diagnosed with HIV with services such as HIV testing, Case management, and RR counseling; Core Medical Services: Outpatient/ ambulatory health services, Medications, Pharmaceutical assistance, Oral health care, Health insurance premium & cost sharing assistance for low-income individuals, Home health care, Medical nutrition therapy, Hospice services, Home & community-based health services, Mental health services, Substance abuse outpatient care, & Medical case management including treatment adherence services
	University of Illinois at Peoria	2		\$635,031			Early intervention services (EIS): to reach people newly diagnosed with HIV with services such as HIV testing, Case management, and RR counseling; Core Medical Services: Outpatient/ ambulatory health services, Medications, Pharmaceutical assistance, Oral health care, Health insurance premium & cost sharing assistance for low-income individuals, Home health care, Medical nutrition therapy, Hospice services, Home & community-based health services, Mental health services, Substance abuse outpatient care, & Medical case management including treatment adherence services
Ryan White Part D (Women, Infant, Children, and Youth)	Washington University			\$1,329,612.00 13.4% of the total clients served by Project ARK are Illinois residents. As such, a proportional amount (\$99,224.78) of Part D funding goes to support services for Illinois clients	From Missouri (Illinois allocation)	The majority of Illinois clients served receive their HIV medical care from Washington or Saint Louis University HIV clinics; some of the WICY clients receive care from Southern Illinois Health Care Foundation. Project ARK has partnered with the Department, Saint Clair CHD, and SIHF to develop and implement two key initiatives: 1) Perinatal Case Management (PCM); and 2) Youth Intervention Specialist.	Project ARK (AIDS/HIV Resources and Knowledge) provides family-centered & community-based services to children, youth, & women living with HIV & their families, including outreach, prevention, primary & specialty medical care, & psychosocial services; supports activities to improve access to clinical trials & research for these populations. Project ARK provides a range of services which are integrated into the delivery of HIV medical care at Part D partner clinics & includes: medical case management, linkage to care services, mental health/substance abuse evaluation, adherence counseling, patient retention activities, support groups, transportation, child care, & HIV prevention education. Project ARK also provides HIV testing, early identification, & HIV prevention services for at-risk WICY populations.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Ryan White Part F (Minority AIDS Initiative for Part A Grantees)	City of St. Louis			\$55,000	From St. Louis (Illinois allocation)	Southern Illinois Healthcare Foundation for linkage to care case manager	Respond to growing concern about the impact of HIV on racial and ethnic minorities in the United States.; provides funding across several DHHS agencies/programs to strengthen organizational capacity & expand HIV-related services in minority communities.
Housing (GRF)	Bethany Place		07/01/2010-06/30/2011	\$75,000			Establish collaborative partnerships with local agencies, organizations and medical providers to increase accessibility to critical services for people with HIV; Provide supportive housing for 20 persons living with HIV; Provide comprehensive on-site case management services for 20 homeless individuals living with HIV who will be placed in permanent housing; Provide life skills and/or resources to achieve & maintain stable income to 95 percent of all residents entering program with no income; Provide life skills training & skill building groups to increase understanding of adherence to medication, symptom management, & independent living skills training to persons living with HIV; Collaborate with local continuum(s) of care to identify permanent housing resources to low income persons living with HIV.
	Fifth Street Renaissance / Sara Center		07/01/2010-06/30/2011	\$75,000	\$75,000		Establish collaborative partnerships with local agencies, organizations and medical providers to increase accessibility to critical services for people with HIV; Provide transitional or permanent housing for 15 persons living with HIV; Provide comprehensive on-site case management services for 25 homeless individuals living with HIV; Provide prevention counseling & testing services for at least 15 persons living with HIV and their partners; Conduct two workshops on drug addiction & healthy living skills for 15 persons living with HIV.
	Greater Community AIDS Project		07/01/2010-06/30/2011	\$55,000	\$55,000		Establish collaborative partnerships with local agencies, organizations and medical providers to increase accessibility to critical services for people with HIV; Provide life skills training sessions for 75 persons living with HIV; Provide comprehensive on-site case management services for 12 individuals living with HIV who reside in transitional housing; Transition five persons living with HIV into permanent housing; Provide emergency health & housing financial assistance for 75 persons living with HIV; Collaborate with local continuum(s) of care to identify permanent housing resources to low income persons living with HIV.
	Phoenix Center		07/01/2010-06/30/2011	\$75,000	\$75,000		Establish collaborative partnerships with local agencies, organizations and medical providers to increase accessibility to critical services for people with HIV; Provide safe transitional housing for 55 homeless men & women who are living with HIV; Provide housing case management services for 55 homeless men & women who are living with HIV; Provide HED & RR training for at least 75 persons living with HIV; Provide individual addiction counseling for 28 persons living with HIV; Provide supportive services for 50 persons living with HIV.
	Heartland Human Care Services		07/01/2010-06/30/2011	\$100,000	\$100,000		Establish collaborative partnerships with local agencies, organizations and medical providers to increase accessibility to critical services for people with HIV; Provide supportive services to assist 90 persons living with HIV located in residential housing; Provide nutritional meals at each housing site to assist 170 individuals living with HIV; Provide comprehensive on-site case management services for 90 homeless individuals living with HIV who will be placed in permanent housing; Provide art therapy session twice weekly for 70 persons living with HIV; Provide life skills education related to preparing healthy meals to 85 persons living with HIV; Collaborate with local continuum(s) of care to identify permanent housing resources to low income persons living with HIV.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Housing (GRF)	Asian Human Services		07/01/2010-06/30/2011	\$75,000	\$75,000		Establish collaborative partnerships with local agencies, organizations and medical providers to increase accessibility to critical services for people with HIV; Provide housing enrollment & assessment for 40 persons living with HIV; Provide comprehensive on-site medical case management services for 20 homeless individuals living with HIV who will be placed in permanent housing; Provide at least three persons living with HIV six months subsidies housing with the goal of becoming financially independent through employment; Provide 20 individuals living with HIV access to at least two HIV/AIDS medical care providers.
	AIDS Legal Council		07/01/2010-06/30/2011	\$40,000	\$40,000		Assist at least 160 unduplicated HIV-positive individuals with no income identify public benefits income programs for which they may be entitled, Assist at least 50 unduplicated HIV-positive individuals with no health insurance identify public or private plans for which they may be entitled, Advise at least 75 unduplicated HIV-positive individuals with Medicare about their options for pharmacy coverage providing enrollment assistance when necessary, Advise at least 45 unduplicated HIV-positive individuals at risk for losing their access to public or private insurance about options.
HOPWA	Alexian Brothers The Harbor		01/01/2011-12/31/2011	\$20,000			Case management and operating costs
	Greater Community AIDS Project		01/01/2011-12/31/2011	\$20,000			Case management and operating costs
	Fifth Street Renaissance		01/01/2011-12/31/2011	\$20,000			Case management and operating costs
	DelaCerde House		01/01/2011-12/31/2011	\$20,000			Case management and operating costs
	Phoenix Center		01/01/2011-12/31/2011	\$20,000			Case management and operating costs
HOPWA Amendments to Ryan White	AFC		1/1/2011-3/31/2011	\$12,754			Ryan White Lead Agency Grant
	Champaign HD		1/1/2011-3/31/2011	\$18,623			Ryan White Lead Agency Grant
	Jackson HD		1/1/2011-3/31/2011	\$13,544			Ryan White Lead Agency Grant
	SIU School of Medicine		1/1/2011-3/31/2011	\$15,667			Ryan White Lead Agency Grant
	St. Clair HD		1/1/2011-3/31/2011	\$4,000			Ryan White Lead Agency Grant

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
HOPWA Amendments to Ryan White	UIC Peoria		1/1/2011-3/31/2011	\$41,137			Ryan White Lead Agency Grant
	Winnebago HD		1/1/2011-3/31/2011	\$44,216			Ryan White Lead Agency Grant
HOPWA Lead Agent Grants	AIDS Foundation of Chicago		4/1/2011-12/31/2011	\$51,014			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
	Champaign-Urbana Public Health District		4/1/2011-12/31/2011	\$74,491			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
	Jackson CHD		4/1/2011-12/31/2011	\$54,175			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
	St. Clair CHD		4/1/2011-12/31/2011	\$16,000			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
	SIU School of Medicine		4/1/2011-12/31/2011	\$62,669			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
	UIC College of Medicine		4/1/2011-12/31/2011	\$164,550			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
	Winnebago CHD		4/1/2011-12/31/2011	\$202,865			These grants are awarded to HIV regional administrative offices to provide housing and support services to low-income, uninsured, or underinsured people in Illinois living with HIV disease.
Minority Health (MAI)	Aunt Martha's Youth Center	8	07/01/2011-06/30/2012	\$65,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	Asian Human Services	9	07/01/2011-06/30/2012	\$60,000			Provide outreach and education projects targeting HIV positive individuals linking client to medical care.
	Brothers Health Collective, The	9	07/01/2011-06/30/2012	\$45,000			Provide outreach and education projects targeting HIV positive individuals linking client to medical care.
	Brothers Health Collective, The	9	07/01/2011-06/30/2012	\$80,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Champaign Urbana Public Health District	6	07/01/2011-06/30/2012	\$40,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Champaign Urbana Public Health District	6	07/01/2011-06/30/2012	\$20,000			Provide syphilis testing and linkage to care services for men having sex with men and partners.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Minority Health (MAI)	Chicago Recovery Alliance	9	07/01/2011-06/30/2012	\$85,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Community Wellness Project	4	07/01/2011-06/30/2012	\$45,000			Provide syphilis testing and linkage to care services for men having sex with men and partners.
	Fifth Street Renaissance	3 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$225,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	Illinois Public Health Association	3 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$100,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	McDermott Center	9	07/01/2011-06/30/2012	\$60,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Project of the Quad Cities	1	07/01/2011-06/30/2012	\$60,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	Project of the Quad Cities	1	07/01/2011-06/30/2012	\$60,023			Provide outreach and education projects targeting HIV positive individuals linking client to medical care.
	Prologue, Inc.	9	07/01/2011-06/30/2012	\$60,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	Puerto Rican Cultural Center	9	07/01/2011-06/30/2012	\$30,000			Provide syphilis testing and linkage to care services for men having sex with men and partners.
	Regional Care Association	7 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$39,225			Provide outreach and education projects targeting HIV positive individuals linking client to medical care.
Regional Care Association	7 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$70,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.	

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
Minority Health (MAI)	Regional Care Association	7 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$60,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Renz Addiction Counseling Center	7	07/01/2011-06/30/2012	\$75,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Sisters Helping Each Other	7	07/01/2011-06/30/2012	\$40,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	South Side Help Center	9	07/01/2011-06/30/2012	\$60,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	Southern Illinois Healthcare Foundation	4	07/01/2011-06/30/2012	\$30,000			Provide outreach and education projects targeting HIV positive individuals linking client to medical care.
	Springfield Community Federation	3 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$60,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Springfield Urban League, Inc.	3 (Also provide services across the regional lines)	07/01/2011-06/30/2012	\$175,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	TaskForce Prevention & Community Services	9	07/01/2011-06/30/2012	\$75,000			Utilizing CDC approved DEBI, provide outreach and education services targeting at-risk populations.
	TaskForce Prevention & Community Services	9	07/01/2011-06/30/2012	\$100,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.
	Tower of Refuge, Inc.	3	07/01/2011-06/30/2012	\$100,000			Provide HIV outreach and education services to include HIV counseling and testing services and referral for care.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
QOL (GRF)	Asian Human Services		09/01/2010-12/31/2011	\$120,000	\$120,000		Provide HIV CTR to 300 high-risk individuals; Provide comprehensive risk reduction counseling & services (CRCS) sessions; Conduct group prevention & support sessions consisting of HIV 101, healthier relationships, negotiate for safer sex, HIV/STI testing, partner testing, healthy living, HIV treatment options, & related services; Conduct community outreach (street/ fixed sites) & provide condoms; provide HIV/AIDS peer education & outreach in selected communities & townships; Enroll clients to ongoing quarterly health education workshops & support groups; Conduct Partner Services for HIV positive persons. High risk populations included are: MSM, black male HRH, black female HRH, limited English speaking Asian Americans
	Bayard Rustin Access Center		01/01/2011-12/31/2011	\$100,000	\$100,000		Provide HIV CTR to black MSM; Conduct four cycles of Many Men Many Voices intervention; Conduct PS for HIV-positive persons; Conduct individual level interventions at 6 events including: World AIDS Day, National HIV Testing Day, African American HIV Awareness Day, LGBT Pride Citywide, LGBT Black Pride, and Community Health & Wellness. Intervention activities will include condom & safe-sex kit distribution, health communication, HIV risk assessment.
	Chicago Child Care Society Amendment #1		09/01/2012 - 12/31/2011 06/30/2012	\$209,991	\$174,991.00 \$35,000.00	For positive clients, referrals will be made to the Chicago Department of Public Health Specialty Clinics. Clients whose confirmatory HIV tests are positive will be referred to the CORE Center.	Provide comprehensive HIV prevention, education, CT services to those at risk or living with HIV through the QOL program; Provide seven cycles of Focus on Youth with ImPACT (FOY) reaching AA & Latino youth 13-24 years of age; Conduct CTR sessions with black MSM, black female HRH, black male HRH, Hispanic female HRH & Hispanic male HRH, 13-24 years of age; Provide monthly drop-in support meetings to reach HIV positive youth 13-24 years of age; Conduct PS for HIV-positive persons.
	Emmaus Ministries		01/01/2011-12/31/2011	\$144,407	\$144,407	Subcontract with MATEC for Prevention with Positive Training for staff & volunteers. Subcontract with a Department-approved agency to refer clients for HIV Counseling & Testing as well as Partner Counseling Referral Services.	Conduct targeted outreach activities to 100 MSM sex workers to increase awareness of HIV & behavioral risk; Distribute verbal & written information on HIV/STI testing, safer sex & RR kits, counseling & testing information, & other non-HIV support services; Conduct 75 RRC sessions with 70 black MSM, two White MSM, and three Hispanic MSM; Conduct weekly group prevention & support (GPS) sessions reaching approximately 75 MSM; Refer all HIV-positive clients to Ryan White care & case management; Conduct PS for HIV-positive persons.
	Harm Reduction Outreach (To Be Part of THAT)		09/01/2010-12/31/2011	\$99,289	\$99,289		Conduct 110 CTR sessions with 40 black female HRH, 10 black MSM, 20 white MSM, 20 Hispanic male HRH, 10 Hispanic female HRH & 20 white FHRH; Conduct 185 risk reduction counseling (RRC) sessions with 60 black female HRH, 15 black MSM, 40 white MSM, 20 Hispanic male HRH, 20 Hispanic female HRH and 30 white FHRH; Facilitate provider focus group containing stakeholders for each priority population; Facilitate "population specific" community focus groups containing seven to 15 people per population for each priority population, Implement a community assessment survey; Conduct Real AIDS Prevention Project reaching 75 black HRH females; Conduct four sessions of Popular Opinion Leader reaching 25 white MSM and 5 black MSM between 18 – 64 years of age; Conduct key informant interview, surveys, & focus groups to identify an evidence based intervention for use with FHRH sex workers; Conduct PS for HIV positive persons.

Attachment 5. State Fiscal Year and Federal Fiscal Year 2011 Illinois HIV Grant Resources –May 30, 2012

Type	Agency / Company	Region(s)	Funding Term	Total Funding	GRF	Subcontractors	Description of Services
QOL (GRF)	Phoenix Center		9/1/2010-8/31/2011	\$100,000	\$100,000		Provide HIV testing to at least 92 individuals determined to be at high risk of HIV infection; Offer CTR sessions for those who present risks for HIV. Testing will be offered five days per week during outreach efforts in the community for ages 35 and under; Offer partner counseling & referral services (PCRS) & link new positives into CARE & other services; Provide one-on-one harm reduction counseling sessions to 25 white MSM/IDU and 15 African-American MSM/IDU to reduce HIV transmission among the population; Conduct the intervention “Popular Opinion Leader (POL)” through outreach efforts in the community the population congregate (i.e. bars and schools).
	Phoenix Center Amendment #1		09/01/2010 - 08/31/2011 12/31/2011	\$100,000	\$100,000		Conduct the intervention RESPECT & risk reduction counseling through outreach in the community where the target population congregates, (i.e. bars and schools); Phoenix Center staff will: conduct a community assessment to identify and address the community needs, services, locations & within each targeted populations (i.e. WMSM, AA MSM, W MSM/IDU and AA MSM/IDU). Also staff will use the community assessment to identify gatekeepers, stakeholders and other venues.
	Proactive Community Services		01/01/2011-12/31/2011	\$100,000	\$100,000		Conduct 12 cycles of SISTA consisting of five weekly sessions for approximately 72 high-risk African-American women, 18-39 years of age, with two recruited AA peer educators; Conduct one cycle of SISTA consisting of five weekly sessions that incorporates reproductive HED for 10 teen females, junior and senior students, 16-19 years of age, attending the Regional Institute for Scholastic Excellence (R.I.S.E.) School, Chicago Heights Campus; Conduct targeted outreach activities to 200 high-risk AA females 18 years of age & older at homeless shelters, substance abuse facilities, community centers, park districts, & beauty shops; Participate in an on-going community discovery process within the service region; Conduct partner services for HIV-positive persons.
	Southern IL Healthcare Foundation		01/01/2011-12/31/2011	\$175,000	\$175,000		Identify 15 African-American HIV-positive gay/bisexual youth 13-24 years of age who have left medical CARE & re-engage these individuals by completing linkage agreements & document linkages; Provide face-to-face HED RR messages targeting 125 youth & adult African- American MSM through community outreach; For identified HIV-positive individuals provide referrals & linkages to CARE; Provide 3 cycles of Many Men, Many Voices with 15 African-American MSM reaching 45 individuals; Provide three cycles of SISTA with 30 African- American women; Provide HIV pre-post counseling & testing, RR counseling & group prevention activities for 125 individuals recruited via community outreach in targeted local venues.
	Southern IL Healthcare Foundation Amendment #1		01/01/2011 - 12/31/2011 06/30/2012	\$210,000	\$175,000.00 \$35,000.00		Provide comprehensive HIV prevention, education, counseling and testing services to those at risk or living with HIV through the QOL Program
ADAP	MATEC		4/1/2012 - 3/31/2013	\$119,419			Conduct chart audits in Part B-funded HIV clinics that prescribe antiretroviral medications under IL-ADAP. The audits will assess the extent to which clinics are enrolling clients in Illinois ADAP and providers’ ability to meet clinical guidelines for HIV/AIDS treatment. Additionally, MATEC will develop, coordinate, & deliver a series of trainings to meet the needs of IDPH funded providers.

Revised 5/30/2012 by J. LaFata

