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

April 14, 2017, 9:30 am-12:00 pm

- **9:30 am:** Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence

  The Co-chairs welcomed everyone to the meeting, introduced the facilitator and presenters then led the group in recognizing a moment of silence for our HIV community.
- Review agenda

  The Co-chair reviewed the agenda items with participants.
- **9:35 am:** Webinar process; Attendance; Announcements; Updates
  - Webinar meeting, online meeting survey, and online discussion board instructions

    Instructions for the webinar and accessing meeting documents, the online meeting survey, and the discussion board were explained. The survey and discussion board will close on April 21st.
  - Attendance will be taken by announcing members logged in, taking roll call of voting members, and sign-in sheets from host sites

    The names of members who had logged into the webinar were announced and roll call of other voting members was called. IDPH staff members on the call were also announced. Members not present will have the opportunity to review the presentation slides and view the recorded meeting.
  - Review meeting objectives and Concurrence checklist

    The primary goal of the planning group and its alignment with the goals of the National HIV/AIDS Strategy (NHAS) was reiterated by the Co-Chair. She recognized the importance of community engagement and input in the planning process. The meeting objectives were reviewed.
  - Announcements

    Participants were reminded that all documents for this meeting are available online at www.ilhpg.org/webinar. Previous 2016 and 2017 meetings and their corresponding documents are also available for review on the website. Articles for the summer edition of the Integrated ILHPG/ RWPB Advisory Group Newsletter are due by May 26th. RWPB Advisory Group Members were reminded to complete the required Open Meetings Act training by April 30th if not yet complete (ILHPG members completed the training in March). It was reported that 19 community/ agency representatives in addition to voting members and regular non-voting members had participated in ILHPG/ Integrated meetings thus far in 2017.
- **9:50-10:20 am:** Present, discuss, and vet Proposed IHIPC Bylaws, Procedures, and Membership Plans -

  Jeffrey Maras, IDPH Ryan White Part B Administrator, Integrated Planning Steering Committee Co-chair

  Janet Nuss, IDPH HIV Planning Coordinator, Integrated Planning Steering Committee Co-chair

  Janet provided an overview of work done thus far by the Integrated Steering Committee 2, which was formed to help guide development of the Illinois HIV Integrated Planning Council (IHIPC) by 2018 and to draft new IHIPC Bylaws and Procedures. She recognized and thanked the committee for their great work and

commitment to the planning process. Janet reviewed the proposed mission and purpose of the IHIPC with the group. She reminded them that the mission, purpose, and other proposed components of the group directly align with the goals of NHAS and the expectations of federal Prevention and Care partners.

The presentation focused on providing an overview of the bylaws and procedures related to the structure and function of the IHIPC and proposed membership composition. Janet explained the target composition of the IHIPC: 27elected voting members that represent all regions, both care and prevention, and a variety of service areas and areas of expertise; 1 appointed IDPH voting member (IHIPC Coordinator/Government Co-chair); and 7 appointed governmental programmatic representatives/EMA/TGA planning council liaisons. Specific membership targets (see list in presentation) will be prioritized. She also explained that up to 3 at-large members will be selected from the applicant pool. These non-voting members will have the opportunity to fill in any unexpected vacancies in elected membership that may occur throughout the year for various reasons. At-large members will be held to the same requirements as voting members (committee and full meeting attendance, completing trainings, etc.). Other non-voting members like IDPH staff and community stakeholders that regularly attend committee and full body meetings will still be a part of the IHIPC. The IHIPC will also be led by a steering committee that will consist of the following leaders: Government Co-Chair, Community Co-chair, Community Co-chair Elect; Parliamentarian; Secretary; and Co-chairs of four standing committees (Primary HIV Prevention Committee, Linkage/ Retention/ Reengagement/ Antiretroviral Therapy/ Viral Suppression Committee; Epidemiology/ Needs Assessment Committee, and the Membership Committee).

Janet noted a few caveats for IHIPC's initial year regarding membership. The typical procedure for membership selection will be completion of an application followed by a phone interview of applicants conducted by established Interview teams(s). For IHIPC's initial year, however, the membership application process will not include phone interviews as a large pool of applicants is expected. This will keep the task more manageable for the Steering Committee. Next, the bylaws state that each IHIPC voting member will hold a two year term with an opportunity to extend their membership for an additional two years. In order to avoid losing all our knowledgeable and experienced members at the end of the first two-year term, IHIPC members elected in 2018 will be randomly assigned to two or three year terms to keep membership "staggered". Assignments will be made across all regions and areas of representation to ensure equitable representation.

In addition to reviewing bylaws and procedures related to membership, Janet reviewed the tentative 2018 IHIPC schedule (see presentation). The group will continue to function under modified Robert's Rules of Order and the Illinois Open Meetings Act. She reported that the full text of the draft IHIPC Bylaws and Procedures will be released to the full group after the May 11 meeting for review/comment. She encouraged everyone to review the document, share it with the community, and send any questions or recommended modifications to her for consideration. After input from the full group is collected, the steering committee will discuss the recommendations and incorporate any changes into the final draft of the Bylaws and Procedures, which will be shared with the full group and voted on at the August 24th Meeting (tentative). ***Important Note:*** *Janet explained that there is a possibility that both the Integrated Planning Group and ILHPG August meetings may have to be moved to July due to an earlier Prevention grant application deadline than in previous years (If the concurrence vote is due at the same time as the application and we find out that both are due in early August, the meetings will likely need to be scheduled in correspondence with this due date). Janet has asked CDC for guidance and is awaiting a response. She will keep the full group updated on this possible schedule change as she receives a response.*

- Questions & Answers, Discussion, Input –

  Comment: *Jill said that the committee had done wonderful work.*

  There were no questions about the presentation during the meeting. Janet encouraged participants to contact her with questions/comments after the meeting.

- **10:20-10:55 am:** Demonstration of Linkage Between 2017 RW Part B Application and Budget and Integrated Plan Priorities -

  : NHAS Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH), and Goal 3(Reduce HIV-Related Health Disparities); Steps of the HIV Care Continuum: All steps

  Jeffrey Maras, IDPH Ryan White Part B Program Administrator

  Jeff provided an overview of IDPH's 2017 Ryan White Part B Grant Application, which included explanations of budgeting and alignment with the priorities of the Integrated Plan. He noted that the application, which was due in November, was a collaborative effort among the HIV Care Unit.

  Jeff began by reviewing the components of the grant application: Introduction and Executive Summary; Organization Staffing Chart (centralized model for ADAP and CHIC, decentralized Consortia Model for Care); Epidemiological & Unmet Need (completed with help from the Surveillance Unit); Care Service

Overview of the Consortia (included overview of needs assessments and core and supportive services); Implementation Tables (includes comprehensive goals and objectives as well as HRSA funding totals for all core and supportive services scopes as well as outlines for operational procedures for ADAP-MAP and CHIC-PAP (example included in the presentation)); and a Full Budget Narrative (includes a line item budget analysis on funding usage and the grant making process for decentralized work) . Jeff mentioned that Illinois is eligible to complete for an ADAP supplemental award, and it is reported in the Implementation Tables. Jeff cautioned that the Implementation Tables only include HRSA funded dollars. GRF awards (including HRSA required state revenue matches) were not included in this application but will be reported to the group by Jeffrey at the May meeting when he presents on FFY 2016 HIV Care service delivery. Jeff continued by explaining the many assurance and agreement procedures included in the award process that the Care Unit abides by to ensure appropriate use of funding through accounting and data systems. These include the ADAP-MAP Statewide Profile Report (3-year profile); Maintenance for Effort and Match reports; IDPH Federal Agreements, Compliances, and Assurances; and Audit and Federal Reporting signoffs.

Jeff presented estimates of how this year's Care awards (state and federal) will be distributed by category. The graphs include the full award amounts for the following areas: MAP/PAP (71% of total award), DSU/ Care (21% of total award), MAI (1% of total award), Corrections (5% of total award), HOPWA (2% of total award (HUD funding)). Graphs of the projections of funding for Consortia core and supportive services were also included in the presentation (please see presentation for detailed breakdowns). The distribution of core/ supportive services abides by the 75/25 split funding rule as mandated by HRSA. Service projections for MAP/PAP were also included in a separate graph.

Jeff noted that the final report on the 2016 Care budget and outcomes will be presented at the Integrated Meeting in May.

- Questions & Answers, Discussion, Input -

  There were no questions about the presentation during the meeting.

- **10:55 – 11:40 am:** Chicago Area HIV Integrated Services Council (CAHISC) Overview and Update -

  : NHAS Goal 4(Achieving a More Coordinated National response to the HIV Epidemic); Steps of the HIV Care Continuum: All steps

  Cynthia Tucker, AIDS Foundation of Chicago, CAHISC Liaison to the ILHPG

  Peter McLoyd, CORE Center, CAHISC Community Co-chair

  Cynthia and Peter co-presented on the transition to Chicago Area HIV Integrated Services Council's (CAHISC), an integrated planning council, and its current planning/ membership processes. As a planning body representing the Chicago EMA, CAHISC's jurisdiction includes the City of Chicago, Suburban Cook County, and 8 collar counties. Cynthia explained how past events/activities led to development of a fully HIV integrated group from Prevention, Care, and Housing planning bodies. Local/federal findings in HIV care and prevention pointed the city towards integration in 2012. Challenges faced in this process included community pushback, assurance of balance between Prevention and Care programs, integration of housing in planning, synchronization of planning cycles, and creation of integrated bylaws/procedures and planning guidance. Respectful transition of current members from separate planning bodies was something that was a concern of planners. Despite challenges, the transition was made possible with support from HIV stakeholders, federal partners, planning body leadership, and CDPH leadership.

  Similar to Illinois' current integration efforts, an Integration Work Group was formed to create a new Integration Model guided by review of previous Care and Prevention Planning Models. Jurisdictional models from other states, TGAs, and EMAs were reviewed. The Work Group included 12 CDPH employees and 14 community members. In order to avoid conflict of interest in the member selection process, an ad hoc Selection Committee was also formed to compliment the Work Group. The Selection Committee reviewed the Ryan White Primer and Prevention Planning Guidance to develop scoring criteria for candidates. Candidates were ranked and approved CDPH and the Mayor's Office before beginning their terms.

  Peter continued by explaining the next steps of integration. He noted that a large, collective epidemiological data review was completed to properly conduct an integrated Prevention and Care needs assessment to identify the communities most vulnerable to HIV. After this data review, the CAHISC vision was developed:" Develop a city-wide plan that identifies and addresses how housing, treatment, substance abuse, mental health, and other essential services can prevent HIV infections through suppressed viral load and behavioral interventions". The following committee structure was also developed: Primary Prevention and Early Identification Committee; Linkage and Retention to Care Committee; Adherence/Access to ART & Viral Suppression Committee; Membership and Community Engagement

Committee; and the Steering Committee. All committees are in alignment with NHAS goals and the steps of the Continuum of Care, and each performs gap analyses to recommend high priority services within the context of their committee goals (see presentation for detailed responsibilities of committees). Work within committees is structured to prevent perpetuating Care and Prevention silos within the planning group. Peter reviewed the Chicago Continuum of Care and indicated that measures at each step/ committee have improved since the initiation of the integrated group and hopes that CAHISC's work contributed to these outcomes.

Peter concluded by reviewing CAHISC's next steps which include a reduction in voting members for better member engagement, possible restructuring of committees to support Chicago's Getting to Zero Initiative, better inclusion of housing representatives/stakeholders in the HIV planning process, increasing access to PrEP and supportive services for people who are at-risk of acquiring HIV, and the continuation of strategic planning for the new health care landscape.

- Questions & Answers, Discussion, Input - (10 minutes)

  Question: *Janet asked "How and at what time was CAHISC's leadership established?" Janet noted that elected leaders and committee Co-chairs will not be immediately established on the IHIPC, since we are estimated it will take at least six months to get our committees fully in place and the co-chairs selected. She wondered how CAHISC had addressed that.*

  Answer: *Peter said that the leadership of the group was selected at the first membership retreat. Cynthia noted that the retreat took place approximately a year into the planning process after CAHISC, new guidelines, job descriptions, and bylaws were created and in place. Peter mentioned that CAHISC also had staggered terms for members at the initiation of the group.*

  Comment: *Catherine said that it was a great presentation.*

  Comment: *Cynthia noted that CAHISC is working on making some revisions to its bylaws. There will now be 30-36 voting members, 6 mandatory liaison voting members, and 1 voting CDPH member. This reduction in members is being initiated in hopes of better engagement/participation from members.*

  Comment: *Peter applauded Illinois for making the move towards integration. It is rationalized and an effective to holistically look at the epidemic.*

  Comment: *Janet thanked Peter and said that we have been guided by learning from other integrated planning bodies such as CAHISC.*

  Comment: *Mildred thanked the presenters for their reports.*

  Comment: *In support of Cynthia's comment, Janet said that planning group bylaws and procedures are dynamic documents. They will need to be reviewed regularly and may need to be modified based on new guidance or direction from our federal funders or because plans do not always work as anticipated. Janet clarified that changes in the bylaws are not indications of poor planning group performance.*

  Question: *Candi asked "Can you talk more about breaking down Prevention and Care silos on the planning group?"*

  Answer: *Janet noted that when creating new IHIPC committee structures, it was pointed out that committees can become siloed, for instance, if the Primary Prevention Committee includes mostly prevention representatives and the Linkage/Retention/Re-egagement/AVR/Viral Suppression Committee includes mostly care representatives. In making committee assignments, we know we need to be cautious that this does not happen, because that could perpetuate silos. We want to ensure that the IHIPC will be fully integrated at all levels. Peter agreed and said CAHISC had a similar experience.*

- Public Comment Period/Parking Lot -

  There was no request for public comment at this time.

- Adjourn

  The meeting adjourned at 11:40 am.

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