INTEGRATED HIV/AIDS PLANNING IHAP TA CENTER

targetHIV.org/IHAP

HIV Care Continuum

Integrated HIV Prevention and Care Plan 2017-2021: A Roadmap for Collection Action in Illinois

REGION	Midwest
PLAN TYPE	Integrated state-only prevention and care plan
JURISDICTIONS	State of Illinois
HIV PREVALENCE	High

Illinois' HIV Care Continuum is a clear example of a combined prevalence-based (for first step) and incidence-based (for last four steps) model. There are strong visual depictions of HIV Care Continuum disparities based on gender, race/ethnicity, and age and describes disparities for at least three key populations. In addition, this section contains a very detailed description of how the HIV Care Continuum informs plan activities and how it will share community viral load data with the community.

SELECTION CRITERIA: HIV CARE CONTINUUM

Exemplary HIV Care Continuum sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Description of diagnosed- or prevalence-based HIV Care Continuum, including the numbers with clear definitions of numerators and denominators, for each step in the HIV Care Continuum
- ☑ Clear visuals of the HIV Care Continuum
- ☑ Description of HIV Care Continuum disparities among key populations
- ☑ Description of how the HIV Care Continuum informs Integrated Plan activities and use of available resources in response to needs of people living with HIV (PLWH) in the jurisdiction
- ☑ Description of how the HIV Care Continuum is used to improve engagement and outcomes of PLWH

Additional exemplary plan sections are available online: www.targetHIV.org/exemplary-integrated-plans

HOPWA provides housing assistance and supportive services for low-income people living with HIV/AIDS and their families who are at risk for homelessness. Eligibility in Illinois is based on 80 percent of the area median income. Funds are used for emergency and short-term rental, mortgage, and utility assistance; currently Winnebago County Health Department provides Tenant-based Rental Assistance (TBRA), a long-term rental assistance program. HOPWA also assists with emergency out of pocket HIV-related expenses that threaten the ability of PLWHA to stay in their home A portion of HOPWA funds are awarded to AIDS-designated housing facilities for the following purposes: provision of meals and lodging to residents; rehabilitation and repair of facilities, operating costs—which may include maintenance, security, insurance, utilities, furnishings, equipment, supplies, and other incidental costs; and supportive services such as case management, mental health counseling, and substance abuse treatment provided to facility residents.

Of the 470 individuals living with HIV/AIDS who were served by HOPWA in FY 2015, approximately six percent were under 17 years of age, 11 percent were 18 to 30 years of age, 68 percent were between the ages of 31 to 50, and 15 percent were 51 or older. Almost seven in 10 HOPWA clients in Illinois in that fiscal year were male; 68.4 percent were white, 26.5 percent were black, 3.9 percent were Hispanic, 0.2 percent were Asian/Pacific Islander, and 0.5 percent were Native American or Alaskan Native.

By helping low-income PLWHA in Illinois access stable housing, HOPWA funds play an important role in maintaining access to HIV care and treatment. All 470 PLWHA served through the Illinois HOPWA formula grant had contact with a primary health care provider at least once in the calendar year.

Community Health Centers

The National Association of Community Health Centers reports that the 42 federally funded community health centers in Illinois serve 1,153,336 patients in 450 health center sites across Illinois. Of those patients, 30.4 percent are uninsured. Community health centers play an important role throughout the state in helping people become aware of their HIV status and ensuring that PLWHA get the full benefits of care and treatment.

In June of 2016, HRSA awarded 12 community health centers in Illinois a combined $4,374,000 to increase access to integrated oral health care services and improve oral health outcomes for their patients.

HIV Care Continuum

The goal of the Illinois HIV Care Continuum, formerly the Cascade, is to achieve viral suppression for PLWHA in order for them to stay healthy, live longer, and reduce the probability that they will transmit HIV. The five steps of the continuum—HIV disease diagnosis, linkage to care, retention in care, antiretroviral use, and viral load suppression—identify the necessary care components to achieve individual viral suppression and community suppression rates that have far-reaching implications not only for the quality of life for PLWHA but also for the health care system.

Monitoring the HIV Care Continuum requires collaboration across surveillance, prevention, and care. Tracking the proportion of people at each step of the Care Continuum helps guide IDPH, planning body, and community partner efforts to allocate and use resources effectively, plan programs and services, increase diagnosis rates, improve linkage to and retention in care, and increase antiretroviral use. To maximize the utility of the Care Continuum, IDPH collects, analyzes, and distributes Care Continuum data by region.

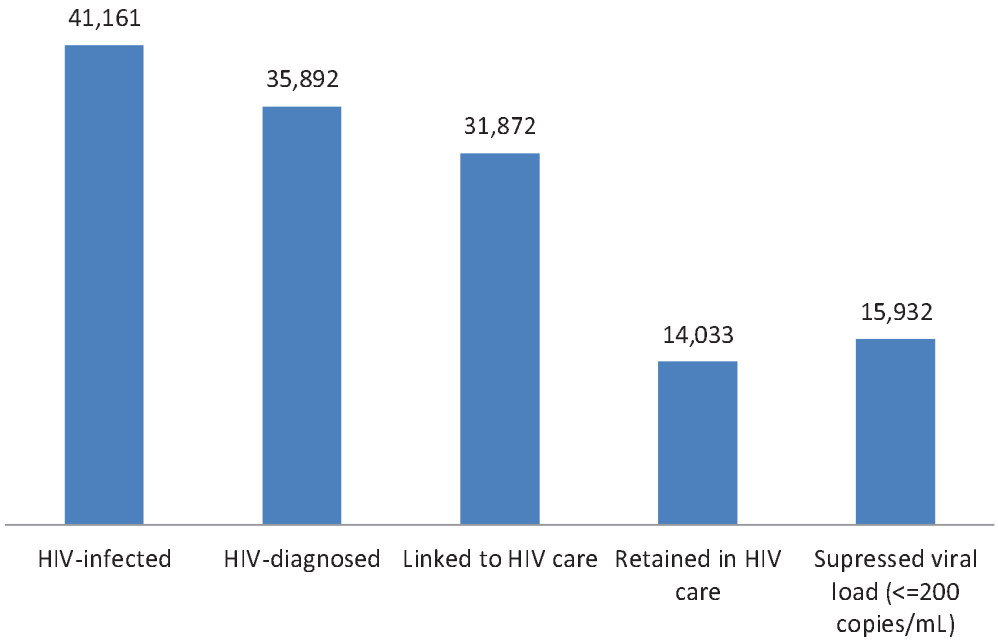
The Illinois HIV Care Continuum is prevalence-based for the first step and incidence-based for the other four steps. The HIV disease diagnosis step of the continuum is calculated as a percentage of the total number of PLWHA in Illinois, which includes people who have been diagnosed with HIV/AIDS and an estimated number of people who are HIV positive but have not yet been diagnosed. For the latter number, Illinois uses CDC's national estimate that 12.8 percent of people who are HIV positive are unaware of their status. Retained in care is defined as persons who had two or more care visits, at least 3 months apart, between January 1, 2015 and December 31, 2015. Because data on antiretroviral use in Illinois is incomplete, some of the analyses in this section do not include this step. Viral suppression is defined as persons whose most recent viral load test result between January 1, 2015 and December 31, 2015 was ≤ 200 copies/ml. Therefore, viral suppression can be achieved in one annual visit, and viral suppression rates may surpass retention in care rates in the HIV Care Continuum.

Overview

Based on surveillance data reported through June 30, 2015, 36,965 people received an HIV disease diagnosis and were living with HIV/AIDS on December 31, 2014. Total 2014 HIV estimated prevalence was 41,161; this figure includes 5,269 people who were estimated to be unaware of their HIV-positive status according to CDC's current estimate that 12.8 percent of HIV-positive individuals nationally are unaware of their status (see Figure 48). Further breakdown of these figures is included in the analyses that follow.

Figure 48

Estimate of Persons Infected with HIV Not in Care and Engagement in HIV Care in Illinois for Persons Diagnosed with HIV Infection (Age ≥ 13 Years) Through 12/31/2014 and Living with HIV on 12/31/2015



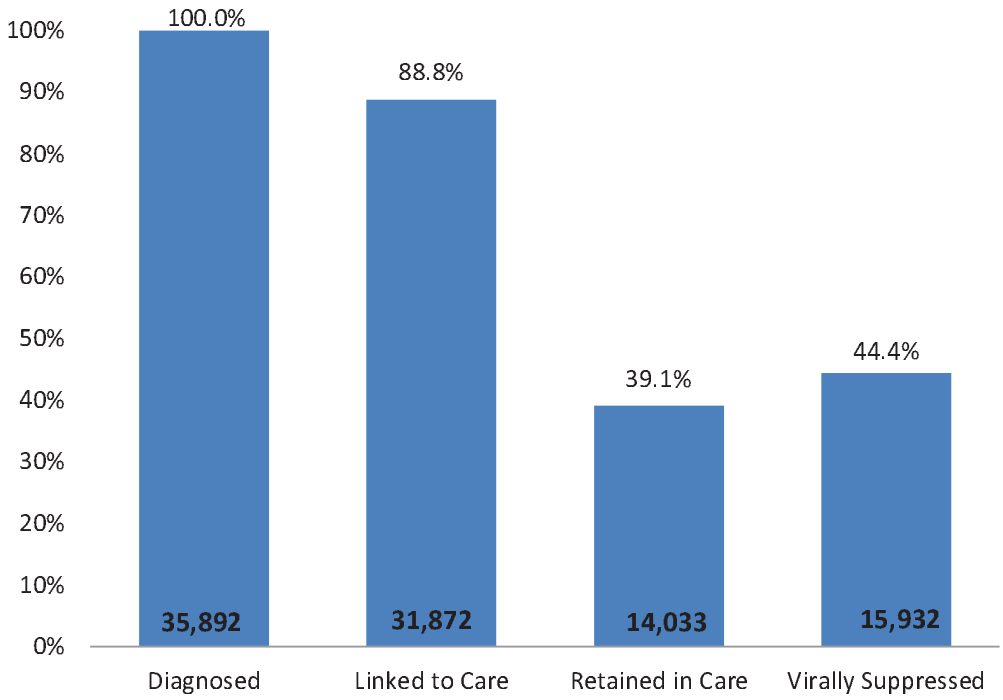
Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data
Diagnosed: Based on 9/2015 CDC report that 12.8% of HIV-infected individuals were unaware of their serostatus.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Retained in Care: Persons who had ≥two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.

Source: IDPH, HIV Surveillance Unit.

Figure 49 on the following page shows the percentage of people ≥13 years of age who were living with diagnosed HIV disease in Illinois in 2015 at four steps of the HIV Care Continuum.

Figure 49

Engagement in HIV Care for People Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015, Illinois



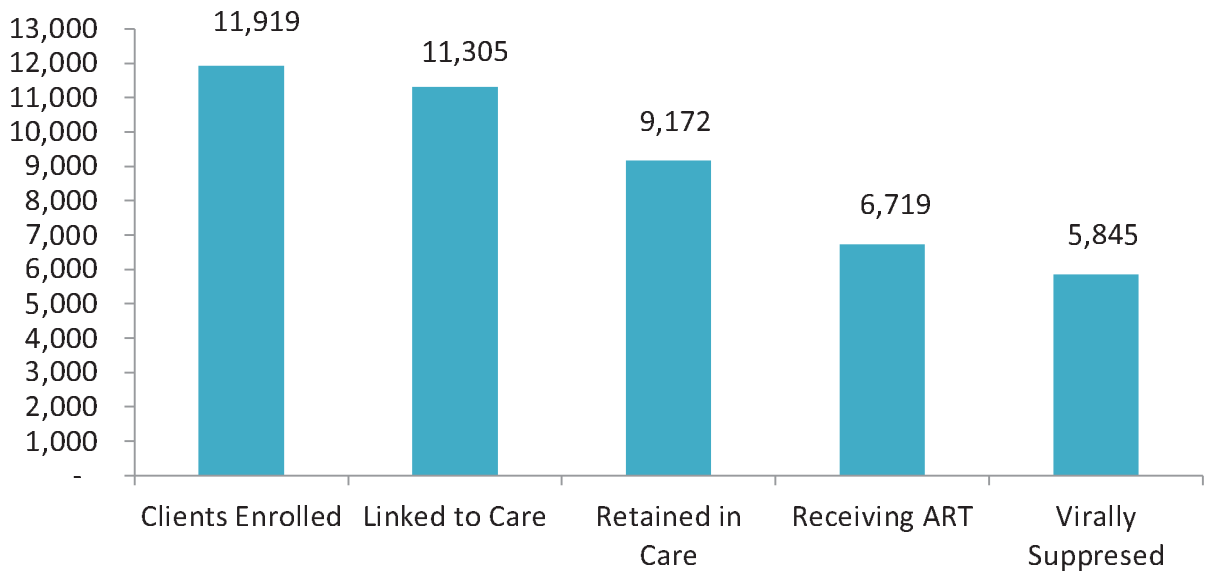
Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data
Diagnosed: based on 9/2015 CDC report that 12.8% of HIV-infected individuals were unaware of their serostatus.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Retained in Care: Persons who had ≥ two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally Suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.

Source: IDPH, HIV Surveillance Unit.

On the following page, Figure 50 shows the number of Ryan White Part B clients ≥13 years of age who were living with HIV disease in Illinois in 2014 at each step of the HIV Care Continuum. According to Ryan White Program data, 49 percent of clients enrolled in any Part B program and 86 percent of clients receiving ART were virally suppressed.

Figure 50

Engagement in HIV Care for Ryan White Part B Clients ≥13 Years, Illinois 2015



Source: Illinois Department of Public Health, Ryan White Part B Program. Data as of March 31, 2016

HIV/AIDS Diagnosis

In 2014, 1,670 people—13 per 100,000 population—were diagnosed with HIV disease in Illinois. Approximately 30 percent of these new diagnoses were late, which is defined as a diagnosis that did not occur until the person either had AIDS at the time of diagnosis or developed AIDS within 12 months of that initial diagnosis. Late diagnoses are missed opportunities to achieve the goals of the HIV Care Continuum—helping individuals stay healthy, live longer, and reduce the probability that they will transmit HIV to others.

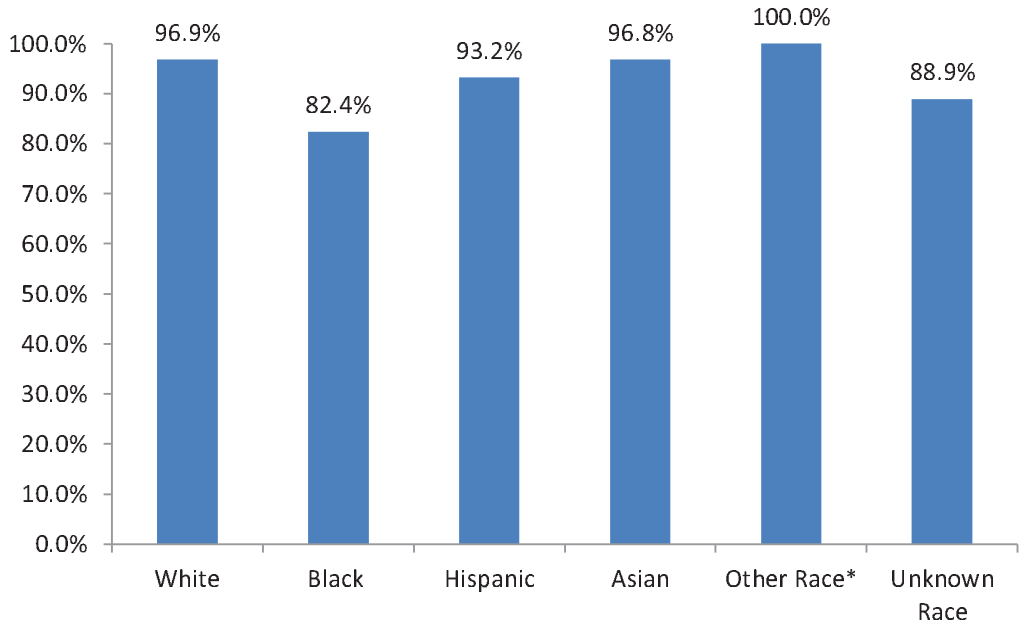
Linkage to Care

Approximately 89 percent of individuals diagnosed with HIV disease in Illinois in 2014 were linked to care within three months of diagnosis. On the following pages, Figures 51 and 52 show linkage to care rates by sex and race/ethnicity for people who were diagnosed with HIV in 2015. The numbers of new diagnoses varies among different racial/ethnic groups and are listed for males and females in Tables 3 and 4 on the following pages, respectively.

Among males, blacks had the lowest rate of linkage to care within three months at 82.4 percent. People belonging to the "Other Race" category—including American Indian/ Alaska Native, Native Hawaiian/Other Pacific Islander, and people of multiple races—had the highest linkage to care rate at 100 percent.

Figure 51

Percentage of Persons Linked to Care Within 3 Months of Diagnosis among Persons Diagnosed with HIV in 2015 (≥13 Years of Age at Diagnosis)—Males by Race/Ethnicity, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Based on HIV surveillance data reported through 05/01/2016.
*Other races include American Indian/ Alaska Native, Native Hawaiian/ Other Pacific Islander, and people of multiple races.

Source: IDPH, HIV Surveillance Unit.

Table 3

Number of Males Diagnosed with HIV in 2015 (≥13 Years of Age at Diagnosis) by Race/Ethnicity, Illinois

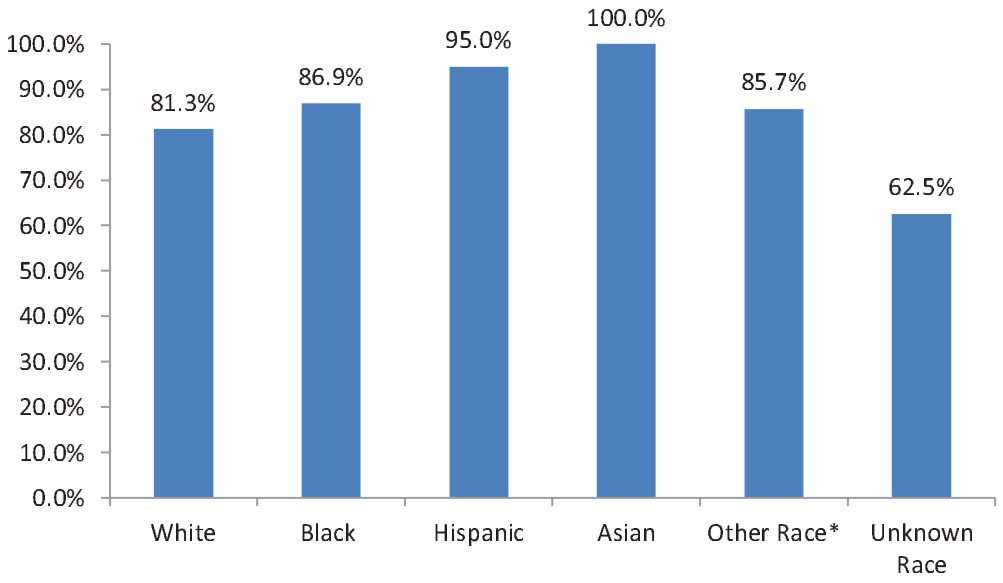
White	Black	Hispanic	Asian	Other Race*	Unknown Race
287	522	264	31	28	36

Source: IDPH, HIV Surveillance Unit.

Among females, the lowest rate of linkage to care was among whites at 81.3 percent. This was lower than among white males, whose rate of linkage to care was 96.9 percent. Asians had the highest rate of linkage to care among females at 100 percent but also had a small population size (n<5). The next highest rate of linkage to care for females was among Hispanics at 95 percent.

Figure 52

Percentage of Persons Linked to Care Within 3 Months of Diagnosis among Persons Diagnosed with HIV in 2015 (≥13 Years of Age at Diagnosis)—Females by Race/Ethnicity, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Based on HIV surveillance data reported through 05/01/2016.
*Other races include American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and people of multiple races.

Source: IDPH, HIV Surveillance Unit.

Table 4

Number of Females Diagnosed with HIV in 2015 (≥13 Years of Age at Diagnosis) by Race/Ethnicity, Illinois

White	Black	Hispanic	Asian	Other Race*	Unknown Race
32	160	20	<5	7	8

Source: IDPH, HIV Surveillance Unit.

Retention in Care

Approximately 39 percent of the 35,892 people who were living with an HIV disease diagnosis in Illinois were retained in care by the end of 2015 (see Figure 49). Among Ryan White Part B clients, approximately 77 percent of clients enrolled in any Part B program and 81 percent of clients linked to care were retained in care during the year ending March 31, 2016

Antiretroviral Therapy

The data on antiretroviral therapy in Illinois are incomplete. Reporting on the number of PLWHA in care who have a documented antiretroviral therapy prescription in their medical records in any given year has been inconsistent. However, using MMP data, IDPH estimates that 88 percent of PLWHA in care were on ART in 2014. Among Ryan White Part B clients, 56 percent of clients enrolled in any Part B program and 73 percent of clients retained in care were receiving ART during the year ending March 31, 2016.

Viral Load Suppression

Among all PLWHA in care in 2015, 44.4 percent were virally suppressed, defined as ≤200 copies/ml for the most recent viral load test result between January 1, 2015 and December 31, 2015 (see Figure 49). Among Ryan White Part B clients, 49 percent of clients enrolled in any Part B program and 86 percent of clients receiving ART during the year ending on March 31, 2016 were virally suppressed.

Disparities in the Care Continuum

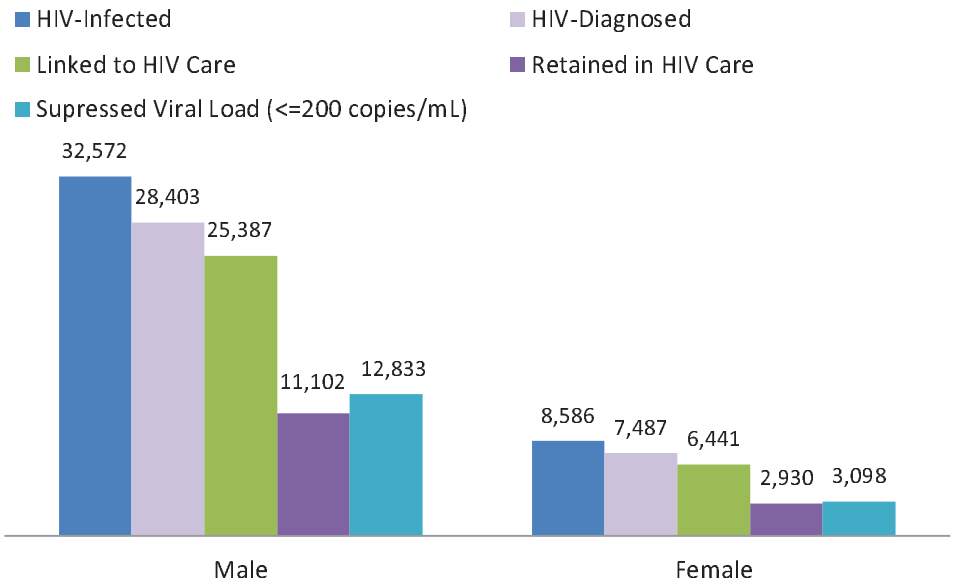
Disparities exist across the HIV Care Continuum by sex, race/ethnicity, age, and risk transmission category.

Sex

Although rates of retention in HIV care in Illinois in 2015 were similar among men and women diagnosed with HIV, viral suppression rates among women in care were lower than among men in care (see Figure 53 and Table 5). The reasons for lower viral suppression among women are not well understood, but similar patterns have been seen nationally (Beer, Mattson, Short, & Skarbinski, 2014). Women may be more likely than men to discontinue ART. A better understanding of barriers to staying on ART is needed to improve viral suppression rates (Beer, et al., 2014).

Figure 53

Engagement in HIV Care for People Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015 by Sex, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Diagnosed: Based on 9/2015 CDC report that 12.8% of HIV-infected individuals were unaware of their serostatus.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Retained in Care: Persons who had ≥ two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally Suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.

Source: IDPH, HIV Surveillance Unit.

Table 5

HIV Care Continuum Proportions for PLWH ≥13 Years by Sex, Illinois 2015

	Male	Female
Linked to HIV medical care within 3 months of diagnosis	89%	86%
HIV diagnosed and retained in care	39%	39%
Viral suppression among linked to care	51%	48%
Viral suppression among diagnosed	45%	41%

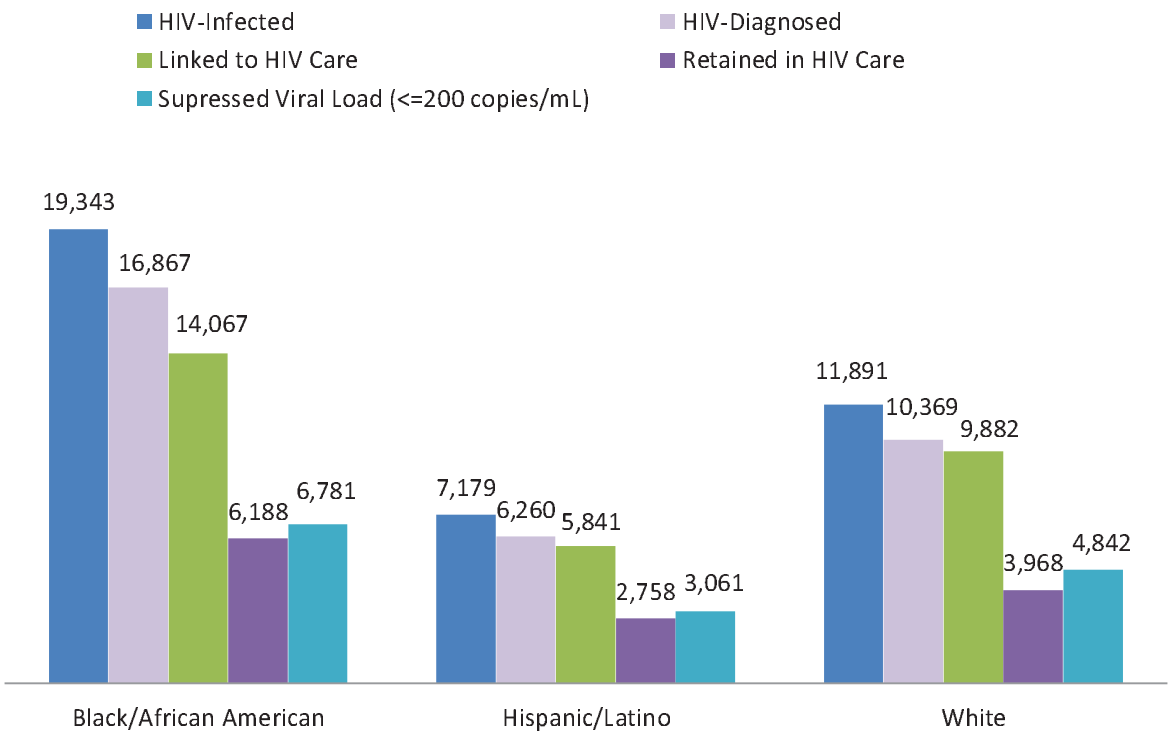
Source: IDPH, HIV Surveillance Unit.

Race/Ethnicity

In 2015, rates for linkage to HIV care within three months of diagnosis varied by race/ethnicity (see Figure 54 and Table 6 on the following pages). Blacks were least likely to be linked to care—83 percent, compared to Hispanics at 93 percent and whites at 95 percent. Hispanics were more likely to be retained in care than PLWHA in the other racial/ethnic groups. Rates of retention in HIV care for all racial/ethnic groups remained low at 37–44 percent. Differences in viral suppression rates among PLWHA by race/ethnicity were seen in 2015. Only 40 percent of blacks were virally suppressed, while Hispanic and white rates of viral suppression were 49 percent and 47 percent, respectively.

Figure 54

Engagement in HIV Care for People Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015 by Race/Ethnicity, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data
Diagnosed: based on 9/2015 CDC report that 12.8% of HIV-infected individuals were unaware of their serostatus.
Linked to care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Retained in care: Persons who had >=2 care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was <=200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.

Source: IDPH, HIV Surveillance Unit.

Table 6

HIV Care Continuum Proportions for PLWH ≥13 Years by Race/Ethnicity, Illinois 2015

	NH White	NH Black	Hispanic
Linked to HIV medical care within 3 months of diagnosis	95%	83%	93%
HIV diagnosed and retained in care	38%	37%	44%
Viral suppression among linked to care	49%	48%	52%
Viral suppression among diagnosed	47%	40%	49%

Source: IDPH, HIV Surveillance Unit.

Sex and Race/Ethnicity

In addition to the disparities related to sex alone and race/ethnicity alone, disparities associated with the combination of sex and race/ethnicity also exist. Figure 55 on the following page depicts engagement in care of HIV-diagnosed males by race/ethnicity (see Table 7 for population sample sizes). Among persons with reported races/ethnicity, black males had the lowest rates of retention in care and viral suppression at 36.1 percent and 40.3 percent, respectively. Males belonging to the "Other Races" category had the highest rates of engagement in care, as 52.4 percent were retained in care and 59.5 percent achieved viral suppression.

Table 7

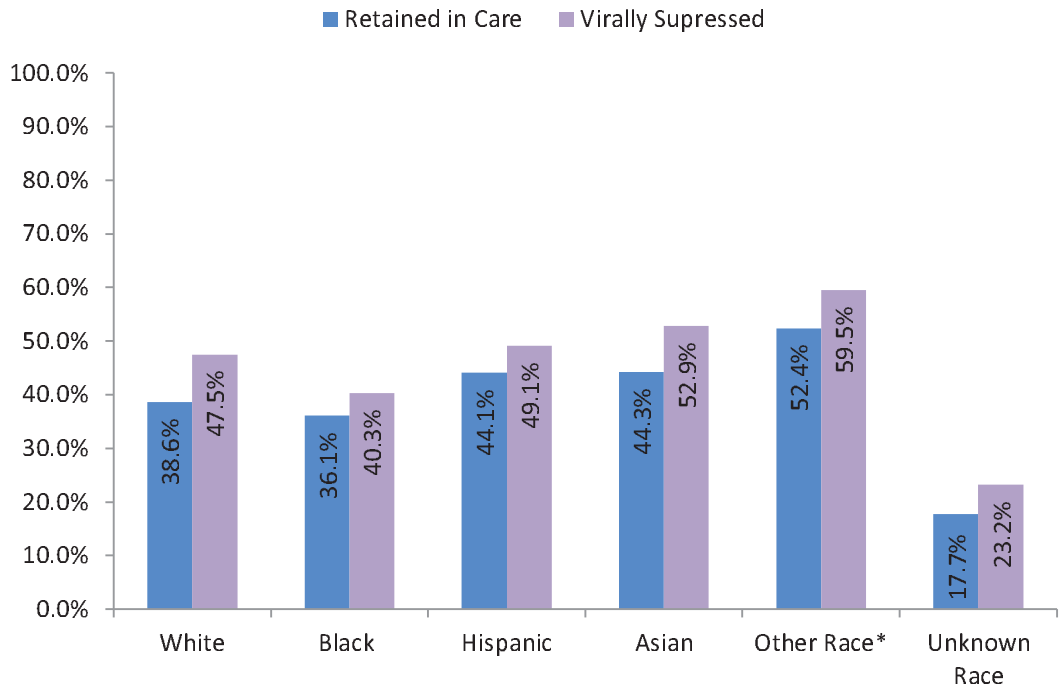
Number of Males Diagnosed with HIV Disease (Aged ≥ 13 Years) through 12/31/2014 and Living with HIV Disease on 12/31/2015 by Race/Ethnicity, Illinois

White	Black	Hispanic	Asian	Other Race*	Unknown Race
9,217	11,977	5,257	350	1,348	254

Source: IDPH, HIV Surveillance Unit

Figure 55

Engagement in HIV Care for Persons Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015—Males by Race/Ethnicity, Illinois



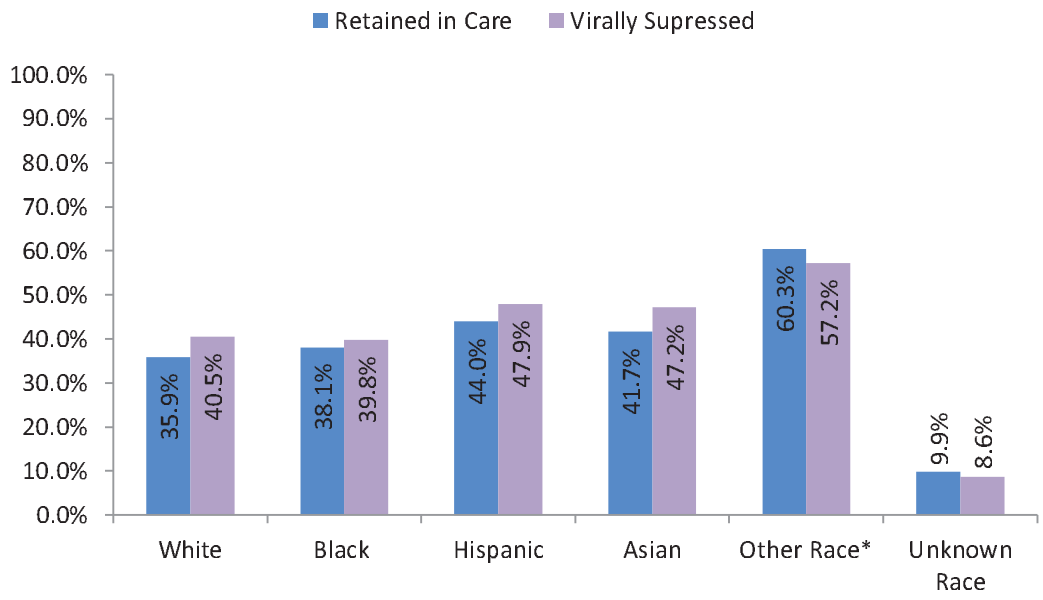
Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Retained in care: Persons who had ≥ two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally Suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.
*Other races include American Indian/ Alaska Native, Native Hawaiian/ Other Pacific Islander, and people of multiple races.

Source: IDPH, HIV Surveillance Unit.

Disparities are also recognized among females of differing race/ethnicity and are depicted in Figure 56 on the following page (see Table 8 for population sample sizes). Among persons with reported races/ethnicity, whites had the lowest rates retention in care at 35.9 percent, while blacks had the lowest rates of viral supression at 39.8 percent. Like their male counterparts, females belonging to other races had the highest rates of both retention in care and viral supression at 60.3 percent and 57.2 percent, respectively.

Figure 56

Engagement in HIV Care for Persons Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015—Females by Race/Ethnicity, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Retained in Care: Persons who had ≥ two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally Suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.
*Other races include American Indian/ Alaska Native, Native Hawaiian/ Other Pacific Islander, and people of multiple races.

Source: IDPH, HIV Surveillance Unit.

Table 8

Number of Females Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV on 12/31/2015 by Race/Ethnicity, Illinois

White	Black	Hispanic	Asian	Other Race*	Unknown Race
1,152	4,889	1,003	72	290	81

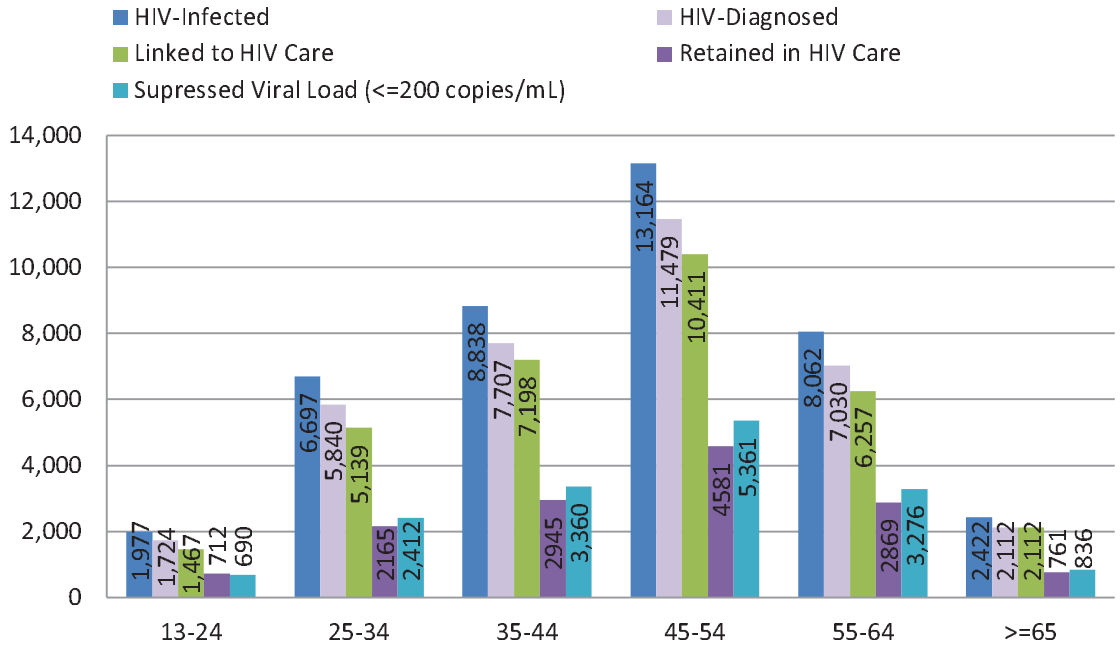
Source: IDPH, HIV Surveillance Unit.

Age

Adults ≥ 65 years had the highest linkage to care rates in 2015—100 percent—and young adults (13–24 years) had the lowest rates, at 85 percent. These two groups, however, had the same viral suppression rate among those diagnosed—40 percent—the lowest rate of any age group. The highest rate of viral suppression among those diagnosed was among adults 45–54 years and 55–64 years, at 47 percent. Those same two groups had the highest viral suppression rates among PLWHA who were linked to care—51 percent and 52 percent respectively. (See Figure 57 and Table 9.)

Figure 57

Engagement in HIV Care for People Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015 by Age Group, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Diagnosed: Based on 9/2015 CDC report that 12.8% of HIV-infected individuals were unaware of their serostatus.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Retained in Care: Persons who had ≥ two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally Suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤200 copies/ml.
Based on HIV surveillance data reported through 05/01/2016.

Source: IDPH, HIV Surveillance Unit.

Table 9

HIV Care Continuum Proportions for PLWH ≥13 Years by Current Age, Illinois 2015

	13-24	25-34	35-44	45-54	55-64	≥65
Linked to HIV medical care within 3 months of diagnosis	85%	88%	93%	91%	89%	100%
HIV diagnosed and retained in care	41%	37%	38%	40%	41%	36%
Viral suppression among linked to care	47%	47%	47%	51%	52%	40%
Viral suppression among diagnosed	40%	41%	44%	47%	47%	40%

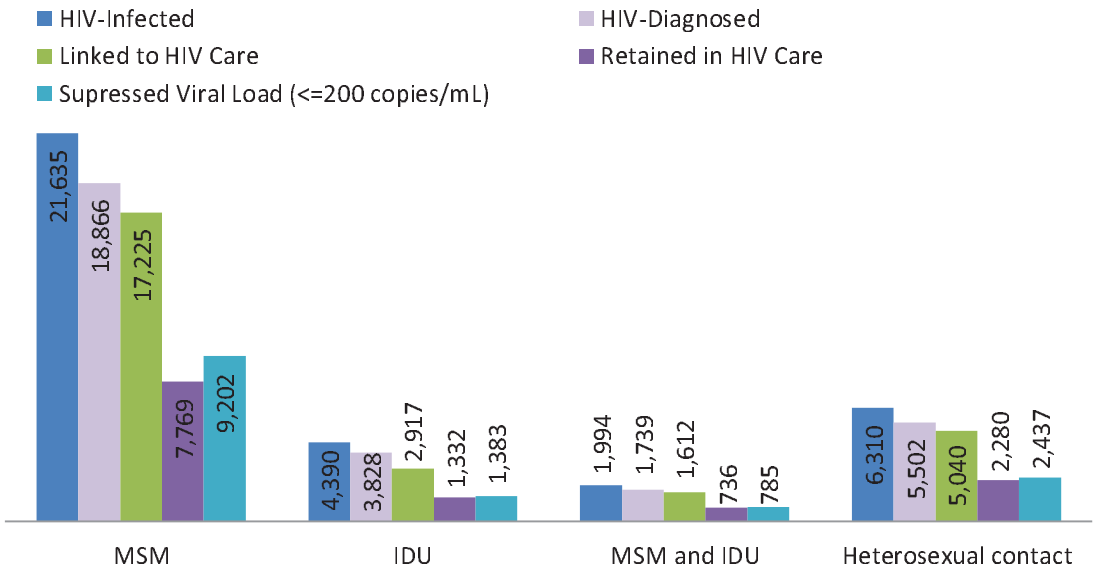
Source: IDPH, HIV Surveillance Unit.

Transmission/Risk Category

Among PLWHA in Illinois in 2015, people who inject drugs had the lowest rates of viral suppression at every step of the HIV Care Continuum; just 36 percent of those diagnosed were virally suppressed (see Figure 58 and Table 10 on the following page). These lower rates may be due to the variety of medical, psychological, and social problems IDUs face that can negatively affect their ability to adhere to ART, resulting in lower rates of viral suppression (Bruce & Altice, 2007). MSM and MSM who also inject drugs had the highest rates of viral suppression, at 53 percent and 49 percent respectively. They also had the highest rates of linkage to care and retention in care.

Figure 58

Engagement in HIV Care for People Diagnosed with HIV Disease (Aged ≥ 13 Years) Through 12/31/2014 and Living with HIV Disease on 12/31/2015 by Transmission Risk Category, Illinois



Note: The CDC-supplied NHAS Indicator SAS Program was modified to generate these data.
Diagnosed: Based on 9/2015 CDC report that 12.8% of HIV-infected individuals were unaware of their serostatus.
Linked to Care: Persons diagnosed with HIV between 1/1/15 and 12/31/15 (had at least one CD4, viral load, or HIV-1 genotype test) within 3 months of their diagnosis.
Retained in Care: Persons who had ≥ two care visits between 01/01/2015 through 12/31/2015, at least 3 months apart.
Virally Suppressed: Persons whose most recent viral load test result between 01/01/2015 through 12/31/2015 was ≤ copies/ml.
Based on HIV surveillance data reported through 05/01/2016.

Source: IDPH, HIV Surveillance Unit.

Table 10

HIV Care Continuum Proportions for PLWH ≥13 Years by Transmission Risk Category, Illinois 2015

	MSM	IDU	MSM/IDU	Heterosexual
Linked to HIV medical care within 3 months of diagnosis	91%	76%	93%	92%
HIV diagnosed and retained in HIV care	41%	35%	42%	41%
Viral suppression among linked to HIV care	53%	47%	49%	48%
Viral suppression among diagnosed	49%	36%	45%	44%

Source: IDPH, HIV Surveillance Unit.

High-Risk Uninfected Individuals

To reach high-risk uninfected individuals, Illinois' HIV prevention efforts are guided by the Illinois HIV/AIDS Strategy, which itself is guided by the National HIV/AIDS Strategy. Using scientifically proven, cost-effective, and scalable public health strategies and interventions targeted to the right populations and the right geographical regions, Illinois is pursuing a high-impact prevention (HIP) approach to reducing new infections.

Prioritized Populations

The IDPH HIV Prevention Program, in conjunction with the ILHPG Epi Profile/Needs Assessment Committee, prioritizes populations for HIV prevention services each year in order to provide services to the populations at highest risk and most affected by the epidemic in Illinois. Statewide surveillance data—excluding the City of Chicago—are used to derive priority populations.

The 2017 priorities, included as Appendix F, were determined using HIV disease incidence cases and late diagnosis cases between 2010 and 2014, and HIV disease prevalence data as of December 31, 2015, which was collected based on residence at diagnosis. Only cases with known exposure categories were considered to maximize proportional accuracy. On the recommendation of the ILHPG Epi Profile/Needs Assessment Committee, weights of 90 percent, five percent, and five percent, respectively, were applied to each set of data.

MSM continues to be the number one priority exposure group. Heterosexual exposure is priority two, injection drug use is priority three, and MSM/IDU is priority four. Transgender individuals are included within any priority population based on personal risk history and current gender identification. Gender reassignment surgery is not assumed. Unless a transgender client opts to disclose an operative status, risk assessment is based on self-reported sexual risk behaviors inclusive of the possibilities for male and female anatomy.

Each exposure category also includes a sub-ranking by race/ethnicity. For example, within the MSM category, black MSM is the highest priority sub-population. The goal of the prioritization process is that statewide HIV prevention services reach each priority population and sub-population in equal proportion to the percentages specified in the prioritized populations ranking.

After the priority exposure groups are identified, the ILHPG uses information from research and other social determinant data to define a set of recommendations and points of consideration. These recommendations and points of consideration assist

service planners and providers in further targeting prevention services to reach disparately impacted subpopulations, such as young MSM of color, and special populations, such as HIV positives, youth, and transgender individuals. Finally, a regional gap analysis is conducted to determine prevention services gaps, then regional funding and grant scopes specific to the high-risk targeted priority populations are established for each region throughout the jurisdiction using an epidemiology-based allocation.

In its most recent priority setting process for 2017 prevention services, the Chicago Department of Public Health and the Chicago Area HIV Services Council adopted the following priority populations, geographic areas, special concerns populations, and interventions/services model for the **Chicago EMA**:

- People living with HIV/AIDS
- All men who have sex with men
- Non-Hispanic black cis-women
- Transgender individuals
- Individuals who inject drugs or other substances
- Chicago geographical areas that make up 80 percent of the burden of HIV
- Interventions targeting directly along the path to PrEP or viral suppression
- Continued external evaluation of innovations focusing on outcomes of the path toward PrEP and viral suppression

Risk Group Definitions

To make the best use of limited HIV prevention dollars and make the greatest impact on the HIV epidemic in Illinois, the IDPH HIV Prevention Program and the ILHPG annually review and revise the definitions of the risk groups—specifically what factors within each exposure category are associated with the highest risk of new HIV infection. This involves a review of current literature and research results as well as analysis of the jurisdiction's seropositivity data and self-reported risk assessments. Grant scopes for HIV testing and risk reduction activities are targeted to high risk individuals who fall within these definitions. Appendix G provides detailed information on the 2017 prioritized populations including definitions and points of consideration developed by the ILHPG Epidemiologic Profile/Needs Assessment Committee and ILHPG membership and approved by the ILHPG in May 2017.

Key Public Health Strategies and Interventions

Illinois has adopted the following core set of proven, cost-effective behavioral, biomedical, and structural interventions that are important components of a

comprehensive prevention program to address the HIV prevention needs of the hardest hit and prioritized populations in Illinois:

- **HIV testing** that identifies people who are infected, links them to care, and prevents transmission to others
- **Linkage to care** that helps ensure people living with HIV/AIDS receive medical care and treatment, improving their quality of life and reducing the risk of transmitting HIV to others
- **Antiretroviral treatment** that dramatically reduces the risk of HIV transmission for people living with HIV/AIDS and improves the quality of their lives
- **Access to condoms and sterile syringes**, especially when accompanied by education and behavioral interventions, that reduces the risk of HIV transmission
- **Prevention programs for people living with HIV/AIDS** that reduce risk behaviors among PLWHA and reduce the risk of transmitting the virus to others
- **Partner services** that reduce new HIV infections by facilitating partner solicitation and notification, providing them with testing, and linking them to testing, prevention, and care services
- **Prevention programs and services for people at high risk of HIV infection** that are cost-effective and effective in reducing risk behaviors
- **Screening and treatment for other sexually transmitted infections** that reduce the risk of acquiring and transmitting HIV and other STIs

Approved Prevention Strategies and Interventions

Annually, the ILHPG Interventions and Services Committee and the IDPH HIV Prevention Program review new and existing CDC guidance on approved HIV prevention strategies and interventions that have been determined to be most effective at reducing HIV risk behaviors and cost-effective as well. Guidance in CDC's current federal prevention FOA for health departments and other new CDC guidance is solicited and reviewed to help determine how best to direct the focus of the state's funded prevention activities. Through these efforts, the ILHPG provides a core set of recommendations on key public health prevention strategies, interventions, and services for the prioritized populations. The 2017 HIV Prevention Interventions & Strategy Guidance that lists and describes these approved interventions and services as well as the targeted risks, ages, race/ethnicity, and serostatus for each, is available at the following link: http://dph.illinois.gov/sites/default/files/publications/2017-hiv-prevention-guidance-final-061716-090216.pdf. The document is also referenced in Appendix H.

The HIV Prevention Program uses these recommendations to develop guidance on its approved set of prevention strategies, interventions, and related considerations. These

are included in all requests for proposals released for prevention grants, including the Request for Application (RFA) to the regional prevention lead agents. This process helps support the state's application of CDC's high impact approach to its prevention planning.

Illinois will maintain and strengthen its implementation of High Impact Prevention through efforts to diagnose, treat, and achieve viral suppression among people living with HIV/AIDS and to promote HIV, STD, and viral hepatitis screening and cost-effective behavioral and biomedical risk reduction among Illinoisans most at risk for HIV acquisition or transmission. The following improvements are planned for 2017:

- Implementing the new CDC guidelines for risk-targeted HIV testing in non-clinical settings
- Targeting risk-focused testing and risk reduction interventions to heterosexuals statistically most likely to seroconvert by heterosexual HIV exposure by updating the high risk heterosexual risk group definition
- Expanding clinical routine HIV testing focused on high incidence communities throughout Illinois by establishing at least 10 new testing sites within the top 20 zip code areas currently unserved by routine HIV testing with the highest number of HIV incident cases in the past five years; these areas were identified through a gap analysis process that cross-referenced HIV incidence by zip code with routine HIV testing data from Medicaid reimbursement and IDPH-supported grantees
- Restricting funding for risk reduction activities in the Regional Prevention Grants (PS12-1201 supported) to CDC-supported Effective Behavioral and Biomedical Interventions and public health strategies using the latest CDC curricula for which training and materials are available
- Increasing the percentage of Regional Prevention Grant program funding allocated for HIV testing and surveillance-based services and decreasing the amount allocated for prevention for high risk negatives services
- Providing value-based supplemental payments to HIV testing providers for diagnosis of new positives, linking PLWHA to care within 30 days and achieving retention for six months following linkage to care, conducting partner services, prompt case reporting, and provision of effective medical adherence counseling
- Improving locating information provided for not-in-care PLWHA referred for surveillance-based services through the use of a contact information database service
- Enhancing fee-for-service reimbursements for HIV treatment engagement within 30 days of case assignment for not-in-care PLWHA referred for surveillance-based services

Using the HIV Care Continuum

IDPH planning bodies use the HIV Care Continuum to plan, prioritize, target, and monitor resources available to respond to the needs of PLWHA in the jurisdiction, including those who are HIV positive and do not know their status, to improve health outcomes at every step in the HIV Care Continuum. A Linkage to Care Workgroup of IDPH Ryan White Part B HIV staff from care, prevention, and surveillance programs meets periodically to facilitate data sharing across programs, conduct gap analyses, and track referral records in the Provide® Enterprise database.

As part of Integrated Plan implementation, IDPH will address the following action steps in connection to the Care Continuum in order to increase the number of Illinoisans living with HIV/AIDS who advance through the Care Continuum to viral suppression:

1. Regularly analyze IDPH HIV Section priorities and procedures to ensure that they promote public health goals related to Integrated Plan implementation; identify opportunities to educate stakeholders; describe the success of local HIV prevention and care efforts
2. Use resources to mobilize highly affected communities to address systems-level barriers to HIV prevention and care
3. Ensure increased partnership between HIV surveillance, HIV programs, and HIV care providers in order to use surveillance data better to improve health outcomes
4. Identify opportunities for IDPH staff and stakeholders to discuss ways that available data, information, and communication technologies can be leveraged to improve systems of HIV prevention and care
5. Identify all opportunities to expand access to medications, condoms, and syringes to the individuals and communities most in need of them
6. Identify opportunities to address the multiple needs of people at risk for or living with HIV/AIDS by increasing possibilities for service delivery through public and private systems
7. Focus integrated prevention and care efforts on prevention for positives by aligning programmatic efforts to support people living with HIV/AIDS through the HIV Care Continuum
8. Identify innovative ways to engage communities, people living with HIV/AIDS, and affected population groups to ensure that HIV prevention and care activities respond to their needs

Community Viral Load

To maximize use of HIV Care Continuum data, IDPH will generate, compare, and analyze community viral load (CVL) data as part of the Integrated Plan implementation. Individual viral load measurements will be aggregated for various population groups or subgroups—such as young MSM of color, Hispanics who inject drugs, or black high risk heterosexual women—an average viral load will be calculated for each group, and those averages will be compared to identify disparities across groups, including by geographic community when needed. Using community viral load as a population measure will allow IDPH to target HIV resources better and intervene where the need is greatest.

Financial and Human Resources Inventory

Appendix I is the Illinois HIV Resources Inventory table. It includes public and private funding sources for HIV prevention, care, and treatment services; the dollar amount and percentage of total available funds in FY 16 for each category; how the resources are being used to deliver services; and the prevention programming components and HIV Care Continuum steps affected.

HIV Workforce Capacity

The HIV workforce in Illinois encompasses clinical health care providers, allied health professionals, and other licensed providers; community health workers, patient navigators, and other HIV-specific and non-HIV-specific providers. IDPH will work with MATEC as the Integrated Plan is implemented to further enumerate, define, and describe the HIV workforce in the state. Appendix J is a preliminary workforce assessment for the State of Illinois excluding Chicago, and Appendix K is a preliminary workforce assessment for the City of Chicago only. Both assessments were developed by MATEC.

Until that work is completed, the following is an initial effort to enumerate the HIV workforce in Illinois:

- 89 health departments, CBOs, and private medical and dental practices are providing Ryan White Part B services in Illinois.
- 699 medical providers are serving Ryan White Part B clients.
- 150 case managers provided medical case management to clients through Ryan White Parts A-D and HOPWA in 2014 and 2015 (see Table 11 on the following page).