



Chicago-Area Unified HIV Plan

For HIV Prevention, Care, Housing and Essential Services
2014-2016



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DEPARTMENT OF HEALTH & HUMAN SERVICES

February 24, 2014

Dear Ryan White HIV/AIDS Program and CDC HIV Prevention Colleagues:

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and the Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention (DHAP) are pleased to support integrated HIV prevention and care planning groups and activities. Integrated planning, reports, and activities will help further progress in reaching the goals of the National HIV/AIDS Strategy and improving outcomes on the HIV Continuum of Care.

HRSA and CDC have determined that the Ryan White HIV/AIDS Program (RWHAP) Parts A and B Comprehensive Plans and the CDC Jurisdictional HIV Prevention Plan will be due in September 2016. Also due at that time will be the RWHAP Part B Statewide Coordinated Statement of Need (SCSN). HRSA and CDC are working to align the guidance(s) for the RWHAP Comprehensive Plans/SCSN and the Jurisdictional HIV Prevention Plan to enable the submission of an integrated HIV Plan that is responsive to the requirements of both HRSA and CDC.

HRSA and CDC encourage RWHAP and HIV prevention programs at the local and state level to integrate planning activities. These encompass comprehensive needs assessment, information and data sharing, cross representation on prevention and care planning bodies, coordinated/combined projects, combined meetings, and merged planning bodies. Planning groups are encouraged to streamline their approaches to HIV planning so that it increases access to and effectiveness of prevention, care and treatment services within the jurisdictions.

Good planning is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV infection and people living with HIV. Activities to collaborate and/or develop a joint planning body are supported by both HRSA and CDC. Community involvement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States.

We look forward to continued work with all our partners and stakeholders involved in HIV prevention and care and treatment planning to accomplish the goals of the National HIV/AIDS Strategy and the HIV Continuum of Care Initiative.

Sincerely,

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Outline

The Unified Plan describes the collaborative efforts of the Chicago Department of Public Health (CDPH) and the Chicago Area HIV Integrated Services Council (CAHISC) to develop the most effective plan to implement and evaluate an integrated Continuum of HIV services. This is the first Unified Plan for Integrated HIV services in Chicago and describes an ongoing process of community planning to meet the primary goals of the National HIV/AIDS Strategy (NHAS): 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

Section 2. Where We Are Now

Section I describes the current state of the epidemic in the Chicago Area. It presents an epidemiological profile developed by the HIV/STI Surveillance, Epidemiology and Research Section of CDPH and develops an analysis of trends in the epidemic and of gaps and disparities within the continuum of care. This analysis has been developed collaboratively with CAHISC committees and this section includes a set of recommendations formulated according to each area of the continuum. It also includes a discussion of how the Affordable Care Act (ACA) will influence the funding and delivery of HIV services in Chicago.

Section 3. Where We Are Going: Envisioning an Ideal System of HIV Prevention and Care

This section provides a vision of an ideal continuum of care that will reduce new HIV infections and decrease the community viral load in Chicago. The Chicago Area's Continuum of Care has developed strong Prevention, Care and Housing components and has increasingly integrated the planning and implementation of services and interventions. The ongoing development of an integrated Continuum of Care has resulted in a combined cooperative planning effort that will continue to address the complications and episodes of serious illness experienced by those who have AIDS and at the same time seek to address the medical and psychosocial needs of those at highest risk of infection.

Section 4. How We Will Get There: The Chicago Area Unified Plan's Strategies

This section of the plan provides a summary of the strategies, goals and critical action steps to guide the successful improvement of the Chicago Continuum of HIV Care. It has been developed through a review of previous regional plans and through recommendations provided by CAHISC through its analysis of regional data on the Continuum of Care.

Four strategies have been developed to organize the goals, critical action steps and activities of the Unified Plan.

- I.** Improve administrative systems to support coordination of planning and implementation of integrated services
- II.** Develop a holistic HIV High Impact Prevention approach that helps both HIV-negative and HIV-positive individuals prevent HIV transmission.

- III.** Fully integrate the system of Early Intervention and Linkage and Retention services
- IV.** Closely monitor progress across the continuum of care toward decreasing community-level viral load.

Section 5. How We Will Monitor Progress

Evaluation Staff from The Chicago Department of Public Health will develop quality measures and timeframes for the goals of the Unified Plan.

Section I - Introduction

This document describes the collaborative efforts of the Chicago Department of Public Health (CDPH) and the Chicago Area HIV Integrated Services Council (CAHISC) to develop the most effective plan to implement and evaluate an integrated continuum of prevention, care, and housing services. This continuum of services is designed to meet the primary goals of the National HIV/AIDS Strategy (NHAS): 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

The 2014-2016 Chicago Area Unified Plan has been developed by CDPH and CAHISC. The format is derived from previous comprehensive, jurisdictional and housing plans and complies with the guidance that Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) have provided for previous plans. However, this is a new effort to create an approach to integrated planning for services across the continuum of prevention and care and Chicago is joining two other regional planning groups to demonstrate how a unified process could be developed to direct future federal HIV funding initiatives. For the purposes of the Unified Plan, the Chicago Eligible Metropolitan Area (EMA) geographically represents the City of Chicago, suburban Cook County and the 7 collar counties.

In its four sections, the Unified Plan will:

1. Describe the current system of HIV prevention and care services in the Chicago EMA
2. Describe an ideal system of HIV prevention and care services for the Chicago EMA
3. Outline the specific activities needed to make progress toward this ideal system; and
4. Describe how progress toward an ideal system will be measured.

The Unified Plan documents an ongoing process of HIV community planning based on the HIV/AIDS Continuum of care model and the work of CAHISC committees and CDPH staff in developing an integrated process of needs assessment, gap analysis and the formulation of planning priorities and strategies. The plan is developed to contribute to the National HIV/AIDS Strategy of achieving a more coordinated national response to the HIV epidemic in the United States.

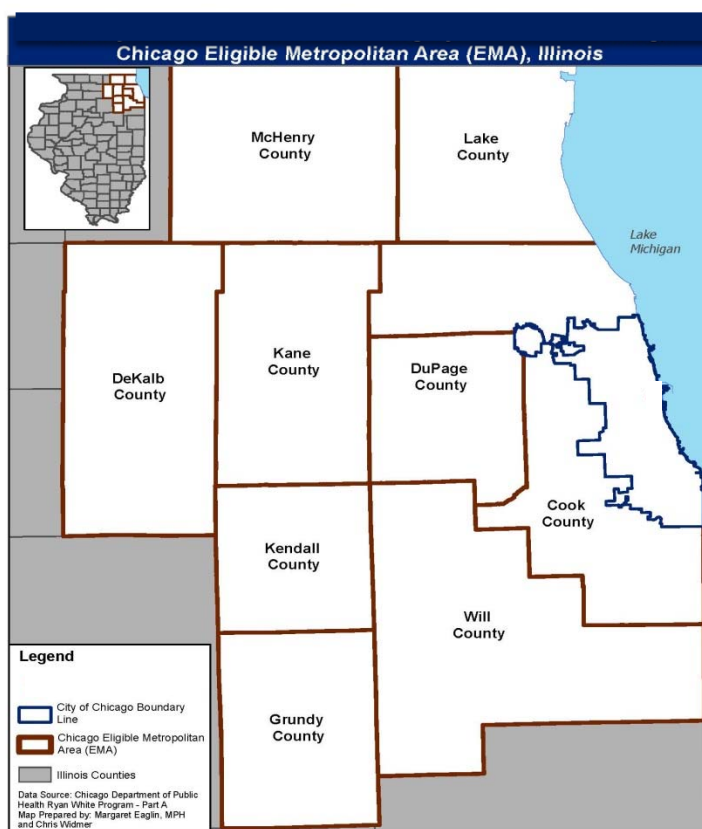
This is the first unified plan for HIV prevention, care, and housing in Chicago and it will be used by community stakeholders, health authorities and funding agencies to guide the development of a fully integrated continuum of HIV/AIDS services. The City of Chicago's current HIV Prevention Jurisdictional Plan required by the Centers for Disease Control and Prevention (CDC) and current Eligible Metropolitan Area (EMA) HIV Care & Services Comprehensive Plan required by the Health Resources and Services Administration (HRSA) both span the years of 2012 to 2014. According to guidance issued by the United States Department of Health and Human Services in February 2014, new HIV Prevention Jurisdictional Plans and Comprehensive Plans will be due in September 2016. In the coming years, CDC and HRSA will issue instruction on how to develop a single integrated plan that will meet both funders' requirements.

The Chicago Area Unified Plan reflects efforts to develop an integrated plan as we await further instructions from CDC and HRSA on the plan that is to be submitted in 2016 and that will inform service in 2017. It serves as a bridge from separate 2012 – 2014 Jurisdictional and Comprehensive Plans to an integrated plan that will be due in 2016. The plan honors the work of the CAHISC Committees that were formed in alignment with a Continuum of Care that spans HIV prevention and early identification, linkage to care and retention in care, and access and adherence to ART and viral suppression. The plan also reflects a point in time at which the Affordable Care Act (ACA) is being implemented and both patients and providers of care are managing shifts in health care coverage.

1.1 Description of the Chicago Area

Chicago is located in the northeastern corner of Illinois along the shores of Lake Michigan. The Unified Plan is developed for the Chicago EMA, which is comprised of nine counties: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Will, and McHenry (Figure 1).

Figure 1. Chicago Eligible Metropolitan Area (EMA)



The estimated population of these counties in 2012 was 8.7 million people who represent nearly 66% of the population of the state of Illinois. The Chicago EMA encompasses about 5,046 square miles and reflects urban, suburban, and rural communities. Chicago, the largest urban center in the area, is the nation's third most populous city. Ninety-four percent of EMA residents live in urban areas and in the smaller cities in the collar counties, 2% live in suburban areas and 4% live in rural areas. There are 33,856 people living with

HIV and AIDS (PLWHA) in Illinois. Eighty-five percent (28,741) reside in the EMA and 64.5% (21,844) reside in the City of Chicago.

1.2 History of Chicago's Response to the HIV/AIDS Epidemic: Prevention, Care, and Housing

In 1991, due to a growing number of AIDS cases, Chicago was designated as an Eligible Metropolitan Area to be funded through Title I (now Part A) of the Ryan White CARE Act. The CARE Act was focused on funding services providing care for those already infected and needing care. In 1992, the CDC created a separate funding stream to develop prevention services to inform the public about HIV and to offer HIV testing and counseling to those at risk of infection. Two separate Planning Councils comprised of professional and community stakeholders were formed to assist and advise CDPH and other local public health authorities in how needs in the community were to be assessed and funding distributed. One was the Ryan White Planning Council (RWPC) and the other was the HIV Prevention Planning Group (HPPG), each was directed to form and develop *separate* planning processes which while effective in engaging community participation also created a duplication of effort and inhibited the integration of services planning and resource allocation. At the same time, the increasing need for stable housing for those infected with HIV created a network of housing services funded through the Housing and Urban Development's Housing Opportunities for People with AIDS (HOPWA) program and other sources. Although housing stakeholders were represented on the existing Councils and had associations of their own, there was an increasing awareness of the NHAS operational goals^{i ii} and the central role of housing in prevention and care and the need to fully integrate the need for stable housing into comprehensive HIV Planning. As needs and services evolved, it became increasingly apparent to federal funding sources, to CDPH and other local health authorities and to the consumers and providers on the Councils that there was a need for an integrated approach to HIV/AIDS planning.

Merging of the 'HIV Prevention' and 'Ryan White Care' Planning Councils

From the beginning of the planning process, both the Prevention and Ryan White Planning Councils established separate goals to improve the integration of care and prevention services. Research and clinical experience highlighted the fact that the earlier a person's infection was identified and treated, the better the outcome. Beginning in 2006, the CDC and HRSA developed policy initiatives to promote linkage and retention in care. In 2009, Chicago began to plan the implementation of a system of peer interventions that would support linkage and retention in care and the Ryan White Planning Council for the first time, prioritized Outreach and Early Intervention Services (EIS). Since these services bridged and integrated Prevention and Care activities, they served as a springboard to collaborative planning efforts culminating in the merging of the two Councils.

In May of 2011 the two councils formed the Integration Workgroup. This was comprised of fourteen community members and leadership from both the Ryan White Services Planning Council and the HPPG, (50% consumers) and twelve CDPH Employees representing the Prevention, Care, Housing, and Public Information units within the Division of HIV/STI services. The group reviewed models of integrated councils formed in other locations and

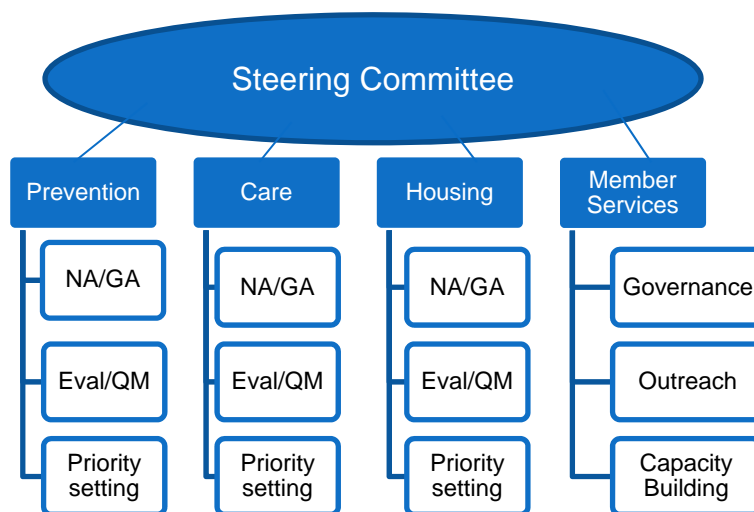
proposed the formation of an integrated council model for Chicago. The membership recruitment activities of the RWPC and HPPG were suspended and the outcome of the work group was to recommend selection of a newly constituted *integrated* planning body.

In December of 2011, the workgroup approved interim bylaws and proposed the formation of the Chicago Area HIV Integrated Services Council (CAHISC) and in January of 2012, a selection committee was formed to create and process membership applications for the newly formed Council. In February, at a joint meeting of the RWPC and the HPPG the members voted to dissolve the two existing Councils and form CAHISC to develop a fully integrated planning process and a Unified Plan for the Chicago EMA.

1.3 Description Chicago's HIV Continuum of Care Model in the Planning Process

In 2012, CAHISC recruited and oriented the new Council membership and defined issues and recommendations through a committee structure that maintained a *separate* consideration of services. This provided an interim opportunity to define the specific needs of Prevention, Care, and Housing to prepare for eventual integration but perpetuated planning activities in separate “silos” of expertise that did not allow for integration of planning activities (Figure 2).

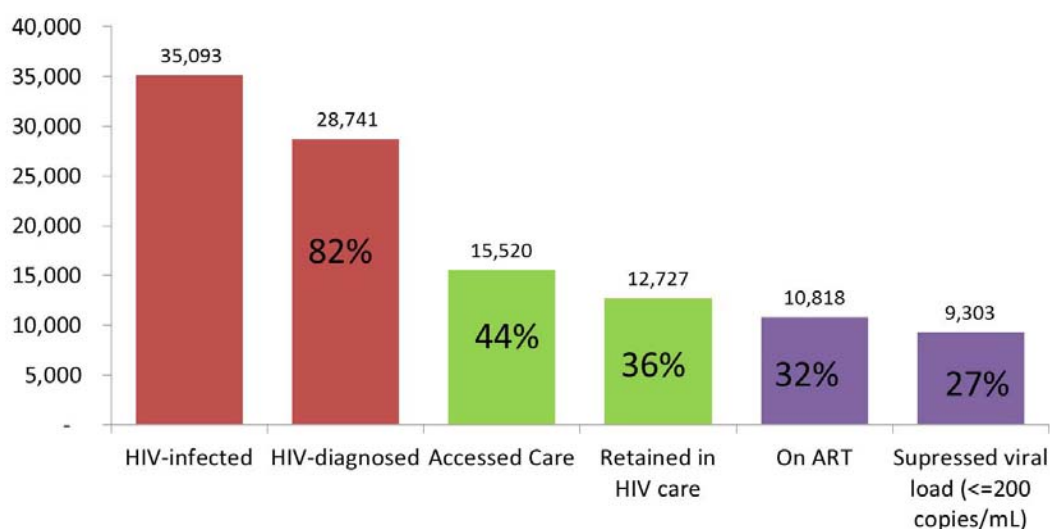
Figure 2. CAHISC Organizational Structure – Year 1



At the end of its first year of planning, Council members decided that a new structure was needed to fully integrate the planning process. In January 2013, CAHISC met in a two-day strategic planning retreat and developed a new committee structure based on the Continuum of Care model (Figure 3).

The continuum of care model presents estimates and measures of client and service activity at key points of intervention. This continuum of care model also provides a gap analysis depicting declining client engagement and unmet need across the continuum identifying the need for assessment and intervention at key stages. CAHISC views this model as an effective guide to structuring Council Committees to achieve integrated planning and to avoid the silos of the past.

Figure 3. The Chicago HIV Continuum of Care



CAHISC has redesigned its structure into three working committees assigned to focus on specific continuum of care areas, plus a Membership and Community Engagement Committee (Figure 4).

1. Primary Prevention and Early Intervention Committee (PPEI)
2. Linkage and Retention to Care (LRC)
3. Anti-retroviral Therapy (ART) and Viral Suppression (AVSC)
4. Membership and Community Engagement Committee (MCE)

Figure 4. CAHISC Council Model



This structure was selected to foster collaborative planning and to provide focus on needs assessment and planning activities specific to ‘continuum of care’ areas. The PPEI, LRC and AVSC Committees are each charged with developing a needs assessment and gap analysis for its area, determining effective interventions and services, and engaging the involvement of community stakeholders in committee work.

The Membership and Community Engagement Committee (MCE) oversees governance, community engagement and recruitment activities. The MCE Committee has been specifically charged with reviewing and revising the bylaws of the newly structured Council to assure that the membership and leadership structure is representative of the epidemic and that policies and procedures are in place to assure full participation of the membership. It also conducts community engagement activities and is responsible for the recruitment and selection of new members. In the new structure, the Membership and Community Engagement Committee is responsible for forming committees that are representative of the population served, to assure that there are members with experience and perspective from Prevention, Care, Housing and other Essential Services.

A Steering Committee is convened monthly to oversee the integration of the work of the individual committees and to plan and manage meetings of the full CAHISC Council. The Steering Committee is managed by two council co-chairs elected by the Council and a governmental co-chair appointed by the grantee. It is comprised of the eight co-chairs (two from each committee) plus two members at-large. It meets monthly to consolidate information and recommendations formulated by each of the four committees.

CAHISC implemented the new Council structure in 2013 and 2014 and in an ongoing process of development, has formed working and ad-hoc committees, engaged new members within the structure and, is successfully using the continuum of care model to integrate various service needs into unifying themes that comprise the strategies outlined in the 2014-2016 Chicago Area HIV Unified Plan.

1.4 Community Engagement: Developing the Chicago Area HIV Unified Plan for 2014-2016

The 2014-2016 Chicago Area Unified Plan is the result of many hours of participation and effort by members of the community and Chicago Department of Public Health staff who are committed to improving the planning and implementation of HIV services in Chicago. The Chicago Area HIV Integrated Services Council (CAHISC) membership is representative and inclusive of all populations and geographic areas affected by the epidemic and includes consumer, provider, professional and academic representatives with experience and expertise in HIV Prevention, Care, and Housing. The involvement of this diverse Council in developing the Unified Plan helps ensure that the strategies, goals and objectives of the Unified Plan address the different needs of populations and geographic areas affected by the epidemic.

The CAHISC Membership and Community Engagement Committee oversee an ongoing process of recruitment and selection to assure continuous engagement of key stakeholders

in the planning process. The committee has carefully revised the CAHISC bylaws to assure that the governance structure defines roles and responsibilities of the MCE Committee and Council co-chairs and clearly states the requirements and expectations of Council members. The updated bylaws have been developed to maximize membership attendance and facilitate community engagement in the newly structured council.

To ensure parity, inclusiveness and representation in the Council as required by HRSA and CDC, the ad-hoc committee reviewed epidemiologic data and compared community data to the gender and race/ethnicity characteristics of the Council membership and this helped target recruitment efforts. The ad-hoc Committee recruited possible candidates from many sources, and developed a system to review and score candidate applications. The ad-hoc Nominations Committee then conducted interviews with prospective members and selected a final list of candidates to be approved by: the MCE Committee, then the Steering Committee, and finally prospective candidates were presented to the full Council for approval.

CAHISC Committees and Community Engagement Plan: While conducting surveys and site visits to gather local input to the needs assessment process, the PPEI, LRC and AVSC Committees were also coordinating activities with the MCE Committee to engage participation of new members to CAHISC and to increase awareness of the Council's activities. Community engagement efforts included: forums, needs assessment surveys distributed by each CAHISC committee, and the development of the CAHISC website. The forums and the surveys served the dual purpose of gathering data and informing community stakeholders about CAHISC and inviting their participation. The CAHISC website provides a centralized location for information about CAHISC-related activities and resources.

Future plans for the Membership and Community Engagement Committee: The Membership and Community Engagement Committee plans to continue community engagement activities to make sure the CAHISC membership reflects the necessary requirements outlined in the updated bylaws. Continued community outreach will allow the committee to approach community-based organizations and diverse populations and have a conversation about CAHISC and/or HIV-related issues that affect them. This will include advocating for and promoting CAHISC-sponsored events, soliciting CAHISC membership applications, representing CAHISC by attending existing community events, and hosting more community forums and unofficial community forums (done in coffee shops, street corners, etc.). CAHISC brochures, palm cards, and informational materials enhance outreach and will be developed to provide engaging information on the purpose and mission of CAHISC.

The Membership and Community Engagement Committee will develop training for CAHISC members to cultivate the ongoing development of the leadership of the council and the mentoring of its membership. It will also enhance CAHISC integration and member engagement by encouraging cross-committee communication and attendance at different committee meetings. Lastly, the committee can establish a formal program for acknowledging and honoring member participation and growth.

Section 2 - Where We Are Now

Section I describes the current state of the epidemic in the Chicago Area, the needs assessment and gap analysis conducted by the CAHISC committees, and Committees' recommendations to guide planning and implementation of services. It starts with an *epidemiological profile* developed by the CDPH HIV/STI Surveillance Section staff with input from CAHISC Committees. Each of the CAHISC Committees reviewed data presented by surveillance staff who regularly attended monthly meetings. Presentations included data from:

- Chicago HIV/AIDS Reporting System (eHARS)
- Chicago Medical Monitoring Project (MMP), a supplemental surveillance project that is conducted annually and produces nationally representative data on people with HIV/AIDS receiving care in the United States
- National HIV Behavioral Surveillance System (NHBS) that monitors selected risk behaviors, HIV testing experiences, use of prevention programs, and HIV prevalence in three populations at high risk for HIV infection: MSM, injection-drug users, and heterosexual adults at increased risk.

Presentations highlighted data specific to each CAHISC Committee's area of the continuum of care and invited specific inquiries by Committee members to focus data presentations. The profile presented here reflects these discussions and presents data by the continuum of care area as well as identifying overarching trends and concerns.

In addition to these data, CAHISC Committees reviewed: 1) prevention programs, 2) service utilization, 3) client level data presented by CDPH staff, 4) published literature and local reports, and 5) local resource inventories. The Committees then identified needs and service gaps in the epidemic that were specific to their area of concentration and formulated recommendations to guide the development of the 2014-2016 Chicago Area HIV Unified Plan's goals and objectives.

The findings from individual Committees were presented and reviewed in monthly meetings of the CAHISC Steering Committee where the information was integrated and presented for further review and feedback in the monthly meetings of CAHISC's Full Council. Working within this structure, the CAHISC Committees and CDPH staff developed a gap analysis of area services and resources and determined populations and geographic areas where there were noted disparities that needed priority consideration. A comprehensive summary of these findings was presented to CAHISC's Full Council for inclusion in the 2014-2016 Chicago Area HIV Unified Plan.

2.1 Epidemiological Profile

2.1.1 HIV Cases by Demographic Characteristics and Exposure Category

Figure 5 shows the demographics and characteristics of the 21,555 persons living with HIV/AIDS in Chicago as of 2011.

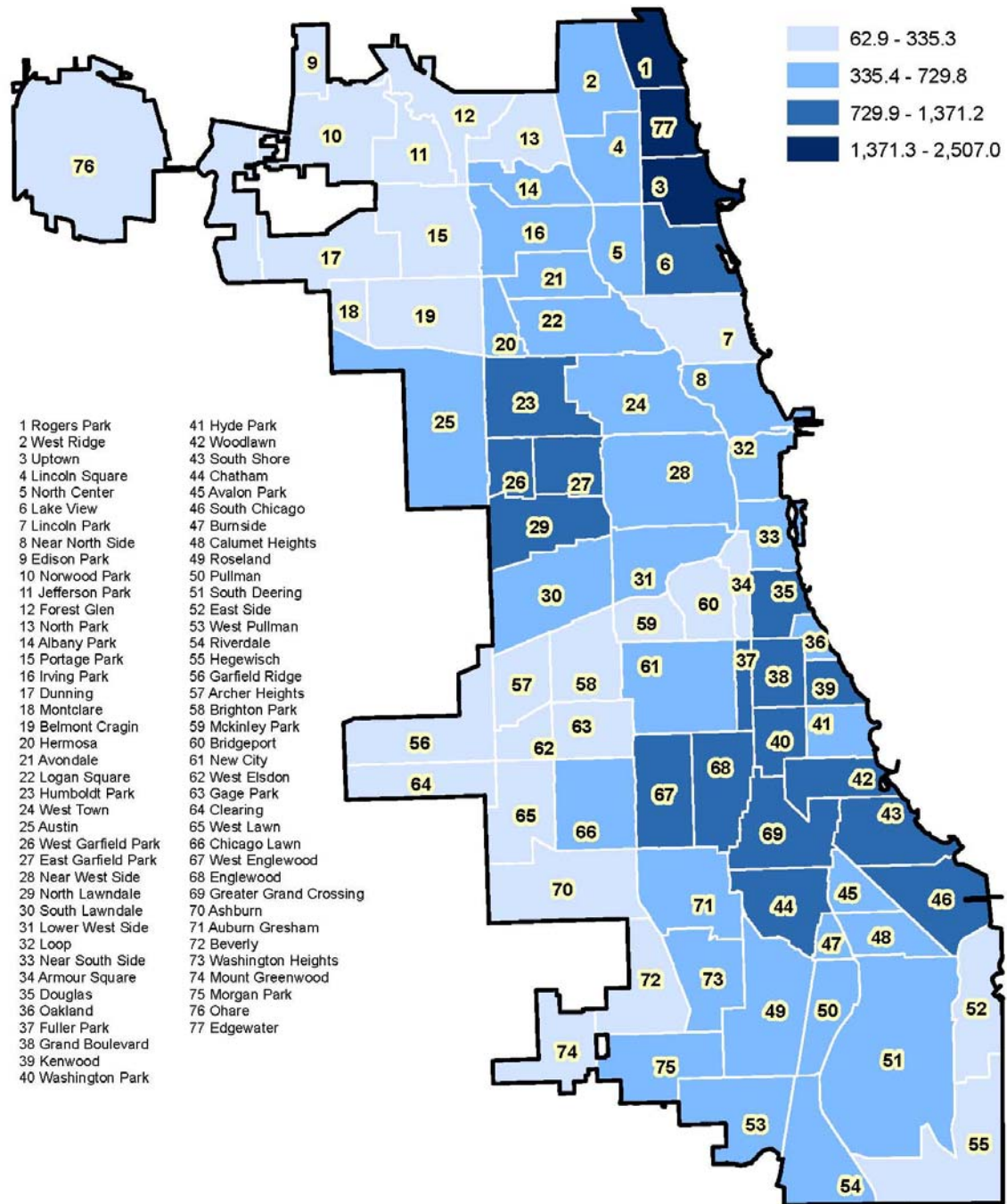
Figure 5. Mode of HIV Transmission by Race/Ethnicity, 2011

	Race/Ethnicity [^]													
	Black, NH		White, NH		Hispanic		Asian/PI, NH		AI/AN, NH		Multiple, NH		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Mode of Transmission														
Males														
Male Sex w/Male	4,862	62.8	4,607	90.3	2,348	74.6	160	80.3	16	67.5	602	76.8	12,610	73.9
Injection Drug Use	1,486	19.2	149	2.9	352	11.2	5	2.6	2	9.6	70	8.9	2,064	12.1
MSM and IDU [§]	641	8.3	251	4.9	209	6.6	11	5.6	2	9.2	83	10.5	1,198	7.0
Heterosexual	645	8.3	73	1.4	214	6.8	21	10.6	2	9.6	25	3.2	981	5.8
Other [¶]	107	1.4	20	0.4	25	0.8	2	1.0	1	4.2	4	0.5	159	0.9
Age category[†]														
13-19	117	1.5	3	0.1	13	0.4	0	0.0	1	4.2	5	0.6	140	0.8
20-24	511	6.6	54	1.1	91	2.9	4	2.0	1	4.2	32	4.1	695	4.1
25-29	611	7.9	188	3.7	212	6.7	7	3.5	3	12.5	48	6.1	1,078	6.3
30-39	1,316	17.0	773	15.2	765	24.3	69	34.7	4	16.7	160	20.4	3,104	18.2
40-49	2,249	29.0	1,994	39.1	1,161	36.9	68	34.2	8	33.3	280	35.7	5,770	33.8
50-59	2,075	26.8	1,540	30.2	636	20.2	38	19.1	7	29.2	201	25.6	4,506	26.4
60+	838	10.8	549	10.8	268	8.5	13	6.5	0	0.0	57	7.3	1,728	10.1
Total Males	7,746	100.0	5,101	100.0	3,150	100.0	199	100.0	24	100.0	784	100.0	17,055	100.0
Females														
Injection Drug Use	990	30.2	140	43.0	137	22.0	5	14.1	1	28.0	60	43.1	1,336	30.3
Heterosexual	2,157	65.8	175	53.6	461	73.8	28	82.9	4	72.0	75	54.0	2,900	65.7
Other [¶]	128	3.9	11	3.4	26	4.2	1	2.9	0	0.0	4	2.9	170	3.9
Age category[†]														
13-19	88	2.7	6	1.8	6	1.0	0	0.0	0	0.0	0	0.0	100	2.3
20-24	164	5.0	5	1.5	24	3.8	0	0.0	0	0.0	5	3.6	198	4.5
25-29	240	7.3	8	2.5	40	6.4	2	5.9	0	0.0	6	4.3	296	6.7
30-39	755	23.0	66	20.2	145	23.2	9	26.5	0	0.0	21	15.2	998	22.6
40-49	1,021	31.2	112	34.4	208	33.3	14	41.2	0	0.0	49	35.5	1,407	31.9
50-59	753	23.0	102	31.3	140	22.4	6	17.6	4	80.0	46	33.3	1,053	23.9
60+	226	6.9	27	8.3	59	9.4	2	5.9	1	20.0	10	7.2	326	7.4
Total Females	3,277	100.0	326	100.0	625	100.0	34	100.0	5	100.0	138	100.0	4,413	100.0
Total Transgender: MtF	41	100.0	5	100.0	18	100.0	0	0.0	0	0.0	6	100.0	70	100.0
Total Transgender: FtM	15	100.0	0	0.0	2	100.0	0	0.0	0	0.0	0	0.0	17	100.0
All HIV Infections in 2011	11,079	100.0	5,432	100.0	3,795	100.0	233	100.0	29	100.0	928	100.0	21,555	100.0

*Note: Groups may not total 100% due to rounding. Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. *HIV infection diagnoses represents people newly diagnosed with HIV in a given year, at any stage of disease through 4/1/2013. **Current gender identity or gender with which a person identifies. ^ Multiple, non-Hispanic indicates more than one race identified; NH = not Hispanic. §Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion and hemophilia. †Age at time of diagnosis.*

Figure 6 shows HIV prevalence by community area. In the beginning of the epidemic, HIV/AIDS cases were concentrated in the North Side Community Areas of Chicago along the lake. Though prevalence in these areas remains high, the epidemic has now spread throughout Chicago and highly impacts African American and Hispanic populations living in community areas on the South and West sides of the City of Chicago.

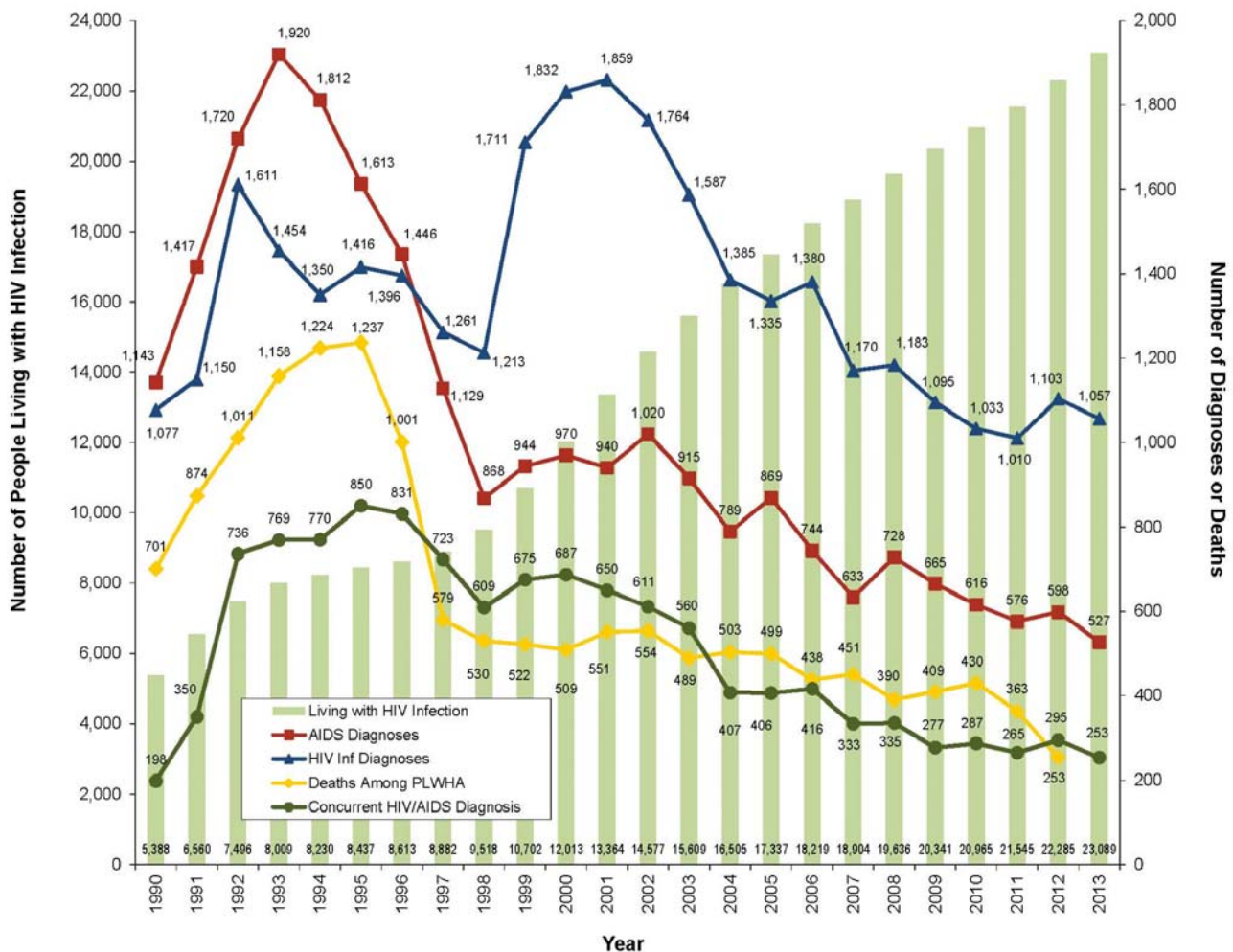
Figure 6. Persons Living with HIV/AIDS, Chicago, 2011 by Chicago Community Area



2.1.2 Trends in the Chicago EMA HIV/AIDS Epidemic

Surveillance data have been evaluated and reviewed collaboratively by CDPH's Office of HIV Surveillance, Epidemiology, and Research and the CAHISC Committees to determine trends in the local epidemic. Comparisons with national data have been noted where significant and enhanced through a literature review developed by each CAHISC Committee. The trends have been delineated by continuum of care area and highlight disparities, disproportionate impact and populations of special concern.

Figure 7. Trends in HIV/AIDS Diagnoses in Chicago – 20 Years



As seen in Figure 7, over the past decade the number of reported cases of HIV and AIDS in Chicago have dropped significantly (i.e., 46% HIV, 43% AIDS). There has also been a decrease in the number of new HIV diagnoses reported concomitant with an AIDS diagnosis, from 38% in 2001 to 25% in 2011. Major reductions in HIV and AIDS have occurred across the decade among male and female, across all racial/ethnic groups, and

modes of transmissions. Despite these positive trends, Chicago, like most urban areas in the United States, continues to have significantly higher rates of HIV diagnosis than the country overall. Chicago's 2011 HIV prevalence rate is three times greater than the national rate, while new HIV infection and AIDS diagnosis rates are both at least double. At the same time, as illustrated in Figure 7, the total number of people living with HIV/AIDS continues to increase which impacts the system of Care, Housing and Essential services.

2.1.3 Primary Prevention and Early Intervention

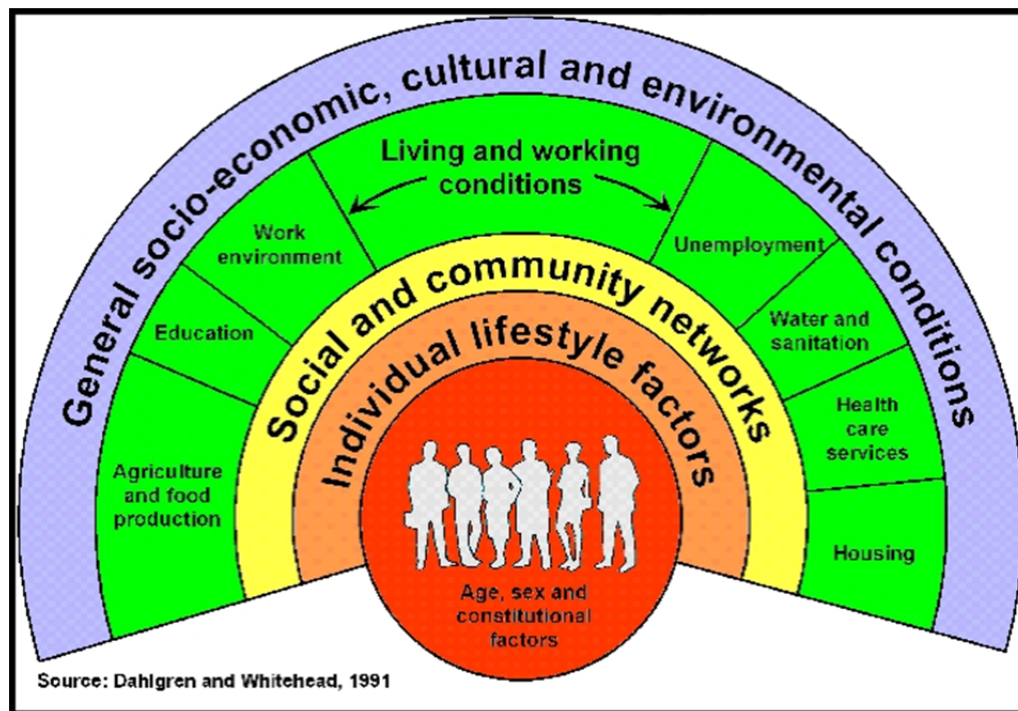
It is estimated that 16% of HIV infected individuals in the EMA are unaware of their status or have not been diagnosed. These estimates have been based on a CDC formula derived from national data and do not describe who and where these individuals are or why they remain unaware and untested. Several local surveys have developed a qualitative depiction of these individuals that will guide efforts to reach, identify and those at risk of HIV/AIDS.

Data from the 2011 Medical Management Project (MMP) found that among 205 respondents, 54% had not been previously tested before being diagnosed with HIV. Among the top three reasons for not being tested, more than half of respondents (55%) did not think they were at risk, 16% feared stigma attached to HIV and 9% stated that drinking or using drugs was the main factor.

The National HIV Behavioral Surveillance System (NHBS) is the primary source of data for monitoring behaviors among populations at risk for HIV infection in Chicago. Local NHBS data were collected in various Chicago neighborhoods and surveyed MSM, IDU and lower socioeconomic heterosexual populations. Overall, findings revealed that there is an increased need for STI/HIV testing opportunities targeted to all high risk populations, as well as an increased need for free condom distribution. For heterosexual women, intervention components must address condom negotiation skills and disclosure of serostatus with sex partners. Priority interventions targeted to MSM groups must address the issue of "condom fatigue," increasing rates of unprotected anal sex, as well as the relationship between drug use and high risk behaviors.

Studies among local cohorts of MSM and high risk heterosexuals clearly describe the role of the Social Determinants of Health (SDH) in HIV risk and infection. The SDH consist of a complex set of intertwining social and economic structures and systems that have helped broaden the conception of prevention activities beyond a narrow focus on changing individual risk behaviors (Figure 8).

Figure 8. Socio-economic, Cultural and Environmental Impact on Individuals



Adverse Childhood Experiences and HIV Risk Behaviors among Chicago MSM (2008)

Adverse childhood experiences (ACEs) are social determinants of health that include psychological, physical, and sexual abuse, as well as family dysfunction. They have been linked to a range of adverse health outcomes and in this study, MSM in Chicago who had high levels of ACE were twice as likely to have unprotected sex with a casual partner, and were twice as likely to report being afraid to find out their current HIV status. Several studies^{ii, iii, iv, v}, also found that Adverse Childhood Experiences are twice as likely to have been experienced by MSM than the general male population and 3.75 times as likely to be experienced by Black and Hispanic MSM.

2.1.4 The Heterosexual HIV Epidemic in Chicago: Social Determinants of HIV (2008)

The findings of these studies confirmed findings of a previous study^{vi} done nationally that in Chicago, aggregate-level poverty can be used to define and locate heterosexuals *at highest risk* for HIV infection. The study recommended that prevention efforts should be focused on reducing unprotected sex and substance use and increasing HIV testing and knowledge of status. Based on findings it also recommended that efforts to change individual behaviors be combined with new approaches that address the Social Determinants of Health. These studies confirm the prevention knowledge of those in the field that those at highest risk of infection and unaware of their status are those most negatively impacted by the social determinants of health and that specific outreach and support needs to be targeted to heterosexual living in poor communities (income curve)^{vii}, to all MSM and specifically to Black and Hispanic MSM.

2.1.5 New HIV Diagnoses

As noted previously in Figure 7, in the last decade, there has been a steep decline in the number of HIV cases reported annually (46%). This decline has been **most** consistent and dramatic among IDUs, which has greatly contributed to the overall decrease in new infections. In 2011, IDUs represented only 7% of new infections. However, as illustrated in Figure 10, disparities in new HIV infection diagnoses persist.

Figure 9. IDU Infection Rates Decrease Almost 90% since the Year 2000

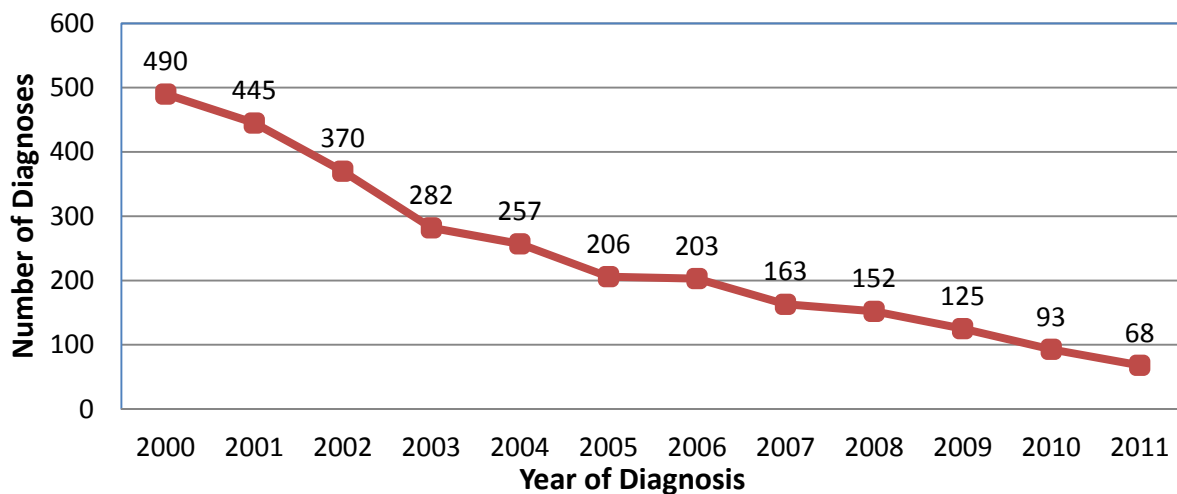


Figure 10. HIV Infection Diagnoses by Select Characteristics, Chicago, 2011

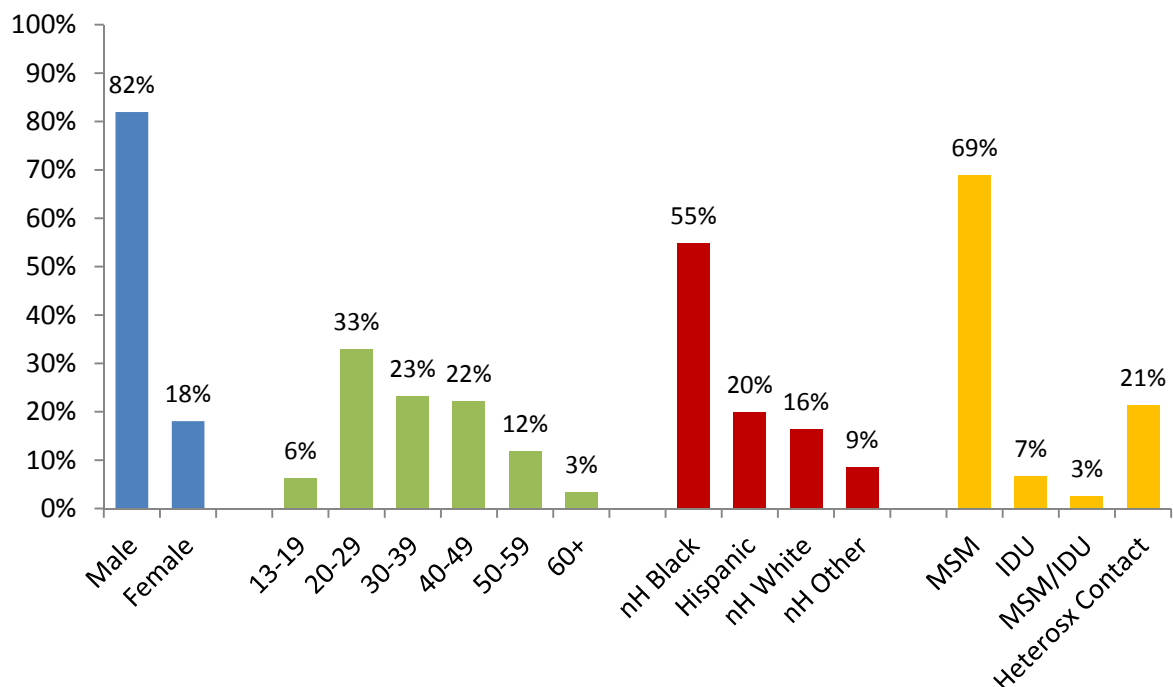
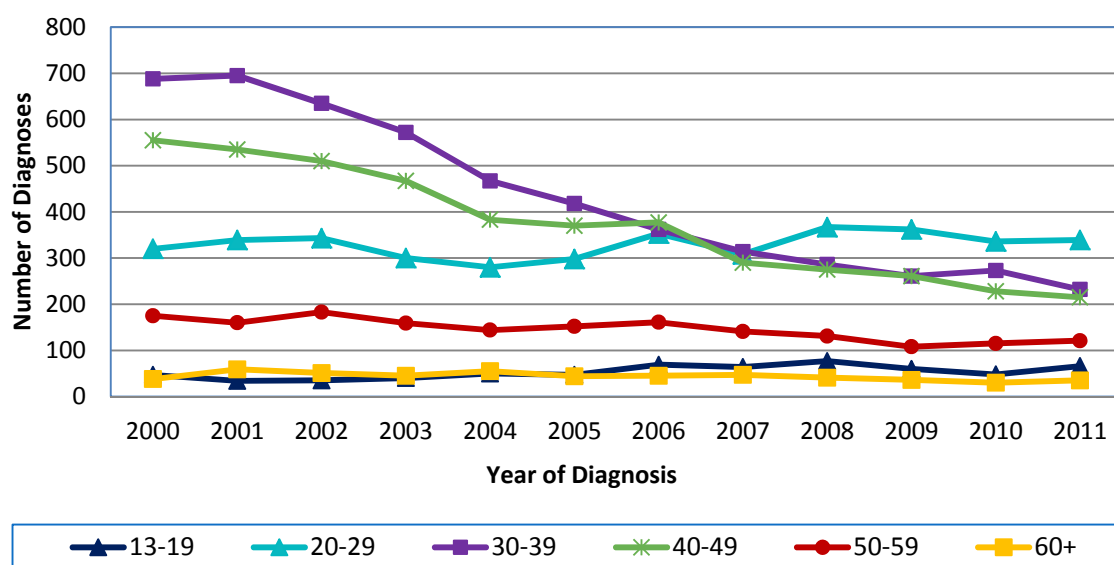


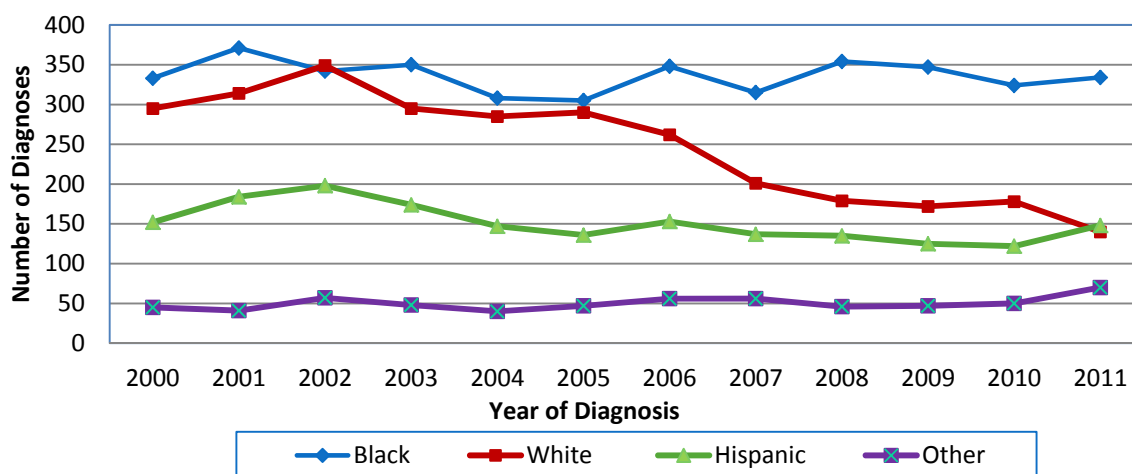
Figure 10 graphically illustrates that the majority of new HIV diagnoses occur in the African American community, 55% of the individuals newly diagnosed with HIV in 2011 were Black. MSM continue to have the highest incidence of new infection, 694 MSM comprising 69% of new HIV diagnosis in 2011. Of these new infections, 334 (48%) were Black. Black and Latino MSM ages 20-29 accounted for the largest proportion of HIV diagnoses among each of these groups. Figure 11 shows, new infections were highest among those under 40 (62%) with the highest percentages among those 20-29 (33%). HIV infection diagnoses among people under age 30 have remained consistently high over the past several years.

Figure 11. HIV Infection Diagnoses by Age Group, 2000-2011



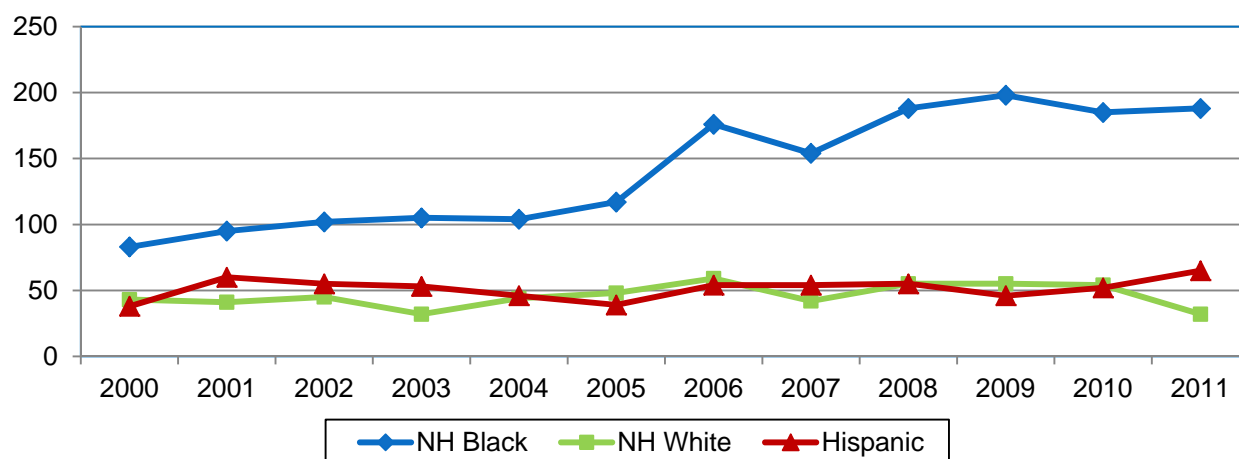
MSM continue to have the highest rate of new infection and while this rate has decreased among Whites, there has been an increase among Black and Hispanic MSM (Figure 12).

Figure 12. HIV Infection Diagnoses Among MSM by Race/Ethnicity, 2000-2011



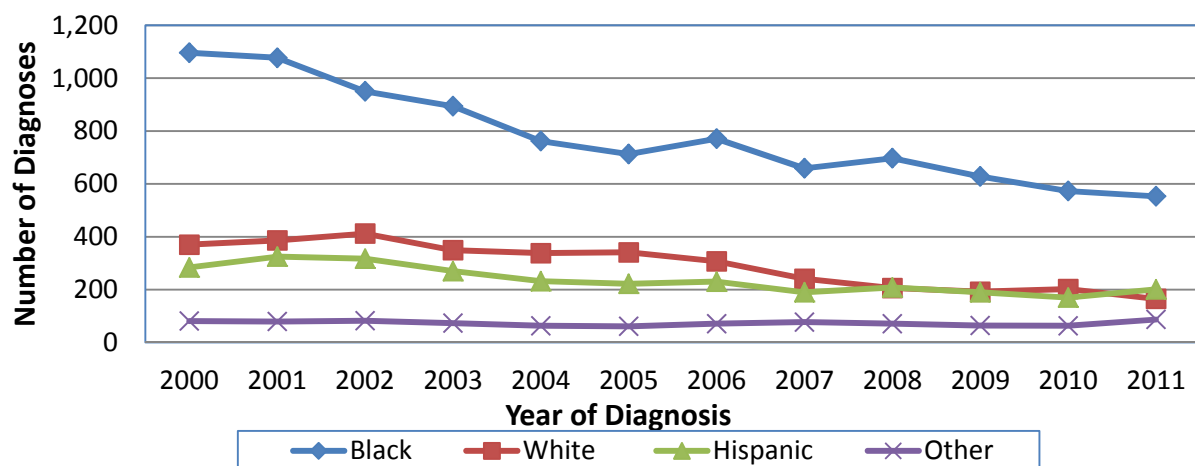
As shown in Figure 13 below, this increase has largely occurred among Black and Latino MSM under thirty.

Figure 13. Newly Diagnosed HIV Infection Among MSM under age 30, by Race/Ethnicity, 2000-2011



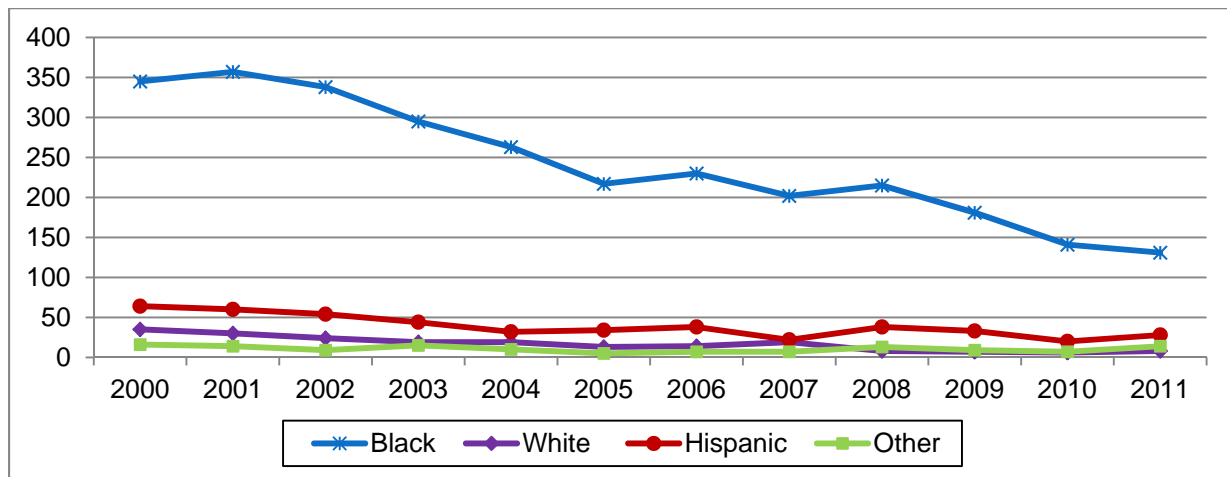
Racial Disparities have persisted over time. Though there has been a decline in new diagnosis in the last decade, non-Hispanic Black males and females comprise the majority of HIV diagnosis (55%) in 2011 and every year have had significantly higher numbers of HIV diagnoses than the other racial/ethnic groups.

Figure 14. HIV Diagnoses by Race/Ethnicity, 2000-2011



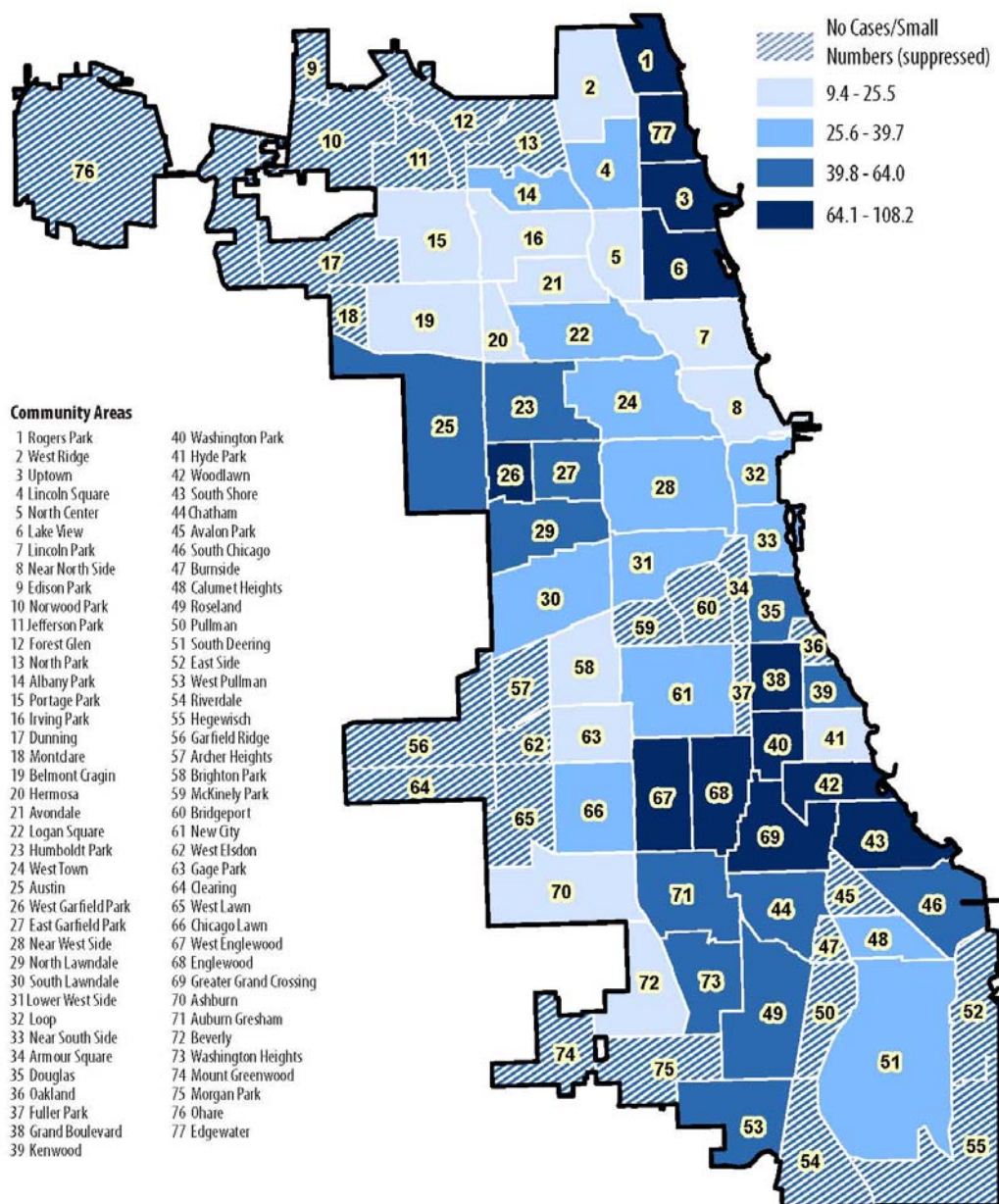
While there has been a notable decrease in new HIV diagnosis among Black women between 2000 and 2011 (Figures 15), there continues to be a marked disparity in the number of new diagnosis when compared to other race/ethnicity groups.

Figure 15. HIV Infection Diagnoses Among Females, by Race/Ethnicity, 2000 - 2011



The following map (Figure 16) indicates the community areas where those newly diagnosed are living. High incidence continues to occur among the MSM population in North Side community areas while high of new infection is also reported by those living in African American communities on the West and South Side. While this clearly indicates highly impacted areas where people infected are residing, we need more information about where people are being infected. Further inquiry needs to be developed to determine whether people are being infected in communities where they live or in other areas of the city, and the role of social networks (i.e. MSM, IDU, Black women) in creating differences in the rate, location and transmission of infection.

Figure 16. 2010-2011 Average HIV Infection Diagnoses Rate (per 100,000) by Community



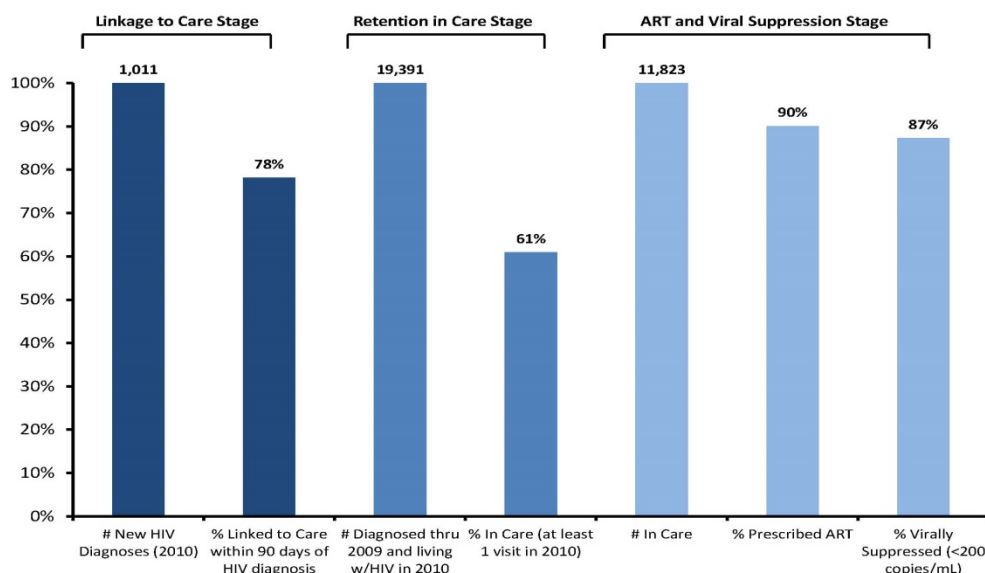
2.1.6 Viral Suppression and the Continuum of Care

Viral suppression among HIV-positive persons is a critical component of the HIV treatment and prevention strategy in Chicago. Recent studies^{viii} have shown that viral suppression decreases the risk of transmitting the HIV virus to others by 96%. Widespread viral suppression among persons infected with HIV could have a major impact on reducing the HIV epidemic in Chicago. In order to achieve this outcome, persons with HIV must engage in a continuum of testing and care services.

These services begin with HIV testing and diagnoses, followed by prompt and effective linkage to HIV medical care and essential support services. Engagement continues with consistent and ongoing retention in HIV medical care, prescription and adherence to antiretroviral therapy (ART), and finally sustained viral suppression. Local surveillance data now allows the Chicago Department of Public Health to monitor many of the indicators along this continuum.

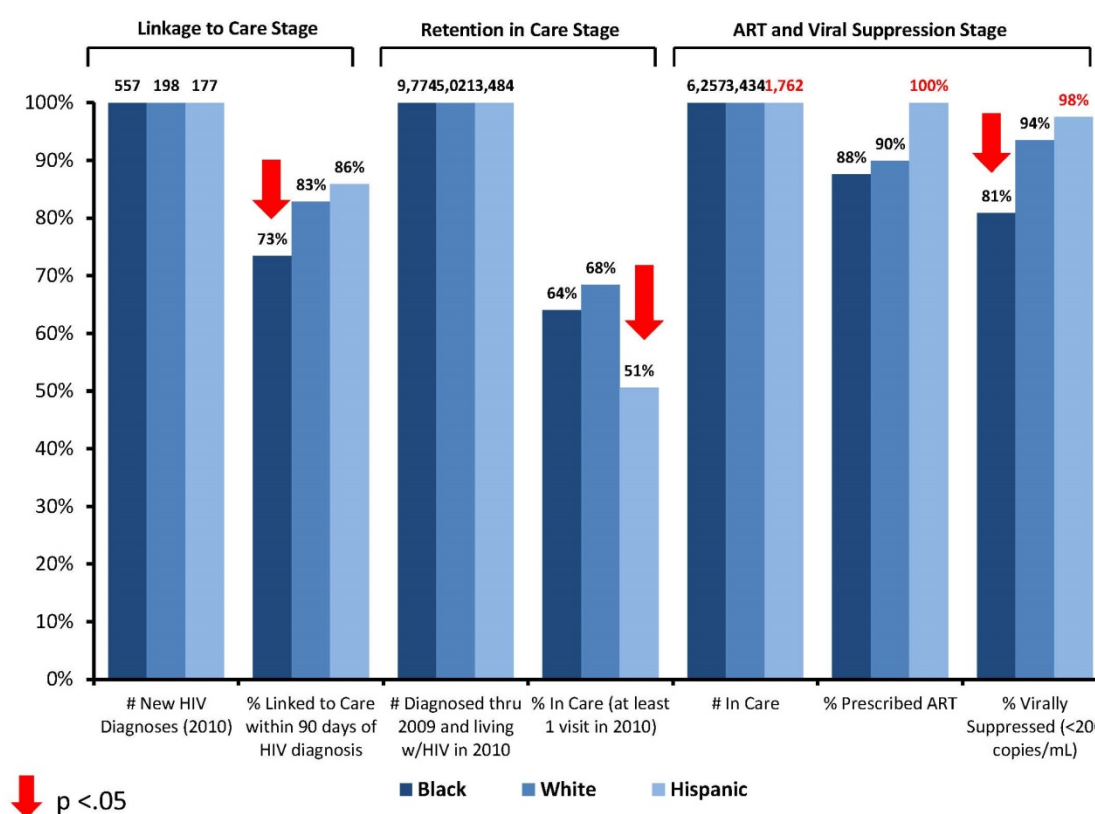
Using data from the Chicago HIV/AIDS Reporting System and the Chicago Medical Monitoring Project (MMP) we determined the number of persons (18 years and over) diagnosed with HIV and the percentages of adults linked to care, retained in care, on ART and virally suppressed in the city of Chicago. Almost 8 of 10 (78%) adults diagnosed with HIV in 2010 were linked to HIV medical care within 3 months of their diagnosis. However, less than two-thirds, (61%) of all adults living with HIV in Chicago in 2010 received HIV medical care in 2010. In addition, we estimate that of those who had received HIV medical care in 2010, 90% were prescribed antiretroviral therapy (ART) and 87% had a suppressed viral load.

Figure 17. The HIV Continuum of Care, Chicago 2010



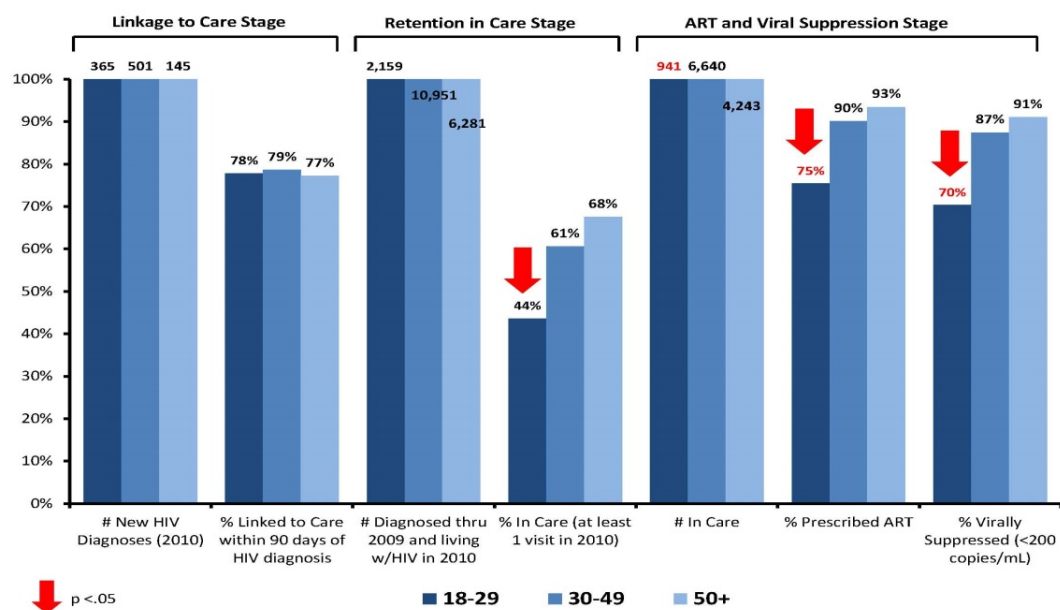
Data has been analyzed to identify characteristic of those who are less likely to be linked and retained in care, on ART and Virally Suppressed. As seen in Figure 18, in 2010 78% of those newly diagnosed with HIV were linked to care, yet among the 19,391 persons living with HIV only 61% were retained in care. Blacks are less likely than others to be linked to care within 12 months and only slightly less likely than Whites to be prescribed ART, they were significantly less likely to achieve viral suppression. Hispanics were slightly more likely to be linked to care (86%); they were significantly less likely to be retained (51%).

Figure 18. HIV Continuum of Care by Race/Ethnicity, Chicago 2010



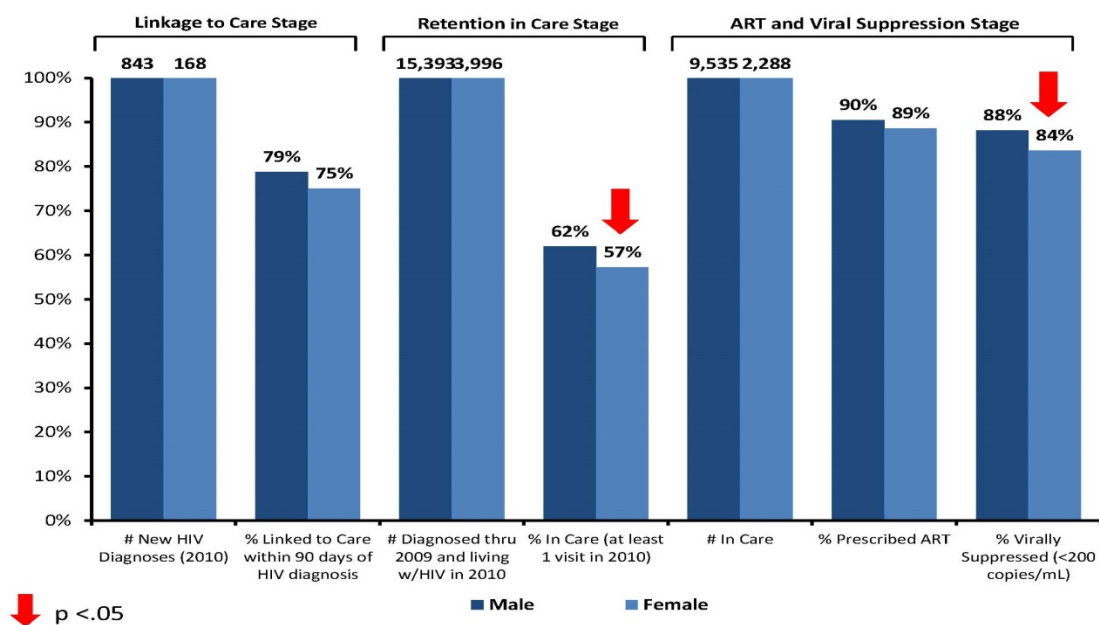
Though data does not indicate significant differences among age groups linked to care, youth are driving the gap *between* linkage and retention both nationally and in the EMA. Among those diagnosed and living with AIDS in the EMA in 2010 only 44% of those 18-29 linked to care were retained in care (Figure 19). This age group also has significantly lower rates of ART prescription (75%) and Viral Suppression (70%).

Figure 19. HIV Continuum of Care by Age, Chicago 2010



Data also indicates that women are less likely to be retained in Care and Virally suppressed, Figure 20.

Figure 20. HIV Continuum of Care by Sex, Chicago 2010



Though surveillance data indicate differences among groups, it does provide information as to why those differences occur. The Medical Management Project (MMP) provided some information about how and why respondents entered the medical system and were linked and retained in care.

Top Reasons Patients First Entered HIV Medical Care After Diagnosis, Chicago, MMP 2011

	<u>Number</u>	<u>Percent</u>
Medical evaluation at the time of diagnosis	34	17
Appointment scheduled for medical evaluation at the time of Diagnosis	44	22
Referral for doctor given	47	23
Self-motivated	66	32
Family or friend motivated	6	3
Other	6	3
Total	204	100

Additional MMP data also provided information on issues in treatment disruption and re-engagement. Only 36% of respondents reported receiving follow up calls or letters from their providers for missed appointments, and of those whose care was interrupted 60% reported that no attempts were made by providers to contact them to restart their care.

Interruptions in HIV Medical Care, Chicago, MMP 2011

- 19% (38/205) had their care interrupted for a period of more than 6 months consecutively at least one time since being diagnosed
 - 56% only once
 - 44% two or more times
- Most Important Reasons provided for most recent time:
 - Drinking or using drugs
 - Missed appointment(s)
 - Did not have enough money or health insurance
 - Had other responsibilities
 - Felt good
 - Dissatisfied with care from provider
- 60% said there were no attempts made by provider at the most recent occurrence to restart their care

Table 1. Summary of Epidemiological Trends

Summary of Trends in the Chicago HIV Epidemic	
Social Determinants of Health (SDH)	<ul style="list-style-type: none"> Local and national studies have emphasized understanding prevention and intervention across the whole HIV continuum in the context of the Social Determinants of Health
Blacks	<ul style="list-style-type: none"> The highest percentage of new infections and the lowest annual decrease Higher incidence of new infection in African American communities on the West and far South Side of Chicago. Less likely to be linked to care Less likely to be on ART and Virally suppressed
Hispanics	<ul style="list-style-type: none"> Lower rate of decrease of new infections than among whites The incidence of late stage diagnosis of new infection has remained the same among Hispanics Low rates of retention in care
MSM	<ul style="list-style-type: none"> MSM 2x as likely and Black and Hispanic MSM more than 3x as likely to have experienced ACE as the general male population. This directly affects risk behavior and entry into care The majority of new infections in the last ten years have been among MSM and while the numbers of new infections have decreased significantly among White MSM, they have only slightly decreased among Hispanic MSM and have significantly increased among Black MSM. Black MSM comprise 44% of new MSM infections
Women	<ul style="list-style-type: none"> Rate of decrease of new infection lower among Black women than white Less likely to be linked to care Less likely to be on ART and Virally suppressed
Youth under 30	<ul style="list-style-type: none"> While the number of new infections has remained consistently high among youth under 30, there have been recent increases of new infections among MSM in this age group Lower rates of retention in Care Less likely to be on ART and VS
Heterosexuals	<ul style="list-style-type: none"> Aggregate-level poverty data can be used to locate heterosexuals <i>at highest risk</i> Less likely to be linked to care Less likely to be on ART and VS

Geographic areas	<ul style="list-style-type: none"> • Community poverty level data can be used to locate those at highest risk of infection • Highest incidence of new infection in Northside gay communities • Higher incidence in African American communities on West and Far South Side • Less likely to be on ART and VS if received HIV Care on the South, Far South, West, and Central community areas of the city
Homelessness	<ul style="list-style-type: none"> • 138,575 people in Chicago were homeless in 2014, an increase of 19.4% over the previous year • In 2013, 4% of homeless individuals served in Chicago Shelters and Housing programs were HIV positive • According to Findings from the National Housing and HIV Research Summit Series: Of the 1.2 million people living with HIV/AIDS in the United States, half will need housing assistance at some point in their lifetime.

Homelessness

An accurate measure of HIV prevalence among the homeless is difficult to obtain because of the transient characteristics of the population. Data gathered by the The Chicago Coalition for the Homeless (CCH) reveal the extreme vulnerability of this population to HIV and other chronic and infectious public health conditions. As reflected in HIV surveillance statistics, youth are particularly vulnerable to HIV infection and difficult to treat. In an analysis conducted in August 2014 it was estimated that there were 12,186 unaccompanied youth (ages 14 through 21 without a parent or guardian) among the homeless. CCH based this estimate in part on the rising enrollment of homeless students in Chicago Public Schools (CPS) – 22,144 in FY14. Eighty-eight percent of homeless students lived in overcrowded conditions in the homes of others and 2,508 were homeless and living without parent or guardian, 98.2% were children of color and 20% have been diagnosed with disabilities or developmental delays.

For the U.S. Conference of Mayors 2013 Survey on Hunger & Homelessness, the city of Chicago reported that 12% were employed but homeless, 6% were veterans, 4% were HIV positive, 30% physically disabled, and 28% severely mentally ill. In a comprehensive 2004 study, 56% of women in Chicago shelters reported that they had experienced domestic violence and 36% said they had experienced physical or sexual abuse in their homes as children. Homeless individuals with chronic medical conditions are at high risk for severe medical complications that can be costly to treat and, if left untreated, can prove deadly. Other factors including poverty, substance use, mental illness and food insecurity compound an individual's health challenges. National studies have found that homeless individuals are less likely to be on Anti-retroviral treatment and less likely to be adherent to HIV or other treatment regimens.

In May 2009, the *Journal of the American Medical Association* (JAMA) published research findings confirming that immediate access to housing and support services improved the

health of HIV-positive homeless people by directly reducing viral loads. This finding clearly indicates the crucial importance of integrating prevention, care and housing services.

Transgender

Though detailed surveillance data is not yet available in Chicago, the transgender population has been identified by CDC as a population of special concern and has been disproportionately impacted by HIV nationally and in Chicago. In a comprehensive review^{ix} of 29 U.S.-based studies focusing on male-to-female (MTF) transgender women findings indicated that 27.7% tested positive for HIV infection. Higher HIV infection rates were found among African-American MTFs (56.3%) and large percentages of MTFs (range, 27–48%) reported engaging in risky behaviors (e.g., unprotected receptive anal intercourse, multiple casual partners, sex work). In contrast these studies found that incidence rates of HIV and risk behaviors were low among FTMs (female to male).

Local Data are limited. CDPH began reporting surveillance data on transgendered persons in their surveillance reports in December of 2013. Though numbers remain low and detailed information is not yet available, the reported sero-positivity rate among transgender is 2.6% as compared to 0.9% among males and 0.3 among females. Highest rates occur among Blacks (4.4%) and Hispanic (2.5%) transgender. A local study^x in 2004, interviewing 51 male to female (MTF) subjects 16-24 years of age found that 22% were HIV positive. 57% of the positives were African American. There was an incidence of life stressors among the sample including history of incarceration (37%), homelessness (18%), sex in exchange for resources (59%), forced sexual activity (52%), difficulty finding a job (63%), and difficulty accessing health care (41%). Within the past year, 98% had sex with men, 49% had unprotected receptive anal intercourse, and 53% had sex under the influence of drugs or alcohol. Substance use within the past year was common. The sample also reported social and familial isolation and a lack of income and economic resources.

The CDPH 2012 Lesbian, Gay, Bisexual Transgender (LGBT) Community Action Plan^{xi} cited local and national findings that transgender people are disproportionately impacted by high tobacco use, bullying, homelessness physical abuse, social isolation, economic marginalization and the practice of survival sex. There is a lack of culturally competent medical and service providers which results in unmet transgender specific needs. This information clearly indicates the severity and complexity of the Health Care needs of the transgender population. The complex interactions among stigma, sexual identity formation, and sexual risk require the development of comprehensive approach to provide outreach and treatment to this population. The CDPH Action Plan recommends collecting gender identity at HIV testing, developing an HIV-related behavioral survey to assess high risk behaviors, allowing agencies to adapt empirical behavioral interventions for transgender individuals and to fund capacity-building for community-based organizations to provide services to address the priority needs of this population.

2.2 Committee Needs Assessments

The Steering Committee charged each of the PPEI, LRC, and AVS Committees to review and evaluate needs assessment data specific to their continuum of care area. Each Committee conducted a literature review of local and national studies and developed inventory of local

services. All Committees also engaged in their own survey activities. The following are summaries of their investigations and their identification of needs and service gaps. Each Need and Service Gap statement is followed by the Committee's recommendations for actions to be taken to address the needs and gaps. Recommendations cover a wide array of activities and include suggestions for delivery of services, planning and future research, training, and coordination. Some may be addressed through the services that are supported in plan years 2014-2016 while others provide a vision for longer-term strategies or components of an ideal system of care. Not all recommendations can be addressed with current funding and resources or without further investigation. However, all are documented here as having been identified by the Committees as part of their needs assessment and planning process.

2.2.1 A Primary Prevention and Early Identification-Committee Findings

The PPEI Committee has reviewed the inventory and specifications for agencies funded for prevention services in Chicago. Site visits were conducted to gather qualitative information on about how agencies are addressing the needs of specific populations and the issues that they encounter. The Committee also conducted a survey of 18 agencies providing prevention services and invited external experts, community organizations, and governmental representatives to deliver presentations during the PPEI monthly meetings. After reviewing this information, epidemiological data and additional articles gathered in a literature review^{xiii}, the Committee identified needs and service gaps and formulated the following recommendations.

2.2.1.a Need and Service Gap: Develop a holistic prevention approach that fully addresses the needs of those at risk

Despite the promotion of secondary prevention/"treatment as prevention" approaches to HIV-prevention, national and local rates of new transmission events have increased or remained stable within particular subpopulations. The Chicago Department of Public Health's 2013 HIV/STI Surveillance report indicates that race, sexual orientation, and age currently moderate vulnerability to HIV infection. Between 2007 and 2011, the city of Chicago witnessed overall declines in annual rates of new HIV infection and yet the rates of new HIV infection have continued to increase by an average of 5% every year during that same time frame among gay and bisexual males. Racial disparities in HIV infection remain persistent with non-Hispanic blacks having HIV-infection rates that are three times higher than non-Hispanic whites and two times higher than Hispanics. Among heterosexual females, non-Hispanic black women continue to comprise nearly three quarters of new infections. Age continues to play a significant factor in Chicago's HIV epidemic with decreases in rates of new HIV infection observed in all age groups except for the 20-24 year old age group in which the infection rate increased by an average of 5% between 2007 and 2011.

Due to the multiple forms of oppression and social disadvantage that many individuals must negotiate, HIV prevention interventions must address the political, economic, social, and technological (PEST) inequalities that continue to perpetuate new HIV transmission events among particular subpopulations. These interventions must address concerns

related to HIV criminalization, stigma, access to health insurance, unemployment, cultural competence in service delivery, confidentiality, and many others. Given the substantial impact that social determinant factors have played in past analysis of HIV vulnerability in the City of Chicago (CDPH MSM Surveillance Report of 2012), there continues to be a need to better understand the role that social determinant factors play in shaping vulnerability to HIV infection. There is a need for reliable data that could potentially be collected across city agencies about the impact that gender identity, housing status, and income level have on HIV-infection risk. This data should inform ongoing conversations about which populations are at greatest vulnerability to HIV-infection and should be construed as priority populations within a holistic and integrated HIV-prevention strategy.

Recommendations:

1. Fund interventions to include the provision of more integrative/holistic services for primary prevention. These services would include mental health/substance abuse direct services, case management, STI testing, and primary care referrals/treatment. This approach has been outlined in the “Double Helix” graphic developed by the Treatment Action Group (See Appendix - A Double Helix of HIV Prevention and Care Continuum^{xiii}).
2. Given the complex structural and social determinant factors that shape vulnerability to HIV infection, more holistic outcome measures for evaluating the efficacy of interventions must be developed and greater flexibility in staffing models and service description types must be employed to effectively respond to emerging trends in the epidemic. These changes could include:
 - Primary process measures for interventions are often based on self-reported behavior change measures (e.g., condom adherence, etc.) for interventions that aim to address risk behaviors through participation in evidence-based interventions, HIV counseling risk reduction sessions, etc. The “double helix” approach would dictate that these process measures be broadened to include the delivery of services, (e.g., STI tests administered, mental health encounter, primary medical encounters, PrEP enrollment, health insurance enrollment, benefits enrollment, etc.) to the highest risk populations.
 - In addition, new constructs could be used to evaluate interventions in the realms of “resilience,” “self-efficacy,” or “normative change” rather than strict self-reported behavior change constructs.
 - Funded agencies could partner with the Chicago Department of Public Health to consider expanding the scope of accepted primary prevention activities to include primary care, STI testing, behavioral health/substance use treatment, and case management services to name a few. Expansion of the service description categories would allow funded agencies the flexibility to identify the most efficacious evidence supported methods for responding to HIV vulnerability within their respective contexts.

- The expansion of accepted primary prevention service activities/interventions might necessitate greater flexibility in primary prevention staffing models. This might include salary allocation for behavioral health professionals, primary medical providers, and case managers/resource advocates.

A.2. Need and Service Gap: Access to Pre-Exposure Prophylaxis (PrEP)

PrEP is a scientifically proven method of HIV prevention and there have been local research and implementation efforts to utilize PrEP to prevent new infections and transmission of the virus. A Chicago PrEP Working Group of researchers, providers and consumers involved in local research and implementation activities is in the process of developing an implementation strategy. Several CAHISC members and CDPH staff are participating in the Working Group.

Recommendations:

1. Develop a city-wide social marketing/education campaign including print, digital and social platforms to provide education on PrEP that will directly address the stigma surrounding PrEP adherence among gay men.
2. Place a greater emphasis on funding prevention organizations that either have a capacity to directly provide PrEP to patients (e.g., Federally Qualified Health Centers, medical centers, etc.) or who have a formal coordinated relationship with a PrEP clinic/referring provider within their health care network. This is an example of an area where greater regional coordination of HIV prevention funding could allow for all funded agencies within a service area to partner with a particular PrEP clinic or provider.

A. 3. Need and Service Gap: Expand use of proven and innovative approaches in targeting High-Impact Prevention Interventions

According to the CDC, the purpose of High-Impact Prevention (HIP) is to use “combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas [to] increase the impact of HIV prevention efforts.” In order to achieve this objective, greater emphasis must be placed on how funded agencies can efficiently identify the individuals who are most in need of HIV-prevention resources.

Recommendations:

1. Wider usage of social network/respondent driven approaches. These approaches have been demonstrated to have much higher rates of HIV sero-positivity identification and are currently widely used as recruitment approaches in network-based HIV research studies, however, are not as frequently used in HIV prevention programs for the identification and linkage of individuals who are most at-risk.
2. Use of geosocial/social media technologies for greater targeting of HIV prevention interventions to the highest risk populations.

3. Implement new approaches for the administration of partner services. Current approaches rely on funded agencies delivering partner information to CDPH who then contact partners either through the mail, by phone, or home visit. Approaches for exploring the use of technology-based patient initiated or public health-initiated notification systems could greatly increase efficiency and accuracy in partner notification.
4. Expand testing technology (4th generation, 1 minute INSTI test)
5. Expand HIV outreach screening to include syphilis and other STIs for MSM and provide comprehensive training in sexual health. Agencies that are funded to provide HIV prevention services to MSM should have staff that can also provide screening, testing and comprehensive sex education (including anal health) to vulnerable populations. Given the strong relationship between the syphilis and HIV epidemics and the high incidence of STI among MSM, greater integration of syphilis and STI testing into MSM HIV prevention programs (either in outreach or clinic settings) is a high-priority.
6. Increase Mobile Medical services—especially targeting MSM on the South and West sides of the city.
7. Provide routine/expanded testing for those who request it.
8. Determine the feasibility of allowing agencies to offer partner notification services to the communities they serve.

A.4. Need and Service Gap: Establish Evidence-informed/Best Practices in Testing, Linkage, and Retention

Consistent with the goals of the NHAS and the CDC's High-Impact Prevention initiative, greater emphasis must be placed on evidence-based services that are provided, specifically in the identification, linkage, retention to care of individuals. Currently, a great deal of flexibility is extended to funded agencies in how services are delivered and there is very little standardization in how funded services are actually delivered. While certain adaptations in service delivery should occur based on contextual factors specific to target populations or service areas, there are scientifically proven best practices for how linkage and retention services should be delivered.

Recommendations:

1. Develop best practice guides/protocols that detail how CDPH funded HIV prevention services should be delivered in the key service areas (e.g., testing, linkage, retention, etc.). These protocols should be used to guide evaluation of fidelity of implementation, process and outcome measures.
2. Provide training through CDPH capacity building unit that is evidenced-based (i.e., anti-viral treatment and access to services for linkage to care).

A.5. Need and Service Gap: Regional Coordination of Prevention Activities

Multiple agencies are funded in the same service areas of Chicago and this has led to what survey respondents called an “over-saturation” of services in specific areas of the city. At the same time, agencies expressed frustration in being able to follow their clients who migrate to other areas because they are limited to providing services within a specific geographically defined area. This results in overlapping and sometimes competitive provision of services and interventions. Grantees are often competing to fulfill similar scopes of service for outreach encounters and behavioral interventions without the informed knowledge of the practices of other agencies in their geographic area or in other areas of the city.

There have been several attempts for prevention agencies to convene to coordinate activities and share best practices (i.e., MSM Testing Task Force, CDPH Prevention Agency Meeting); however, there is a need for a well-managed and consistent meeting to coordinate prevention activities within specific geographic areas across the Chicago area.

Recommendations:

1. Develop and support a mechanism to coordinate quarterly regional prevention meetings.
2. Develop an integrated funding strategy that funds a continuum of prevention and care services for those at high risk and those who are newly infected. For instance, funding one program in each geographic area that has the capacity to offer PrEP to the patients/clients of the funded program areas within that community.

2.2.2 Linkage and Retention in Care – Committee Findings

The Linkage and Retention in Care (LRC) Committee is committed to defining linkage to care programs and best practices that will assure flexibility to meet the needs of the Chicago EMA’s diverse populations and to define common standards and procedures that will facilitate linkage and retention to care. The Committee developed a work plan of three goals to consider each aspect of the LRC process: 1) Linkage to Care, 2) Retention in Care, and 3) Re-engagement in Care. The Committee reviewed over 100 articles on LRC (select articles^{xiv} in Appendix) including the following surveys of linkage to care activities in Chicago:

1. “Connections to Care in Chicago,” MATEC, March, 2012
2. “Chicagoland Linkage to HIV Care,” The Public Health Institute of Metropolitan Chicago December, 2012
3. CDPH Bridge Worker Pilot Implementation – From Data to Care October, 2013
4. Ryan White Early Intervention Services (EIS) Provider Meeting, March 13, 2013
5. Review of EIS Standard, Conference call 2013

The Committee then conducted a provider and consumer survey between January and March, 2014. The LRC survey was distributed to providers, and consumers in the Chicago EMA to determine how respondents define LRC and how LRC activities are practiced. The survey also assessed barriers that inhibit linkage and the reasons that individuals are lost

to care. Findings from this survey have been compared to barriers and best practices determined in previous local surveys (e.g., MATEC, Chicagoland Workgroup) and in studies in the literature reviewed by the Committee.

- Linkage to Care: Issues and Barriers - provider cultural sensitivity, transportation, homelessness, mental health, lack of income, no insurance, and stable housing.
- Lost to Care: Issues and Barriers - lack of consistent definition of lost to care, mental health, HIV and homophobic stigma, housing instability and substance abuse.
- Retention to Care: Issues and Barriers - provider trust, available resources to support treatment, cultural differences, substance abuse and focused intervention efforts for women.

Overall the most frequently cited barriers affecting linkage and retention in care were: housing, a lack of knowledge of services, stigma and fear of discrimination, substance abuse, and a history of incarceration.

Additional information came directly from LRC committee members providing linkage and retention in care activities who described significant issues in being able to effectively accomplish LRC goals.

- One center that provides linkage and follow-up services indicated that the list of follow-up requests has grown and is exceeding the capacity of staff resources.
- Other committee providers have experienced that outreach and follow-up with clients is very complex. It must consider the specifics of populations being served to effectively reach and connect with clients. For example, texting and email works for some clients and may be effective with younger people who use mobile phones, however, it was noted that though many young people have cell phones they change their phones and numbers frequently.
- There are some LTC efforts targeting specific populations (e.g., perinatal youth, IDUs, specific geographic and racial ethnic communities). These are able to develop and fine tune outreach and follow-up efforts, however, there are not enough targeted efforts for defined priority populations (e.g., Youth, Black youth, communities on Chicago's South and West Side).

Based on the findings of these sources, the Linkage and Retention Committee has identified needs and service gaps and formulated the following recommendations to inform the Unified Plan.

2.2.2.a Need and Service Gaps: System-wide Policy for LRC and EIS

Early Intervention services and Linkage and Retention services are the integrating bridge between prevention and care. However, different funding and administrative agencies have created overlapping service definitions, titles and job descriptions for EIS and LRC that inhibit the development of the integrated practice and evaluation of services that will assure that those newly diagnosed will be effectively linked and retained in care. This

could be improved by developing a system for sharing data and information that would strengthen organizations' service provision, bolster inter-agency collaboration and improve coordination throughout the Chicago EMA.

Recommendations:

1. Coordinate EIS efforts throughout the Chicago EMA.

Considerations:

- a. Advocate with federal and local administrative agencies for the funding that will assure that those who are newly diagnosed will be effectively linked and retained in care.
- b. Develop uniform data gathering and reporting forms and a shared database.

B.2. Need and Service Gap: Define Linkage and Retention Services

Early Intervention and Linkage and Retention services have been successfully practiced and evaluated within the Chicago EMA's continuum of care and although there are no consistent protocols or procedures across sites there are common practices. A set of standards for EIS services has been developed by HRSA and CDPH. Though most standards are commonly understood and implemented (i.e., standards for termination, length of service and transfer of cases to case management and care providers tend to be defined functionally); however, services need to be client-centered and adapted to the population being served, rather than determined by units of service or specific time periods.

While EIS and linkage and retention services are provided by various personnel within different organizations, there is a recognized value in assigning these services to identified positions. Peers have played a significant role in implementing these services but their responsibilities are not clearly defined across sites and their roles are not clearly understood by other professionals within the organizations where they work. Though co-location of testing and care services facilitates linkage and retention, testing often occurs in sites that do not provide medical care and there is a need in highly impacted, underserved geographic areas and among special populations for outreach services that can test in the field and have strong linkages to care services and facilities.

Recommendations:

1. Develop an integrated strategy for those at high risk with intensive Prevention, Care, Housing and Essential Services to prevent new infections.
2. Formalize the LRC process through a consistent definition and provide necessary training to provide the service.

Considerations:

- a. Develop a standardized protocol and client flow chart that defines how clients are identified, diagnosed, linked and retained in care and specify the roles and responsibilities of professionals involved.
- b. Develop a definition of successful linkage and retention that focuses more on key milestones and client outcomes than on timeframes.
- c. Define the boundaries and integrating practices between outreach and testing, linkage and retention, medical case management and provider services.
- d. Develop a unified definition of EIS and LRC that assures client access to care can be flexibly applied according to service sites and populations.

B.3. Need and Service Gap: Training and Support

Peers have played a significant role in implementing these services and there is a need for training and orientation of staff at all levels in how peers can successfully enhance linkage and retention within organizations. Patient follow-up to assure that those linked to care are retained in care is a vital and intensive services that have been developed and implemented across service sites and effective practice methods need to be assessed and further developed. LRC services are overwhelmed by service demand and plagued by staff attrition and burn out; there is a need for consistent training and staff support.

LRC requires intensive communication linking patients and providers and is practiced through various methods; best practices need to be evaluated and supported by technology. LRC and EIS services would be enhanced and supported by a comprehensive directory of service providers and locations and by opportunities to meet and confer with other providers.

Recommendations:

1. Standardize expectations for the use of peers throughout the Chicago EMA and support the efforts financially.

Considerations:

- a. Develop and implement a training and education program for all those involved in LRC and EIS services.
- b. Conduct periodic training and support activities for those performing EIS and LRC activities.
- c. Develop an updated directory of EIS and LRC services and a mechanism (e.g., website) to facilitate communication amongst providers.

2.2.3 ART and Viral Suppression - Committee Findings

CDPH and the Art and Viral Suppression Committee (AVSC) have adopted the following standards for anti-retroviral therapy (ART) formulated by the Department of Health and Human Services. ART is recommended for all HIV-infected individuals to reduce the risk of disease progression. Patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence. On a case-by-case basis, patients and their providers may choose to postpone therapy on the basis of clinical and/or psychosocial factors.

The AVSC conducted a literature review focused on providing additional information on the characteristics of those less likely to be on ART or Viral Suppression (VS) and to identify best practices for adherence and engagement in care that have been developed in Chicago and elsewhere. The Committee developed an on-line archive to gather research articles^{xv} (select articles in Appendix) and Committee findings that could be easily accessed and reviewed by Committee members and others interested in this area. The Committee also developed a matrix summarizing characteristics, best practices and an inventory of available HIV care services.

Through a review of recent local resource inventories and discussion amongst Committee members of barriers and best practices, the AVSC developed a survey to be distributed to providers and consumers. The survey presented two separate lists of possible reasons why people retained in care were not taking ART and why some people retained in care and taking ART do not achieve an undetectable viral load. Respondents were asked review the lists, add any additional reasons and then to rank the five most important reasons that inhibited ART prescription and adherence and affected successful viral suppression.

A key finding of the MMP data analysis was that overall levels of viral suppression are high. Yet, the Chicago EMA still notes persistent disparities for key populations. A key finding revealed in the MMP data analysis is that in Chicago, 90% of those retained in care are on ART. This is a significant success and exceeds the national average. Additionally, of those retained in care and on ART, 87% are virally suppressed. This is a significant finding. However, among the 10% not on ART and virally suppressed there continues to be significant disparities. Disparities were observed around age, race, geographic location and ethnicity.

The results of the data analysis are the following characteristics, barriers, and challenges and the recommendations of the committee puts forth to address these.

Table 2. AVSC Provider and Consumer Survey Results 2014

AVSC Provider and Consumer Survey Results 2014 n=134: 24 prescribers (MD, NP, PA); 11 RNs; 34 consumers; 24 case managers; 41 others (e.g. health educators, navigators, LCSW, psychosocial counselors).	
Why not on ART	Why on ART but not Virally Suppressed
<ol style="list-style-type: none"> 1. Challenges with health insurance/medication assistance (e.g. co-pays, deductibles, no health insurance, Part D, coordinating pharmacies) 2. Patient declines / refuses (e.g. due to religious beliefs; prefers alternative therapies, etc.) 3. Poor relationship / lack of good communication between the provider and the patient 4. Not prescribed ART due to concerns about the patient being homeless / having unstable housing 5. Not prescribed ART due to concerns about the patient's substance use/abuse 6. Not prescribed ART due to concerns about the patient's mental health status 	<ol style="list-style-type: none"> 1. Patient non adherence because of competing priorities (e.g., work/school/ family/children, etc.) 2. Patient non-adherence because of issues related to their mental health status 3. Patient non-adherence because of issues related to homelessness / unstable housing 4. Patient non-adherence because of issues related to substance use / abuse 5. Viral load (VL) is poorly monitored because patient misses routine visits with a provider

Committee members identified possible reasons why individuals who received care were less likely to be on ART or virally suppressed, including:

- Lack of social media: Bill boards, community specific presentation
- Social Determinants: Poverty, lack of insurance
- Facility expertise: Lack of specific HIV clinical experience, case managers have less experience and familiarity with resources and have less access to services
- Stigma: HIV and homosexuality in Black and Hispanic communities is still stigmatized to the extent that people fear their status being revealed to friends and family through the discovery of pill bottles and prescriptions.
- People move north for housing services and other resources and case managers need more expertise and familiarity with the resources.
- Services that are there but stigma prohibits access to services within the community.

2.2.3.a Need and Service Gaps, Recommendations

From a review of the findings summarized above the AVSC has identified the following needs and service gaps pertaining to ART prescription and Viral Suppression:

C.1. Need and Service Gap: Monitor Viral Suppression

Data on ART prescription and viral suppression should be monitored to determine if those who are virally suppressed maintain that suppression over time; community viral suppression has reduced the incidence of new infection.

Recommendations:

1. Identify what best practices are in place in the Chicago EMA regarding prescribing ART.
2. Identify what best practices are in place in the Chicago EMA regarding achieving viral suppression.
3. Moving forward, HIV transmission could be an area that the committee reviews in cooperation with the PPEI Committee in an effort to counsel high risk populations on the importance of / access to ART and viral suppression.

C.2. Need and Service Gap: Youth, African Americans and Women even when on ART are less likely to be virally suppressed

Recommendations:

1. Prioritize funded Ryan White Core and Support services for African Americans, women and youth ages 18-29 years old.
2. Increase awareness among clinical providers of the need to focus on youth. Provide youth-specific case managers with lower case loads or provide a linkage coordinator; testing and medical providers coordinate better with smaller case loads.
3. Conduct an inquiry into why African Americans and women are disproportionately impacted by HIV/AIDS.
4. Convene the group of providers who specifically provide HIV care to youth in the Chicago EMA to learn about AVSC findings and to discuss what can be done to improve health outcomes.
5. Develop further inquiry into why youth 18-29 are less likely to be prescribed ART and be Virally Suppressed—even when controlling for access to medication.
6. Develop further inquiry into the prescribing of ART and viral suppression for youth under the age of 18.

C. 3. Need and Service Gap: The following social characteristics of those less likely to be on ART and Virally Suppressed reflect the Social Determinants of Health individuals with: less than a high school education, a corrections background, no private coverage of medical services, Medicaid, time without insurance, recent diagnosis of being HIV-positive, reported drug use, difficulty understanding written information, no Medicare coverage.

Recommendation:

1. Continue to investigate and understand how the Social Determinants of Health create access barriers to ongoing engagement in treatment

C.4. Need and Service Gap: Those receiving care in facilities on the South, far South and Central areas of the city are less likely to be on ART and VS. There is a lack of information about ART and VS in suburban and rural areas of the Chicago EMA.

Recommendations:

1. Further explore reasons why specific geographic areas are less likely to be on ART, and less likely to be Virally Suppressed (while on ART); even though HIV care is provided in the South, Far South, West, and Central areas.
2. Map the HIV medical providers in the Chicago EMA by zip code and type of provider (i.e., Ryan White versus non-Ryan White funded agencies)
3. Inquire about differences on ART and VS between urban, suburban, and rural areas.
4. Inquire about disparities in transportation for clients in the suburbs and rural areas.

C.5. Need and Service Gap: On a case-by-case basis, patients and their providers may choose to postpone therapy on the basis of clinical and/or psychosocial factors.

Recommendation:

1. Develop further inquiry into why and how frequently providers are postponing ART prescription due to clinical or psychosocial factors.

C.6. Need and Service Gap: There is no information on ART and VS for those receiving housing services. CDPH does not gather treatment information from agencies funded to provide housing services.

Recommendations:

1. Consider requiring of agencies funded by CDPH that provide housing services to collect information such as number of individuals: in care, on ART, and virally suppressed.
2. Provide CDPH-funded organizations technical assistance on housing services, so they may develop appropriate agreements with other agencies that can support patients' linkage and retention in care, being on ART, and being virally suppressed.

2.3 Chicago Area Continuum of Prevention and Care Services - Resource Inventory

The Chicago EMA utilizes the continuum of care to describe a well-coordinated system of Prevention, Care, and Essential Services. This continuum of services has been developed to reduce the incidence of new infection, assure early identification and intervention to those most at risk and to link those infected to high quality, culturally appropriate health care. To reduce existing health disparities, the Chicago EMA developed a range of support services to support the linkage, retention and adherence to treatment of those most in need of ongoing care.

2.3.1 Prevention Services

In 2014, The Chicago Department of Public provided funding to 28 community-based organizations which offer 59 programs. Funding was allocated according to priorities determined in an annual priority setting process, which yielded the following priorities:

- Race/ethnicity (63% Black, 18% Hispanic, 16% White, 3% Other)
- Mode of transmission (65% MSM, 17% High Risk Heterosexuals, 19% IDU)
- Geography (32% Westside, 34% Northside, 34% South Side)

CDPH funds more than half of the prevention activities in Chicago. Other funding sources include direct grants from the CDC, the Illinois Department of Public Health (IDPH), the National Institutes of Health (NIH) and local community-based organizations. Individual grants have been made by Gilead, the National Institute of Drug Addiction (NIDA), the Substance Abuse and Mental Health Services Agency (SAMHSA), the State of Illinois and the Department of Alcohol and Drug Abuse (DASA). Prevention programs are often implemented in agencies that offer an array of other HIV services which include case management, primary care, housing resources, substance abuse and mental health treatment and testing for hepatitis and STI. This facilitates linkage to care and strives to fulfill best practice models for fully integrated care.

- A. Interventions to prevent new infections and keep individuals HIV-negative target high risk negative populations of MSM, IDU and heterosexuals and population of special concern: persons with disabilities, the homeless, non-English speaking persons, post-incarcerated individuals, individuals in the sex trade and transgender individuals.

Specific interventions include:

- Recruitment interventions
 - Outreach
 - Health Education/Public Information
- Focused interventions
 - Individual Level Intervention (ILI)
 - Group Level Intervention (GLI)
 - Comprehensive Risk Counseling and Services (CRCS)
- HIV Counseling and Testing
- Needle/Syringe Exchange (for programs targeting IDU)
- Condom distribution
- STI testing
- HCV testing and referral
- Linkage to Care

B. Pre-Exposure Prophylaxis (PrEP) and Other Biomedical Interventions

PrEP is a scientifically proven method of HIV prevention that has been 90% effective in preventing HIV transmission. CDPH and CAHISC participate in a local PrEP Task Force that is meeting to review local research and implementation activities and develop a comprehensive strategy to implement PrEP in Chicago. The PrEP workgroup has identified research and policy initiatives and local implementation activities and issues that need to be resolved so that PrEP may become widely available through the continuum of care.

2.3.2 Linkage and Retention in Care

To identify those unaware of their HIV+ status and link them to care, Chicago implemented both opt-out testing in clinical settings and targeted outreach and testing in non-clinical settings for high risk populations. Early Intervention Services (EIS) and Linkage and Retention to Care services have been developed to assure that those tested are treated as soon as possible. EIS is a prioritized service receiving allocations through Ryan White funding. Five agencies have been funded using peer navigation models to coordinate linkage to care with prevention agencies. All agencies receiving Ryan White and CDC funding are expected to facilitate linkage to care for all those who test positive. Twenty-three agencies were interviewed through the Chicagoland Linkage to Care Workgroup and described common practices in providing Linkage and Retention to Care services. All have the common goal of identifying individuals early in stages of infection and linking them to care. This activity forms the bridge between prevention and care and has formed collaborative alliances between agencies and decreased the number of late testers in the Chicago EMA.

2.3.3 HIV Primary Care and Core Services

HIV care continuum as defined by HRSA consists of 17 service categories; seven core medical services- Outpatient/Ambulatory Care, Medical Case Management, Mental Health, Oral Health, EIS, Health Insurance/co-payment and Substance Abuse Outpatient; and ten support services, non-Medical Case Management, Emergency Financial Assistance, Housing Services, Psychosocial, Food Bank/Home Delivered Meals, Legal, Substance Abuse Residential services, Medical Transportation, Outreach Services and Quality Management, Professional and Technical Assistance. The core medical services enhance the continuum of care and facilitate client access to medical care treatment. The support services builds on the core medical services by providing services that assist clients in adhering to medical care.

Case Management System: CDPH funds a provider to administer the medical and non-medical case management system across the Chicago EMA. The system, called the Cooperative, is centrally coordinated by consumers and providers to determine policies and procedures that funded agencies are required to follow. The Cooperative is a multi-faceted network comprised of 29 agencies with more than 150 case managers serving an estimated 5,000 HIV-positive individuals in the EMA.

Essential Services are crucial in support access and retention in care. Most frequently, a newly diagnosed client enters the system through the integrated case management system or a primary care provider. When a newly infected client enters the case management system, the client is assessed through an acuity scale to determine which level of intensive, medical, or support service and case management best suits the needs of the client. The client is linked to a primary care provider as well as to other support services.

The continuum of care has also developed mechanisms to increase access for highly impacted populations to facilitate and support their linkage and retention in care. Funding through the Minority AIDS Initiative (MAI) is primarily allocated to support core medical services and supports EIS to reach underserved minorities and bring them into care, as well as, to assist them in remaining in care. Homeless outreach and support is provided by an organization that has mobile capacity and housing resources for PLWHA and their families. Service to injection drug users and other substance users have not only dramatically reduced the number of new infections but have successfully linked users to care early in infection. A Community Outreach Intervention Project conducts targeted street outreach to IDUs not in drug treatment and provides on-site primary care, case management and mental health services and linkage with medical and substance abuse treatment. The Illinois Public Health Corrections and Community Initiative (IPHCCI) is implementing a comprehensive care system for PLWHA recently released from regional adult and juvenile correctional institutions which involves CDPH, Cook County, a corrections clinic, and other community based organizations that provide substance abuse services and housing. Funding also supports programs to facilitate linkage and retention for women and children and to identify and secure their access to care and for HIV pregnant women to assure safe delivery and early treatment of their infants.

Chicago is an area rich in medical resources for the provision of HIV primary and specialty care. There are five major medical centers and teaching institutions in the area that play an active role in providing HIV/AIDS care. There are also several large health systems that have actively developed and implemented HIV/AIDS medical services in Chicago.

Ambulatory Primary Care services are offered through a network of 26 Federally Qualified Health Centers (FQHCs), 6 receive Ryan White funding and have been involved in HIV/AIDS planning and implementation. Services are also provided by The Cook County Bureau of Health Services (CCBHS) established an innovative collaboration with the Chicago Department of Public Health which serve more than 25% of the total population of persons with HIV/AIDS known to be in care in the Chicago Metropolitan area. CDPH provides primary care through two primary care clinics in high morbidity community areas. In addition, there are private and community based medical practices which also serve HIV clients.

The Illinois Medicaid program continues to be the largest funding source for care and services provided to PLWHAs. Part A funds are used to fill gaps in multiple ways including providing outpatient treatment for clients that are either ineligible for Medicaid or are pending Medicaid enrollment. In addition, Part A supports non-medical services that are

not covered by Illinois Medicaid for non-institutionalized PLWHA including emergency housing assistance, legal services, and food services.

AIDS Drug Assistance Program (ADAP): The Illinois Department of Public Health (IDPH) utilizes Part B funds, augmented with state general revenue funds to support ADAP, the Continuation of Health Insurance Coverage Program, and the provision of core and supportive services for PLWHA.

The Midwest AIDS Training and Education Center (MATEC): Is a Ryan White Part F grantee that works in collaboration with CDPH to train clinical providers in underserved areas with the goal of increasing capacity in these regions.

Substance Abuse and Mental Health Services: Local, state and federal funding reductions and late reimbursement for providers continue to adversely impact ex-offenders, the homeless and mentally ill populations, as well as, people living with HIV/AIDS in the Chicago. Many health and human services delegate agencies' budgets, including substance abuse providers, have been cut by as much as 10 percent. In Chicago, there are approximately 70 mental health centers funded by the Illinois Department of Human Services; however, Illinois has a limitation on services for patients who are uninsured. Although crisis services and limited case management services remain in place, individual and group therapy is no longer a covered service for uninsured patients. CDPH Mental Health Centers have experienced reductions in funding and 6 centers of 12 centers were closed in mid-2012 with services being continued at city-funded FQHC sites. To partially fill this gap for HIV patients, Ryan White Part A funding has provided outpatient substance abuse services to 3,207 clients and mental health services to 6,388 clients.

2.3.4 Housing Resources

Housing services within the continuum of care have been established to maintain a stable living environment, reduce homelessness, improve treatment access and ensure viral suppression.

CDPH HIV Housing program consist of two main funding sources: Housing Opportunities for Persons with AIDS (HOPWA) and Community Development Block Grant (CDBG) HIV Housing Program. Funding supports facility based housing, supportive services, rental subsidies and housing information services. In 2014, funding has been allocated to 18 community based agencies for housing services and a large provider to coordinate the delivery of rental subsidies.

The AIDS Foundation of Chicago (AFC) has taken a leadership role in promoting strategies to improve the availability of safe and affordable housing for low-income people with HIV, and has worked closely with the CDPH to:

- Promote public and private efforts to increase the stock of affordable housing for people with disabilities, including those living with HIV
- Convene AIDS housing advocates and organizing efforts to assess and improve the housing continuum
- Provide research on the state of Chicago-area housing environment

- Manage a network of regional AIDS housing advocates and coordinate the delivery of AIDS rental subsidies among other housing programs for low-income people with AIDS

AFC has worked with CDPH to leverage mainstream housing resources to support PLWHA. In addition, the agency has worked with the State of Illinois Homeless Prevention Fund to provide emergency rent and utility assistance, and with the Chicago Low-Income Housing Trust Fund to provide rental assistance for PLWHA in a landlord based rental assistance program. Lastly, the agency has collaborated with its various partners to expand supportive housing program units under the HUD Hearth Homeless Assistance funding for PLWHA that are homeless and have co-occurring disorders.

2.4 Priority Populations

During the “brainstorming” session at the retreat, CAHISC members identified the following priority populations (Table 3). They also developed a list of overarching issues and barriers that should be considered in planning an improved continuum of care. These lists enhance information provided in **Section I** of this document that was derived from more formal survey surveillance techniques. These lists emphasize populations and social networks that have not been statistically counted or formally studied but will have to be considered in the improved continuum of care if it is to successfully improve outcomes and address health disparities.

Table 3. Priority Populations

Youth (13-19) Youth (20-29) Young Men Who Have Sex With Men (MSM)	New infections are increasing among youth under 30 and among young MSM particularly Black MSM Youth are driving the gap between linkage and retention Youth are less likely to be prescribed ART or achieve viral suppression
Women (heterosexual) Women and Children Women in Prenatal Care	Women are vulnerable to new infection; domestic violence is a barrier to condom use and other forms of protection and family and childcare issues affect linkage, retention and adherence issues in care

Transgender Individuals	<p>CDC reported that in 2010, the highest percentage of newly identified HIV-positive test results was among transgender people and that Black transgender women have the highest percentage of new HIV-positive test results. Regional data is just beginning to be gathered but experience of council members is that local transgender risk for infection mirrors federal data.</p> <p>There are also transgender social networks and events that have been used to effectively disseminate prevention and care information</p>
All MSM Black MSM Hispanic MSM Unidentified MSM	<p>Incidence of new infection and HIV incidence is highest among MSM</p> <p>Black MSM are most highly impacted</p> <p>Hispanic MSM are less likely to be retained in treatment</p> <p>Stigma of homosexuality is a barrier to care for some MSM</p>
African Americans (AA) African Americans living in community areas on the South, far South and West Side African American Women	<p>HIV Related Stigma especially homophobia</p> <p>Beliefs of Faith Based Communities</p> <p>Fear of others in community knowing HIV status</p> <p>Cultural Insensitivity of providers</p> <p>Incidence of new infection remains high among AA women</p>
Latinos Individuals born in Spanish Speaking Countries and Puerto Rico	<p>Latin cultural divide lack of providers speaking Spanish and understanding Latino diversity and cultural values</p> <p>HIV Related Stigma especially homophobia</p> <p>Fear of others in community knowing HIV status, HIV+ = Gay</p>
Individuals born in Asia	<p>Asian cultural divide – lack of understanding of language and diversity of Asian Cultures</p>
Undocumented residents	<p>Lack of eligibility for benefits and insurance coverage</p> <p>Risk of exposure of status, the need to be silent to stay away from services and interventions</p>
Incarcerated Newly released from incarceration	<p>Housing, unemployment, transition to medical care, lack of coverage, substance abuse, mental health issues, alienated from family and community support</p>

	Young and transgender individuals are often engaged in sex work for survival and lack access to prevention information, condoms and PrEP
Aging population/Seniors	New infection occur among older people and those over sixty are experiencing increasing medical complications resulting from aging, long term side effects of medication and the progression of the viral infection
Injection Drug Users (IDUs)	Though the incidence of new infection among IDUs has dramatically decreased, the need for ongoing care and housing for those infected is complicated by continued substance use and the stigma of drug addiction. IDUs are less likely to be linked to care and have stable housing
High risk negatives Lack of HIV prevention and care services in low income communities throughout the region:	High risk and incidence of new infection occur in communities with high levels of poverty. These communities are negatively impacted by the social determinates of health including a lack of access to prevention and care services
Homeless	Homeless individuals with chronic medical conditions are at high risk for severe medical complications that can be costly to treat and, if left untreated, can prove deadly. Homeless individuals are less likely to be on Anti-retroviral treatment and less likely to be adherent to HIV or other treatment regimens.

2.5 The Priority Setting and Resource Allocation Process (PSRA)

The Ryan White Care Act Part A requires full participation of Regional Planning Councils in establishing priorities to fund HIV services to address unmet needs. Priorities are established according to 30 service categories defined by HRSA and are ranked according to an assessment of need conducted and reviewed by the Council and Grantee. Once priorities are ranked, the Council considers and approves resource allocations to each prioritized category.

CAHISC has established a multi-stage process that first considers priorities and then once these are established considers resource allocations. To conduct this year's process, CAHISC formed the PSRA ad-hoc Committee consisting of representatives from each of the four existing Committees and invited the participation of any interested members of CAHISC. The purpose of the PSRA Committee is to review needs assessment data for

presentation to CAHISC's Full Council, and to guide and outline the PSRA process that will be conducted.

Priority Setting: A number of presentations were given to prepare CAHISC's Full Council to conduct the PSRA process. The full-body Council meeting in June was called "Data Day" and featured presentations of the latest surveillance data, utilization and client service data and information on how the implementation of the Affordable Care Act (ACA) is impacting HIV services and reimbursement at the client and agency level. Information regarding other funding and administrative changes was also presented. The impact of ACA has been a consistent theme of Council discussion especially its potential effect on the allocation of primary care funds in the PSRA process. CAHISC's Full Council discussed whether at this stage of the transition to ACA funding there was sufficient information available to make a shift in priority funding for Primary Care.

In July, the Council discussed priorities and reviewed descriptions of the 30 HRSA defined service categories. A priority of service categories has already been determined by HRSA and adopted by the Chicago EMA. Core services must receive a 75% proportion of funding and Supportive/Essential service categories that received 25% of funding have been funded in previous years. This information is all presented in PowerPoint and augmented with written materials available to all members of CAHISC.

The Council then conducted a balloting process where each of the 30 service categories were presented for a priority vote regardless of whether it is predetermined Core or Essential Service category. Each Council member was given a balloting worksheet listing the service categories and a set of 15 ballots. A tally board was displayed on the wall where the results of balloting were recorded for all to see. The purpose of this exercise was to rank priorities according to the views of the members of the Council. At the end of balloting and after a resolution of any ties, a listing of priorities was presented to the CAHISC Council for final approval.

Resource Allocation: The PSRA Committee met and reviewed the priorities established by the council and the history of previous allocations matched with service utilization data. Though the list of priorities was given primary consideration, the PSRA Committee also considered how allocations would be influenced by the availability of funding from other sources and how the allocations covered services needs defined across the continuum of care. The PSRA Committee also had to assure 75% percent of the final allocation was to the Core services designated by HRSA. The Committee constructed a draft budget based on this year's funding award that included a set of funding scenarios and detailed explanations of the reasons for each allocation.

The Planning Council discussed and provided feedback on six separate scenarios for Part A (level, increased and decreased funding) and MAI (level, increased and decreased funding) funding. The CAHISC Full Body membership unanimously approved the FY2015 PSRA Scenarios for Part A & MAI on August 27, 2014 (see Table 4).

2.6 Understanding the Impact of the Affordable Care Act (ACA) on HIV Services

How the ACA will influence the funding and delivery of HIV services has been a focus of planning discussion for the last two years. Changes and challenges that were previously unknown and the cause of great speculation, are becoming clear as the ACA has been implemented in 2014. Of primary concern to CAHISC is that the coverage provided to uninsured HIV clients for whom Ryan White has been the payer of last resort. As the transition to Medicaid and market place health care coverage occurs, the need to allocate Ryan White funding to cover primary care may decrease and allow funding to be shifted to other service categories. However, this transition has many challenges that are being revealed as the ACA is implemented.

Table 4 - Resource Allocation by Service Category for FY2015

Planned Funded Service Categories	Percent of Funding	
	Part A	MAI
1. Core Medical Services Subtotal	75.00%	83.00%
a. Outpatient/Ambulatory Health Services	27.62%	57.15%
b. Oral Health Care	6.20%	0.00%
c. Early Intervention Services	6.60%	6.95%
d. Mental Health Services	7.50%	12.95%
e. Medical Case Management	19.58%	0.00%
f. Substance Abuse Services - Outpatient	7.50%	5.95%
2. Support Services Subtotal	25.00%	17.00%
a. Case Management (non-medical)	2.50%	0.00%
b. Emergency Financial Assistance	0.40%	0.00%
c. Food Bank/Home-Delivered Meals	5.20%	0.00%
d. Housing Services	1.49%	0.00%
e. Legal Services	4.01%	0.00%
f. Medical Transportation Services	2.12%	0.00%
g. Outreach Services	1.52%	7.15%
h. Psychosocial Services	4.77%	4.50%
i. Substance Abuse Services - Residential	2.99%	5.35%
3. Total Service Allocations	100%	100%

A CDPH grantee has been gathering data to describe the transition of people with HIV to Health Reform Programs in Illinois. The Illinois AIDS Drug Assistance Program (ADAP) has determined that 32% of 7000 enrolled clients are eligible for market place coverage and that 68% are eligible for Medicaid. As of March 31, 2014, 40% of ADAP clients have transitioned to either market place or Medicaid health care coverage. In a separate

estimate based on local data from the Medical Management Project (MMP), of the estimated 4,140 uninsured PLWHA in Chicago 67% will be eligible for Medicaid and 33% for marketplace coverage. This is promising data for covering the uninsured and integrating HIV coverage into the larger system, however many challenges are arising in the transition and it is important to note that these estimates do not include undocumented PLWHA.

One agency has identified the following barriers occurring in the transition to market place coverage: a) formularies are not covering certain HIV medications; b) there are higher co-pays and medication costs out of pocket which ADAP is continuing to cover; c) plans have changed medication coverage without notice; d) it has been difficult for consumers to determine which providers are in a network and to understand the policies and procedures of their new insurance.

Medicaid enrollment poses similar and distinct challenges. There are 27 Care Coordination entities in Illinois and those transitioning through the ACA will have 15 separate plans from which to choose. As with market place choices, it is often difficult to determine whether the provider one chooses is covered by a particular plan. Enrollment is not a passive process and clients must have access to mail and open and actively choose their health care plan which is challenging for some clients and requires case managed assistance.

The Chicago Department of Health conducted a survey of Ryan White agencies providing ambulatory care in Chicago. Most of the 10 providers surveyed indicated that though a high percentage of their patients would be eligible for transition through ACA to market place or Medicaid coverage that most would need other services not covered by ACA to be successfully treated. The main reasons cited for why some patients are not eligible were income level and undocumented status. Provider also reported that clients were reluctant to enroll because of a fear of switching provider/medical facilities, co-pays for specialty referrals, income eligibility for Medicaid and difficulties in navigating the ACA system. Providers also indicated that a patients' lack of stable housing prevents them from receiving documentation for the completion of ACA enrollment, which results in the denial of the application.

Providers recommended that ADAP continue to be strengthened and that transition issues continue to be monitored. In this state of transition, it is important to provide navigational assistance through the use of ACA enrollment specialists. This has been effectively implemented in several sites in Chicago and should be available throughout the system. It is also recommended that specific training and technical assistance be provided to patients and providers to clarify the specifics of Medicaid and marketplace plans and how they intersect with current formulary and provider coverage provided under the Ryan White Care Act and ADAP.

Another concern raised by the implementation of ACA is the expansion of HIV primary care to providers outside the existing network of HIV providers. The Health HIV's Third Annual State of HIV Primary Care National Survey (2014) found that nearly half (49%) of Primary Care Providers surveyed do not provide clinical HIV care; they cite a lack of knowledge about HIV treatment as a significant barrier to providing care. A similar number (48%) say

they need more clinical training to fully integrate HIV care into their practice. This indicates a need to carefully assess this transition in Chicago and determine the need for additional training and the extension of needed prevention, linkage and case management services to new HIV providers.

Section 3 - Where We Are Going: Envisioning an Ideal System of HIV Prevention and Care

Background

Over the past 30 years, Chicago has worked to develop a continuum of HIV Prevention, Care and Housing services that reduces the incidence of new infections, tested and linked increasing numbers of those infected to Care, Housing and other Essential Services. In addition, Chicago has reached a high percentage of those in care who are prescribed anti-retroviral treatment and are virally suppressed. Regional and collaborative federal research efforts have been able to identify characteristics of those who do not know their status and are at higher risk for infection. Those at greater risk and those less likely to be linked and successfully engaged in care have been identified through surveillance and survey efforts.

The Chicago Area's continuum of care has developed strong Prevention, Care and Housing components and through its on-going development, the evolution of the HIV epidemic and the introduction of new bio-medical technology, it has made an increasing effort to integrate the planning and implementation of services and interventions within the continuum. The vision of an improved continuum of care has resulted in a combined cooperative planning effort and integrated and enhanced services. The improved continuum will continue to address the complications and episodes of serious illness experienced by those who have AIDS and at the same time seek to address the medical and psychosocial needs of those at highest risk of infection.

The members of the Chicago Area HIV Integrated Service Council (CAHISC) have engaged in a key role in developing the vision of the ideal continuum of care. CAHISC members work and live in the communities that are most highly impacted by HIV and represent vulnerable populations that are most affected. The ongoing participation of CAHISC members in the planning, implementation and monitoring of the Unified Plan will assure that the improved continuum will successfully improve health outcomes and reduce health disparities.

In January 2014, CAHISC held a strategic planning retreat to review progress and orient new members to Council activities and responsibilities. In a guided brainstorming session, committee members were asked to provide their perspective on overarching issues, barriers to prevention and care and to identify priority populations needing focused attention. Each committee was then asked to state an ideal vision of the continuum of care from the perspective of their area of the continuum of care. The following vision for the continuum of care was comprised from their combined statements and has been used to guide the development of the Unified Plan.

CAHISC and CDPH envision a fully integrated continuum of Prevention, Care, and Housing services that will reduce the number of new infections and decrease community viral load in the Chicago Area.

Research supports that people living in poor neighborhoods are at the highest risk of infection have less access to prevention, testing, counseling and care services. They are less likely to be linked to care and when they are, are less likely to be retained and less likely to be adherent and virally suppressed. The Social Determinants of Health, especially low income and education levels, housing instability, family dysfunction and adverse childhood experiences negatively impact all people living in neighborhoods with high poverty levels and especially those of vulnerable populations: Black and Hispanic MSM, MSM under 40, Black heterosexual women and men and minority transgendered individuals. Racism, homophobia and other forms of social stigma combined with other social determinants, make community prevention, linkage and care efforts more difficult in the areas where they are most needed.

These social determinants have a harsher effect on people living in poverty. Local and national research verifies and describes the connection between social determinants of health and behavior change. Uninfected high risk individuals and the partners of HIV infected individuals are often poor or low income individuals, who are uninsured, lack stable housing, have substance abuse and mental health issues and may be working in the sex industry or involved in high risk sexual activities. They confront the same issues and difficulties as individuals already infected but do not qualify for the housing and resource assistance, case management and medical treatment that would help them avoid risk and stay negative.

3.1 A Model of Improving the Current Continuum of Care

The ideal continuum of care describes the interventions that would be needed to lead to viral suppression. While we have recognized the needs of individuals as being on a continuum of care, we have historically developed care plans and services that treat each stage in isolation, leading to fragmentation and duplication of resources and services, and disrupting continuity of care and relationships from the perspective of the patient.

Therefore, CAHISC's redesigned approach will involve the implementation of a single *continuous* care plan that follows individuals as they progress along the continuum to meet their evolving needs. This approach will make apparent how services and strategies span multiple stages along the continuum, driving a new process determining how these services are resourced and delivered.


Improving the Current Continuum of Care: Moving towards the Ideal

CAHISC has met in separate committees to bring focus to specific areas of intervention; prevention, early intervention, linkage, retention, prescription of ART and community viral suppression. This has been done to develop an understanding of each step of the current continuum of care. This is a necessary step in moving towards developing a fully integrated continuum of care. To move this process forward, four strategies have been developed from the review and recommendations of CAHISC committees to guide the 2014-2016 implementation. These four strategies will be used to organize the goals, objectives and activities of the plan and will help monitor progress and provide quality assurance.

3.2 Strategies:

- I. To improve administrative systems to support coordination of planning and implementation of integrated services
- II. To develop a holistic HIV High Impact Prevention approach that helps both HIV-negative and HIV-positive individuals strive to meet their goals in preventing HIV transmission.
- III. To fully integrate the system of Early Intervention and Linkage and Retention services
- IV. To closely monitor progress across the continuum of care toward decreasing community level viral load.

Figure 20. Model for Improving the Current Continuum of Care

					
Goal Identify those infected and unaware	Goal Confirm HIV positive diagnosis	Goal Assure Linkage to Primary Care	Goal Assure Primary Care Retention	Goal Prescription of ART	Goal Assure ART adherence and viral suppression
Strategies Identify high risk Individuals Reduce high risk behaviors Reduce transmission	Strategies HIV Rapid testing Confirm HIV test Refer for HIV primary care	Strategies Arrange initial Provider appointment Follow with patient and Provider to assure Linkage	Strategies Address access barriers Provide follow-up for those lost to care	Strategies Assess patient treatment needs and issues Prescribe and monitor ART	Strategies Periodic viral load testing Assess and address patient issues to treatment
Services Outreach HIV Risk Assessment HIV Testing Behavioral Intervention	Services Outreach HIV Risk Assessment HIV Testing Behavioral Intervention	Services Behavioral Intervention Condom Distribution HIV Primary care referral	Services HIV Primary Care treatment Medical CM, Peer support	Services HIV Primary Care treatment specialty referral Medical CM follow up Peer Support	Services HIV Primary Care treatment specialty referral Medical CM follow up Peer Support

Condom Distribution	Condom Distribution	Linkage CM, Peer support	CM Assessment of Need	Viral load testing	Viral load testing
Primary Care Referral	Primary Care Referral	Psychosocial Assessment	Viral load testing	Entitlement assistance ADAP, ACA	Entitlement assistance ADAP, ACA
Linkage CM, Peer Support	Linkage CM, Peer Support	Prevention for positives	STD, Hep C PH screening	Access to housing resources	Access to housing resources
Psychosocial Assessment	Psychosocial Assessment	STD, Hep C PH screening	Partner Services	Needle Exchange	Needle Exchange
PrEP PEP	Prevention for Positives	Partner Services	Entitlement assistance ADAP, ACA	MH, SA assessment and referral	MH, SA assessment and referral
STD, Hep C PH Screening	STD, Hep C PH Screening	Entitlement assistance	Access to housing resources	Prescription ART	Prescription ART
Partner Services	Partner Services	Access to housing resources	Needle Exchange	Adherence support	Adherence support
Entitlement Assistance	Entitlement Assistance	Needle Exchange	MH, SA assessment and referral	Transportation assistance	Transportation assistance
Access to housing services	Access to housing services	MH, SA assessment and referral	Prescription ART		
Needle Exchange	Needle Exchange		Adherence support		
MH, SA Assessment and Referral	MH, SA Assessment and Referral				

Section 4. How We Will Get There

The 2014-2016 Chicago Unified Plan has been developed by the Chicago Department of Health (CDPH) and the Chicago Area HIV Integrated Planning Council (CAHISC). It has been developed in a format derived from previous comprehensive, jurisdictional and housing plans and has made every effort to comply with the guidance that HRSA and CDC have provided for previous plans. However, this is a new effort to create an approach to integrated planning for services across the continuum of prevention and care. The strategies and goals of this Unified Plan have also been developed through a review of the most recent comprehensive planning documents developed for the Chicago Area.

These include:

- 1) The 2012-2014 Comprehensive Chicago EMA HIV Care and Services Plan
- 2) The 2012-2014 Jurisdictional Plan
- 3) The 2003-2016 Chicago Area HIV Housing Plans

4.1 Review of Plans

The following are brief summaries describing the goals and strategies of these plans. The 2014-2016 Unified Plan encompasses efforts and activities of these plans, while incorporating additional strategic directions. The 2014-2016 Unified Plan also serves as a bridge from separate 2012 – 2014 Jurisdictional and Comprehensive Plans to an integrated plan that will be developed in 2016.

The 2012-2014 Comprehensive Chicago EMA HIV Care and Services Plan

The Comprehensive Plan was developed in response to the HRSA Guidance for the Comprehensive Plan for the Chicago EMA. The 2012 – 2014 Comprehensive Plan was also developed in alignment with both NHAS and Health People 2020 goals and objectives and reflected the Statewide Coordinated Statement of Need. The plan has been implemented to improve the continuum of care and outlines goals and strategies to develop the continuum. The plan emphasizes extending the collaboration among Prevention, Care and housing in collective planning, strengthening the current centralized data management system, creating a client centered system of medical case management that expedites the availability of services for all clients at all points in their care, and utilizing principles defined under Early Intervention Services (EIS), Expanded Partner Services and in the Enhanced Comprehensive HIV Prevention Planning and Implementation Plan (ECHPP) efforts based on treatment as prevention.

4.1.1 The 2012-2014 Comprehensive Chicago EMA HIV Care and Services Plan

The plan includes strategies to

- Ensure the availability and quality of core services
- Eliminate disparities in access to core medical and supportive services for individuals with HIV among disproportionately affected subpopulations and historically underserved communities
- Coordinate Ryan White services with other systems of care

- Continued coordination with Medicaid, Medicare (including Medicare Part D), Health Insurance Marketplaces, State Children's Health Insurance Program (SCHIP), Veteran's Affairs, HOPWA and Community Development Block Grant (CDBG)-funded housing, services for women and children, and other state and local service programs and public health programs.
- Collaborate with HIV Prevention initiatives to identify HIV positive individuals unaware of their status and link them to appropriate care and services
- Identify HIV-positive persons who are aware of their HIV status but not in care, inform them of the availability of services, reengage them in the care continuum, and assist them with the access and use of these services; and
- Evaluate clinical quality measures

4.1.2 The 2012-2014 Jurisdictional Plan

The Jurisdictional Plan describes how the Chicago jurisdiction has utilized the continuum of care cascade as a means to address the CDC funding opportunity announcement (FOA) and incorporate the strategies of the Enhanced Comprehensive HIV Prevention Planning and Implementation (ECHPP), Healthy Chicago, High Impact Prevention (HIP) and the National HIV/AIDS Strategy. The plan also adopts the Early Identification of Individuals with HIV/AIDS (EIIHA) strategy to create a seamless transition from the time of diagnosis to entry into care.

The plan also outlines the participation of CAHISC in future prevention planning activities.

- Periodic review of priority setting activities as regards to special concerns populations and geographic areas.
- Enhanced community engagement activities

4.1.3 Chicago Area HIV Housing Plans: 2003-2016

A local agency has taken a leadership role in promoting strategies to improve the availability of safe and affordable housing for low-income people with HIV, and has worked closely with the Chicago Department of Public health to identify Housing needs and establish a plan to create housing resources for people living with HIV/AIDS.

These planning and research activities are summarized below:

The Chicago Housing for Health Partnership (CHHP) was a four-year research and demonstration project (2003-2007). Composition of the groups included high rates of long-term substance abuse (86%), mental illness (46%), and medical issues such as HIV/AIDS (34%) and hypertension (33%), as well as a number of other chronic medical illnesses, such as diabetes and cancer. CHHP produced extremely valuable published data on the cost and health benefits of supportive housing and case management that continues to be used to advocate for more housing and case management resources for homeless individuals locally and nationally.

The Chicago Area AIDS Housing Plan: 2008-2012: A Place to Call Home was formed by Housing stakeholders in the Chicago region to establish a formula to determine the actual number of units needed for AIDS housing and to establish a system to estimate the gap

between available and needed AIDS housing on an annual basis. In December 2012, this plan determined that there was a need of 12,520 housing units/subsidies needed for PLWHV and 1,199 housing units/subsidies available, leaving a gap of 11,321 housing units/subsidies needed to support PLWHA.

The SAMHSA Chicago Community Consortium (SCCC) brought together leaders from more than 40 organizations in the City of Chicago and Cook County to develop a strategic plan, beginning spring 2012 through spring 2013. The plan's 23 recommendations were approved on April 18, 2013. They aim to improve housing and health outcomes for people in Cook County who have experienced homelessness and who also have long term histories of mental illness and/or substance use. The consortium has placed HIV/AIDS housing concerns into the consideration of the full array of housing needs for those that are homeless or without stable housing.

The consortium developed a plan of recommendations that fall under four strategic priorities.

1. Increase the number and variety of supportive housing units for the target population
2. Enroll the target population into coordinated care services
3. Simplify and expand eligibility for and access to benefits, services, and entitlements
4. Increase and strengthen outreach to link the target population to housing and health services

These recommendations are being reviewed on a quarterly basis and an annual progress report was published in May of 2014.

4.2 The 2014-2016 Chicago Unified Plan: Strategies, Goals, Objectives and Activities

A review of these previous and in some cases ongoing regional plans makes clear that there is a common vision and goal for the continuum of HIV services in Chicago. That vision is about integration, coordination, access and reducing new infections and caring for those that are infected. The following strategies, goals and critical actions will guide the Chicago Area in its continuing effort to improve the continuum of care to address the goals outlined in the National AIDS Strategy.

Some strategies involve continued support of key interventions and services (e.g. targeted HIV testing). Others involve either new investments (PrEP coordination) or increased investments in services (Early Intervention, Outreach). Still others involve further planning and research (development of an integrated funding strategy, monitoring of impact of ACA).

4.2.1 Strategy I: Improve administrative systems to support coordination of planning and implementation of integrated services

This is a time of transition within health care and both increasing need, the expansion of access and the scarcity of resources mandate the coordination and integration of HIV planning implementation and evaluation of services. This strategy will work towards the goal of developing a unified Priority Setting and Resource Allocation Process that will

consider all of the HIV prevention, care and housing funds available in the EMA. CAHISC and CDPH will work with HRSA, CDC, HOPWA and other funding sources to develop joint initiatives for unified funding

The development of a coordinated data gathering and reporting process from Prevention, Care, Housing and Essential Services will improve coordination of integrated services. Accurate and timely client and service level data is needed to make decisions regarding priority setting and resource allocation. It is important to be able to report unduplicated data which depicts accurately the number of individuals receiving each funded service.

This strategy also considers the impact on HIV funding and service delivery of changes resulting from the implementation of the Affordable Care Act (ACA), state fiscal cut backs and other changes in health care funding. This strategy will closely monitor the impact of these changes and attempt to fully utilize the opportunities of the ACA to assure access to HIV primary care for all those at risk and infected.

4.2.1. A Goals and Action Steps for Success

Goals:

Goal 1: Develop a unified priority setting and resource allocation process and combined funding initiatives utilizing locally administered prevention, care and housing resources.

Action Steps:

1. Participate in ongoing discussion with HRSA, CDC and HOPWA/HUD to develop ways to coordinate planning and funding activities.
2. Continue collaborative efforts to coordinate and integrate resources with local health authorities.
3. Continue participation in UCHAPS and other associations focusing on integrated service planning.
4. Model and report on options for combined funding of services.

Goal 2: Develop and refine existing data gathering and reporting activities that will provide accurate and unduplicated client level service utilization data that can effectively inform planning activities.

Action Steps:

1. Review current data systems in prevention, care and housing to define common data elements needed to inform planning decisions.
2. CDPH will work with providers in implementing the Provide System to refine data gathering and processing to better inform the planning process.

Goal 3: Continue to assess the impact of the Affordable Care Act and other health care changes on the delivery of HIV services.

Action Steps:

1. Conduct local surveys of the impact of the ACA on the provision of services experienced by local HIV providers.
2. Closely monitor disparities in ACA access occurring among HIV populations.
3. Assess and support issues occurring in the transition of individuals from one insurance source to another.
4. Assess the impact of ACA and other changes in Health Care reimbursement changes on the process of priority setting and resource allocation.

4.2.2 Strategy II: Develop a holistic HIV High Impact Prevention approach that helps both HIV-negative and HIV-positive individuals prevent HIV transmission.

High Impact Prevention (HIP) emphasizes the use of effective behavior change strategies and testing and early intervention to decrease the incidence of new infection and slow the progression of disease. It also includes the use of Anti-Retroviral medication at both ends, as prophylaxis (PrEP) and as treatment (ART) to effectively reduce the sexual transmission of the virus.

While high-impact prevention approaches, linkage and retention and adherence practices have helped target and support populations most in need of intervention and care, these populations are most affected by multiple forms of structural disadvantage (e.g., poverty, unemployment, homelessness, incarceration, domestic violence, undocumented status). In addition, these high risk populations operate within distinct social networks that need a coordinated integrative service approach to support change of risk behaviors, full engagement in health care and adherence to treatment regimens.

The CAHISC Primary Prevention Early Identification (PPEI) Committee's recommendations include a call for continued focus on keeping high-risk negatives HIV negative and expanding primary prevention to include services such as mental health services, substance abuse treatment, case management and primary care. While current resources do not allow for complete support of a "Double Helix" approach to HIV Prevention and Care that provides a continuum of care and support services for HIV-negative individuals, the jurisdiction does recognize the need to balance investment in Prevention with Positives (PWP) services with the need to keep high-risk negative individuals negative. As a result, CDPH will continue to fund programs targeting HIV testing to high-risk negatives and allow some flexibility in the interventions provided and outcomes collected. CDPH and CAHISC will continue to explore social determinants, impact on HIV, and strategies for addressing social determinants of health in HIV prevention efforts.

The overall HIV Prevention plan continues support of key components, including the following: social marketing and media; condom distribution; targeted outreach, HIV testing, and linkage to care; prevention with positives; and expanded opt-out testing in clinical settings. The plan also includes a new focus on facilitating access to PrEP and nPEP through support of regional clinic/community-based organization collaborations and

participation in and coordination with the local Task Force. Finally, the strategy includes efforts to support and improve coordination among providers.

4.2.2. a Goals and Action Steps for Success

Goals:

Goal 1: Increase the number of people who are aware of their HIV + status

Goal 2: Decrease the number of new Infections

Goal 3: Reduce the incidence of late stage diagnosis among the newly infected

Goal 4: Increase coordination among HIV Prevention service providers and across HIV Prevention services providers with providers of other services

Action Steps

1. Implement social marketing campaigns targeting vulnerable populations and highly impacted areas of the region.
2. Support community events at which prevention education, HIV Testing, and condom distribution take place.
3. Distribute condoms to high risk negative populations, HIV positive individuals, and the general public.
4. Fund agencies to provide targeted outreach, HIV testing, and linkage to care for high-risk negative populations – funding of programs by geography, mode of transmission, age, and risk-group based on epidemiology; and funding of programs for special needs populations (Intravenous Drug Users, Transgender Individuals, Individuals involved in the Sex Trade, Individuals with Physical and Developmental Disabilities, Non-English/Non-Spanish Speaking Individuals, Homeless Individuals; Post-Incarcerated Individuals).
5. Continue to support prevention with positives- partner services provided by CDPH; Bridge Worker Program for re-engagement, retention in care; and expansion of services provided by community-based organizations.
6. Expand opt-out testing in clinical settings
7. Support a region wide strategy to make PrEP available to those at high risk of infection.
 - Invite a speaker from the PrEP Task Force to present on research findings and local implementation activities
 - Support strategies to make PrEP services available at key access points across the Chicago Area
 - Consider the Administration of PrEP in future unified priority setting and resource allocation process
8. Develop regional coordination of Prevention Activities within service areas of the Chicago region

Meet with MSM Testing Task Force to assess best methods for forming coordinating structures
Establish a mechanism to coordinate quarterly regional prevention meetings

4.2.3 Strategy III: Fully integrate the system of Early Intervention and Linkage and Retention services

Linkage to and retention in care are supported by a variety of programs, services, and funding sources in the Chicago area, including, but not limited to:

- Linkage to care performed by agencies funded for HIV Prevention
- Outreach performed by Ryan White Care Act Part A and MAI-funded agencies
- Early Intervention Services (EIS) performed by Ryan White Care Act Part A and MAI-funded agencies. CAHISC has steadily been increasing investments in EIS services over the past few years, and these increases continue for 2015.
- Partner services provided by CDPH and partner organizations, and Bridge Worker program services for patients who have fallen out of care

In addition, a number of Core (medical case management, substance abuse outpatient, mental health) and Supportive/Essential Services (non-medical case management, housing services, legal services, transportation, psychosocial support services, emergency financial assistance, food bank/home delivered meals, and substance abuse residential services) funded through Ryan White Care Act Part A and MAI support retention in care. Finally, being stably housed greatly contributes to being retained in care, and the role of HOPWA and other housing services is extremely valuable.

Early Intervention and Linkage and Retention in Care are a set of interventions and services that begin with prevention and testing and continue through engagement and retention in care and in adherence to ART and Viral Suppression. These services are the integrating mechanism between prevention and care and should be developed in a consistent way that allows a seamless connection to services for patients across the continuum. The challenge to integration is that different funding and administrative agencies and service organizations have created overlapping service definitions, titles and job descriptions for EIS and Linkage and Retention to Care (LRC) that inhibit the development of the integrated practice and evaluation of services.

This strategy will address these challenges and work to develop a consistent definition and practice of EIS and LRC services that will be flexibly adapted to the mission and capacities of different organizations and the needs of specific populations. It will define adherence support within this service as it applies to treatment and prophylactic regimens.

4.2.3. a Goals and Action Steps for Success

Goals:

1. Increase the number of HIV positive individuals who have met the standardized benchmarks of linkage to care.

2. Re-engage individuals lost to primary care.
3. Increase retention in HIV primary care in Chicago Area.

Action Steps

1. Develop a unified definition of EIS and LRC that assures client linkage and retention in care and can be flexibly applied according to service sites and populations.
2. Develop a standardized protocol and client flow chart for the system that is determined by treatment milestones and outcomes.
 1. Describe how clients are identified, diagnosed and linked to care.
 2. Describe how clients are retained, re-engaged and supported in their adherence to treatment and prophylactic regimens.
 3. Describe the specific roles and responsibilities of professionals involved.
3. Provide on-going training, education and development activities to those providing LTC services
4. Standardize expectations for the use of peers and train staff on how peers can successfully enhance Linkage and Retention within organizations.
5. Evaluate and develop best practices for patient follow-up to assure that those linked to care are retained in care.
6. Research and develop best practices for technologically supported linkage and retention communication.
7. Develop an updated directory of EIS and LRC services and a mechanism (website) to facilitate communication amongst providers.

4.2.4 Strategy IV: Closely monitor progress across the continuum of care towards decreasing community-level viral load

Prescription and adherence to anti-retroviral medications are the key factors in achieving and maintaining viral suppression. Surveillance and research data have indicated the demographic characteristics of individuals and community areas where disparities in the prescription of ART and viral suppression have been observed. Additionally, adherence support is often needed to maintain viral suppression and needs to be understood in the context of retention and reengagement in care.

The goals and objectives under this strategy will be developed to carefully monitor durable viral suppression and to investigate the disparities in ART prescription and VS. The strategy will focus efforts on determining why those with certain demographic and social characteristics and those with specific service needs are less-likely to be on ART and virally suppressed. The strategy will also attempt to define viral suppression as it applies to all areas of the continuum of care and to understand how adherence is supported through case management and linkage and retention services.

4.2.4.a Goals and Action Steps for Success

Goals

1. Increase the number of people living with HIV in the Chicagoland area who access ART.
2. Increase the number of people living with HIV in the Chicagoland area who are virally suppressed.
3. Decrease disparities of those less likely to be on ART or virally suppressed.

Action Steps:

1. Continue to monitor Viral Suppression and the extent to which data informs us of durable community level viral suppression.
2. Develop further inquiry into why and how frequently providers are postponing ART prescription due to clinical or psychosocial factors.
3. Explore the reasons for identified disparities amongst populations, geographic areas and location of services.
4. Develop further inquiry into why youth 18-29 are less likely to be prescribed ART and be Virally Suppressed.
5. Determine Best Practices for Adherence Support and on-going retention and re-engagement activities.
6. Monitor effects of ACA on the expansion of the network of HIV providers and develop training methods to assure familiarity and compliance with HIV standards of Care.

Section 5. How We Will Monitor Progress

Implementation of the 2014-2016 Unified Plan is guided by four strategies, 13 goals and 30 action steps. Process and outcome measures will be developed and tracked overtime to monitor the plan's progress in reducing HIV infections on the EMA. As with any effective implementation of an integrated prevention and care system, we expect to observe the following:

- An increase the number of people newly diagnosed with HIV infection who are linked to care within three months of diagnosis;
- A decrease community viral load;
- An increase the number of individuals living with HIV infection who are virally suppressed;
- A decrease the number of people who are diagnosed with AIDS within one month of HIV infection diagnoses;
- A decrease the number of AIDS diagnoses;
- An increase the number of people living with HIV infection who are in care (i.e. decrease unmet need for HIV-primary care);
- A decrease the number of people who drop out of care; and
- A decrease HIV-related mortality.

These indicators were essential in the needs assessment and gaps analysis activities and will serve as baseline measures to monitor changes overtime. At an EMA-wide level, these measures can be obtained using the HIV surveillance database which contains CD4 and VL test results performed on all PLWHA, as well as the state's vital records registry. Some of these measures can be obtained on Ryan White – Part A clients using the EMA client level database (CLD). Linking surveillance data with CLD data can help identify Ryan White clients who seem to have been lost to care within the Ryan White funded delegate agencies but have actually received care by another provider in the EMA. Additionally, linking these two systems can help assess the degree to which those tested and newly diagnosed were linked to and retained in care. Linked results can also be compared to state-wide results to identify PLWHA in the EMA who may be receiving care outside of the EMA.

In addition to the HIV surveillance system, CDC funds other surveillance systems that describe the characteristics of people at risk of HIV infection, people newly infected with HIV and HIV care for people living with HIV which contribute to our understanding of the effects of the EMA's HIV continuum of care. The National HIV Behavioral Surveillance (NHBS) is a survey of people at high risk for HIV in large metropolitan areas. HIV Incidence surveillance enhances the HIV surveillance system to allow for estimation of new HIV infections. The Medical Monitoring Project (MMP) describes HIV risk behaviors and primary care of people living with HIV. Other programmatic databases such as the state and city counseling and testing database and STD*MIS, the city's partner services database, are key to monitoring the HIV continuum approach.

Thus, data from all surveillance and programmatic databases are at the center of measuring the effectiveness of the National HIV/AIDS Strategy (NHAS). The NHAS has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities; have anticipated benchmark results to be achieved by 2015. To measure progress in reaching the first goal, CDPH is collaborating with other jurisdictions to develop a methodology for estimating the number of unaware. Implementation of this method will provide an estimate to measure reductions in new HIV infections and increases in the percentage of people living with HIV who know their status. The measurable outcomes of the second primary goal of the NHAS, namely, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 percent to 85 percent; and increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routing HIV medical care at least 3 months apart within a 12 month period) from 73 percent to 80 percent will be measured using clinical data obtained from HIV surveillance and linking HIV surveillance data to the Part A and B client-level data.

Collectively, all data systems maintained by the CDPH and IDPH will assist in evaluating the number of HIV positive individuals identified through prevention and early intervention testing efforts that are linked to care and subsequently retained in care. Social marketing campaigns will be assessed for effectiveness through surveys of clients recently entering in care, as well as, long time consumers of services. Data collected will also assist in the evaluation of the new medical case management model, and its ability to improve medical outcomes for clients. Finally, data will be used to accurately identify the number of clients utilizing services, and effectively target resources where they are most needed. The data collection processes will be evaluated on the EMA's ability to collect and use the aforementioned data. Data collected will also further improve the evaluation of the quality of services.

Measuring Clinical Outcomes

Clinical outcomes for clients residing in the EMA receiving more than 90 services will be monitored using the CLD data and CD4 and VL data obtained from a match with the HIV surveillance database. These data will help monitor progress towards meeting the NHAS goal of increasing the percentage of Ryan White clients in care as well as monitor the percent of clients who are virally suppressed. These measures will be analyzed for the EMA overall as well as by Ryan White Part A delegate agencies to track their individual progress towards meeting these clinical outcomes. When individual-level data begin to be collected for clients receiving HOPWA services, a match of this database with CLD will help measure progress towards the NHAS goal of increasing the percentage of HOPWA clients receiving Ryan White services.

Acknowledgements and Dedications



For the countless People Living with HIV/AIDS who have Paved the way
and continue to the Pave the way...

"We say Thank You"

Chicago Area HIV Integrated Services Council

Co-Chairs of the CAHISC Council

Committee Co-Chairs of the CAHISC Council

Primary Prevention and Early Intervention Committee
Linkage and Retention to Care Committee
Anti-retroviral Therapy and Viral Suppression Committee
Membership and Community Engagement Committee

Chicago Department of Public Health

Agencies Delivering Services to Countless Clients and Patients

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Glossary of Terms and Acronyms

ADAP	AIDS Drug Assistance Program – The state’s program that funds HIV medication for people who are HIV+ and unable to pay for the medications they need. This program is administered by the Idaho Ryan White Part B Program.
Adherence	Refers generally to the ability to follow a prescribed treatment regimen, including correct dosage, number of doses per day, and dietary restrictions.
AIDS	Acquired Immune Deficiency Syndrome - The disease which is often the final stage of HIV progression within the body. AIDS is characterized by opportunistic infections, high viral load counts of HIV within the blood, and CD4 counts.
Antibody	Antibodies are produced in response to antigens as part of the body’s defense against disease. Specific antibodies bind to and act upon specific antigens. Neutralizing antibodies destroy or inactivate infectious agents.
ARS	ARS (Acute Retroviral Syndrome; also known as Acute HIV Infection) –The period of rapid HIV replication that occurs 2-4 weeks after infection, characterized by a drop in CD4 count and an increase in HIV levels in the blood. It may be accompanied by flu-like symptoms such as fever, swollen lymph nodes, sore throat, and rash.
ART	Antiretroviral Therapy - medications for the treatment of infection by retroviruses, primarily HIV. Different classes of antiretroviral drugs act at different stages of the HIV life cycle
Bylaws	The written rules and regulations that govern the internal affairs of the Planning Council. The Bylaws are drafted by the Membership Committee and must be approved by the full Council.
CareWARE	The software program used for managing and monitoring HIV disease medical and support services developed by HRSA and made available to all Ryan White grantees.
CBO	Community-Based Organization (CBO) - An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV.
CD4 Cell Count	The number of CD4 cells in a drop of blood. Normal is typically 500-1,400 cells/mm ³ of blood. CD4+ count (or, T-cell count): The actual number of T-helper cells in a microliter of blood. The CD4+ count is lower in people whose immune system has been affected by HIV.
CD4 Cell Percentage	The number of CD4 cells compared with the number of all lymphocytes. Cell percentage is more consistent and reliable than absolute cell count. Normal is typically 30-40%.
CD4 Cells	White blood cells often called “helper” T-cells because they defend the immune system when the body becomes infected. CD4 cells are the main target of HIV.
CDC	Centers for Disease Control & Prevention - The federal agency which conducts prevention and intervention for STD’s and HIV on a national level. The CDC provides every state with some funding for HIV and STD prevention.
CDPH	Chicago Department of Public Health
Chicago EMA	The geographical area defined by HRSA as the City of Chicago and nine counties – Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry and Will.
CLD	Client Level Data (CLD)
Comprehensive Plan	A document developed by the Planning Council every three years that defines the goals of the Planning Council related to improving service delivery and reducing gaps in care and/or barriers in accessing care in the Chicago EMA. This is a requirement of HRSA and timeframes/due dates may change per HRSA.
Conflict of Interest	Planning Council members and Alternates will be considered to have a conflict of interest if they themselves, their relative, spouse, or domestic partner have an interest in issues to be discussed that might affect: A profit or non-profit organization in which he/she has a financial interest in or is serving as an officer, director, trustee, partner,

	paid employee, or consultant; A public agency in which he/she is serving as an paid employee or consultant; Any person or organization with whom he/she is negotiating or has an existing arrangement concerning prospective employment.
Continuum of Care	A full range of emergency and long-term service resources to address the various needs of people living with HIV.
Core Medical	<p>As stated in the Ryan White legislation, the term “core medical services,” with respect to an individual infected with HIV/AIDS (including the co-occurring conditions of the individual) means the following 13 core medical services are fundable</p> <ul style="list-style-type: none"> • Outpatient and ambulatory health services • ADAP AIDS pharmaceutical assistance • Oral health care • Early intervention services • Health insurance premium and cost-sharing assistance • Home health care • Medical nutrition therapy • Hospice services • Home and community-based health services • Mental health services • Outpatient substance abuse care • Medical case management, including treatment adherence services
eHARS	A CDC created database that contains demographic and biomedical information for people diagnosed with HIV disease.
EIS	<p>Early Identification Services (EIS) – is a funded service category in the Chicago EMA and includes identification of individuals at points of entry and access to services and provision of:</p> <ul style="list-style-type: none"> • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable participants to navigate the HIV system of care
ELISA	The enzyme-linked immunosorbent assay (ELISA) is a test that uses antibodies and color change to identify a substance.
EMA	Eligible Metropolitan Area - geographic area which is a defined area by HRSA as highly impacted by HIV/AIDS that are eligible to receive funds under Part A of the Ryan White legislation. EMAs typically have large, established HIV epidemics.
Epi	Epidemiological - is the science that studies the patterns, causes, and effects of health and disease conditions in defined populations. It is the cornerstone of public health, and informs policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare. Epidemiologists help with study design, collection and statistical analysis of data, and interpretation and dissemination of results (including peer review and occasional systematic review). Epidemiology has helped develop methodology used in clinical research, public health studies and, to a lesser extent, basic research in the biological sciences.
Grantee	The entity who is the recipient of Ryan White Part A funds for an EMA. The grantee is responsible for administering the grant award according to HRSA rules and regulations. The grantee for the Chicago EMA is the Chicago Department of Public Health (CDPH).
Grantor	The agency of the federal government that makes annual Ryan White CARE Act grant awards. The Ryan White Part A grantor is the Health Resources Services Administration (HRSA). A United States Health and Human Services agency that administers various primary care programs for the medically underserved, including the Ryan White Treatment Extension Act.
GRF	General Revenue Funds (GRF) - Although in Illinois there are over 602 active funds,

	four funds comprise what is commonly referred to as the General Funds. These four include the General Revenue Fund, the General Revenue - Common School Special Account Fund, the Education Assistance Fund, and the Common School Fund. A state or local government raises general revenue through taxation and that may be used for any purpose. That is, general revenue is not earmarked automatically for functions such as road maintenance or payroll for state workers. Rather, the government may use general revenue for discretionary functions.
HAART	HAART (Highly Active Antiretroviral Therapy) –A term for a potent combination anti-HIV treatment that usually includes a protease inhibitor.
HHS	United States Department of Health and Human Services (HHS) - A federal agency responsible for protecting the health of all Americans and providing essential human services, including administration of the Ryan White legislation.
HIV	Human Immunodeficiency Virus - The virus that causes AIDS by deteriorating the immune system by destroying the T-cells.
HOPWA	Housing Opportunities for People With AIDS (HOPWA) - A program administered by the United States Department of Housing and Urban Development that provides funding to support housing for PLWHA and their families.
HRSA	Health Resources and Services Administration - The federal agency within the Department of Health & Human Services that administers and oversees the Ryan White Care Act.
HUD	United States Department of Housing and Urban Development (HUD) - A federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People With AIDS (HOPWA).
IDU	Injection Drug Users. A target population at risk for HIV transmission.
Incidence	This term refers to the current total number of events or cases, both newly and previously diagnosed, that are living at a particular point in time.
MAI	MAI (Minority AIDS Initiative) This Part of the Ryan White CARE Act Program provides core medical and related support services to non-Hispanic blacks and other disproportionately impacted communities, to improve access to care and reduce disparities in health outcomes in metropolitan areas most affected by HIV disease.
MATEC	Midwest AIDS Training + Education Center – federally-funded center, providing AIDS and HIV clinical training and support to health care professionals. MATEC has built connections with the top HIV clinicians and researchers in our region to offer health care professionals targeted training and direct access to expert information. We are part of a national network of AIDS Education and Training Centers, serving all states and territories and including four supporting national centers.
Median	The median is the middle value of a distribution; half the values are above the median and half are below the median
Medicaid	Medicaid is a governmental health care program for eligible individuals and families with low incomes and resources. It is funded through federal and state resources.
Medicare	Medicare is a governmental health care program for eligible individuals who are retired and/or disabled.
MSM	Men who have sex with men. A target population at risk for HIV transmission.
Needs Assessment	A process of collecting information about the health care and supportive service needs of local people living with HIV.
NGA	Notice of Grant Award (NGA) - The legal document issued to notify the grantee that an award has been made and that funds may be requested from the HHS payment system.
OI	Opportunistic Infection–Infection by an organism that would not harm a healthy person, but causes disease in those with weak immune systems.
Part A	This Part of the Ryan White CARE Act Program provides funding assistance for HIV disease core medical services and related support services in areas most severely

	affected by HIV disease (eligible metropolitan areas and transitional grant areas).
Perinatal Transmission	When a mother passes HIV to her child during pregnancy or through breastfeeding; also called mother-to-child transmission.
PIR	Parity, Inclusion, and Representation - The mandate from the CDC which requires the IACHA to have a membership that reflects the Epi Profile, that all members are provided the opportunity to speak with an equal voice, and that members voice the views of the groups within which they are members. The PIR mandate is the “prime directive” of the Membership Committee with the general goal being a membership which is nearly identical to the Epi Profile of HIV.
PLWHA	Person Living With HIV/AIDS (PLWHA) - Any Individual diagnosed as HIV positive or as having AIDS.
Prevalence	This term refers to the number of cases of a disease that are present in a particular population at a given time.
Priority Setting	The process by which the highest risk populations are determined and in the Chicago EMA, the ranking of the Service Categories in importance to address the HIV/AIDS epidemic.
Protease inhibitors (PIs)	A class of anti-HIV drugs that prevent the HIV virus from making new copies. Protease inhibitors restrict HIV production in cells that are already infected.
Provide	The Provide software system can be used to capture and store the full continuum of health and psychosocial Client information. The software’s architecture supports great flexibility and comprehensive security, so it can be used effectively in all types of HIV/AIDS service delivery models. Provide generates all the required Ryan White federal reports.
PSRA	Priority Setting and Resource Allocation (PSRA) - The process used to 1) establish priorities among service categories to best meet locally identified needs, and 2) determine the percentage / amount of funding that can be used to provide services within those categories.
QM	Quality Management (QM) – HRSA expects Ryan White Grantees and their sub-contracted providers of care to monitor the improvement of care of patient/clients in the Chicago EMA. QM has four main components: quality planning, quality control, quality assurance and quality improvement.
Quorum	A numerical majority of voting members that must be present at a meeting in order to take action on agenda items.
Rapid Test	A type of ELISA test that can detect antibodies to HIV in the blood in less than an hour. A positive rapid test should be confirmed by an HIV Western blot test.
Rate	A rate is a standardized fraction—the upper part (the numerator) is the number of people affected by a condition; the lower part (the denominator) is the standard number of persons in the population. Changing raw numbers into rates allows you to compare different population groups.
RFP	Request For Proposals (RFP) - An open and competitive process for the procurement of goods and services. An RFP is an appeal for entities to apply to be Part A contractors or delegate agencies. Part A notifies the provider community that funding is available to provide Ryan White services. Organizations then respond with a proposal that usually includes a service delivery plan, budget, and other background information. Independent review panels review the proposals and determine which organizations to award Ryan White contracts for a specified amount of time.
Ryan White Program	Federal legislation that addresses the unmet health needs of people living with HIV by funding primary medical care and support services. Part A: A section of the Ryan White legislation that provides emergency assistance to geographic areas disproportionately affected by the HIV/AIDS epidemic. Part B: A section of the Ryan White legislation that provides funds to States and Territories for primary health care, including AIDS Drug Assistance Programs (ADAP), and support services that enhance access to care by

	people living with HIV and their families. Part C: A section of the Ryan White legislation that supports outpatient primary medical care and Early Intervention Services (EIS) to people living with HIV through grants to public and private nonprofit organizations. Part C also funds capacity development and planning grants to prepare EIS programs. Part D: A section of the Ryan White legislation that supports coordinated services and access to research for women, infants, children, and youth with HIV/AIDS and their families. Part F: A section of the Ryan White legislation that includes the AIDS Education and Training Center (AETC) Program, the Special Projects of National Significance (SPNS) Program, and the HIV/AIDS Dental Reimbursement Program.
Scope of Service	The number, type and intensity or complexity of services being provided by a contracted delegate agency. Scopes of Service are defined by the delegate agency for each Service Category that they are contracted to provide. Within each Scope of Service, sub-categories are to be defined with the number of patient/clients to receive the sub-category of service, as well as the number of units of service for that same sub-category. As an example, within the Mental Health Service Category, an agency may have two sub-categories: (1) Assessment proposing to provide this service to 10 clients with 2 assessments per clients; and (2) Counseling Group Sessions, proposing this service to 20 clients with 12 group sessions per client.
SCSN	Statewide Coordinated Statement of Need (SCSN) - A written statement of need for an entire state developed through a process designed to collaboratively identify significant HIV issues and maximize Ryan White CARE Act program coordination.
Seroconversion	The process by which a newly infected person develops antibodies to HIV, which are then detectable by an HIV test. Seroconversion may occur days to weeks to months following infection.
Service Category	The types of services defined by the Health Resources and Services Administration (HRSA) that Part A funds can be used to provide in an EMA. As an example, Mental Health Services and Oral Health are two (20 OF THE Service Categories funded in the Chicago EMA.
Service Gaps	Ideally, all of the service needs of all PLWHA in the community should be met. When there are PLWHA that have service needs that aren't being met, there is a service gap.
SME	Subject Matter Expert (SME) - is a person who is an authority in a particular area or topic, such as a physician who specializes in the care of HIV positive patients.
SPNS	Special Projects of National Significance (SPNS) - A health services demonstration, research, and evaluation program funded under Part F of the Ryan White legislation to identify innovative models of HIV care.
SSI	Supplemental Security Income
STD	Sexually Transmitted Disease - A disease which is passed on to another person by unsafe sexual practices. STDs include gonorrhea, syphilis, chlamydia and HIV. Although the phrase STD includes HIV, funding to the state is separated into HIV and non-HIV STDs, so frequently this term will refer to all STDs except HIV.
STI	Sexually Transmitted Infection - The more politically correct term for STDs.
SUD	Service Utilization Data (SUD) is the data collected from the delegate agencies on a quarterly basis that captures what services were used, who used these services, where these services were provided and how frequently these services were used by patient/clients in the Ryan White Program.
Support Services	A total of 16 support services are approved for funding based on the legislation: <ul style="list-style-type: none"> • Case management (non-medical) • Child care services • Emergency financial assistance • Food bank/home-delivered meals • Health education/risk reduction • Housing services

	<ul style="list-style-type: none"> • Legal services • Linguistics services (interpretation and translation) • Medical transportation services • Outreach services • Psychosocial support services • Referral for health care/supportive services • Rehabilitation services • Respite care • Substance abuse services—residential • Treatment adherence counseling
T-4 cells	A group of T-cells (also known as CD4 cells) that carry the T4 marker and are instrumental in turning on antibody production, activating other T-cells and starting other immune responses. Also known as T4 helper cells.
TA	Technical Assistance (TA) - The delivery of practical program and organizational support to Ryan White Part A grantees, planning bodies, and affected communities. TA is used to assist in the design, implementation, and evaluation of Ryan White-supported planning and primary care service delivery systems.
T-cell	A type of white blood cell essential to the body's immune system; helps regulate the immune system and control B-cell and macrophage functions.
TGA	Transitional Grant Area
Unit Cost	<p>Unit cost is the cost to produce or deliver one unit or product or service. Unit costs have many uses. They can provide the basis for cost comparisons across services, providers, or geographic areas, and provide a benchmark for performance measurement. They are the basis for contract payment where reimbursement is based on units of service delivered. Unit costs are also an essential component of cost-effectiveness analysis. However, unit-cost data are descriptive information; used alone, they do not measure efficiency, effectiveness, quality, or content of services. They cannot easily be compared across agencies unless standards have been developed and implemented, since if more than one provider delivers the same categories of service, the intensity of service, model of care, and quality of care may be different. There are five basic steps to determining unit costs:</p> <ol style="list-style-type: none"> 1. Define the exact units of service 2. Count the total number of units in a given time period 3. Determine all the direct and indirect costs of producing the units of service 4. Add these components of full cost for the same time period, and 5. Divide the full cost by the total number of service units to arrive at the average unit cost during a particular time period.
Unmet Need	The unmet need for primary health services among individuals who know their HIV status but do not receive primary health care.
VL	Viral load-- The number of HIV virus copies per mL of blood plasma. The presence of HIV RNA indicates that the virus is replicating. Changes in the viral load may be used to gauge drug effectiveness and disease progression.
WBCs	White Blood Cells (WBCs) – Cells in the blood that fight infection. The average adult male has about 7,500 white blood cells/mm ³ . This amount can increase following an infection, but decreases in people with HIV.
Western Blot	Blood test to confirm a positive HIV antibody test (ELISA; HIV Rapid test).

Appendix

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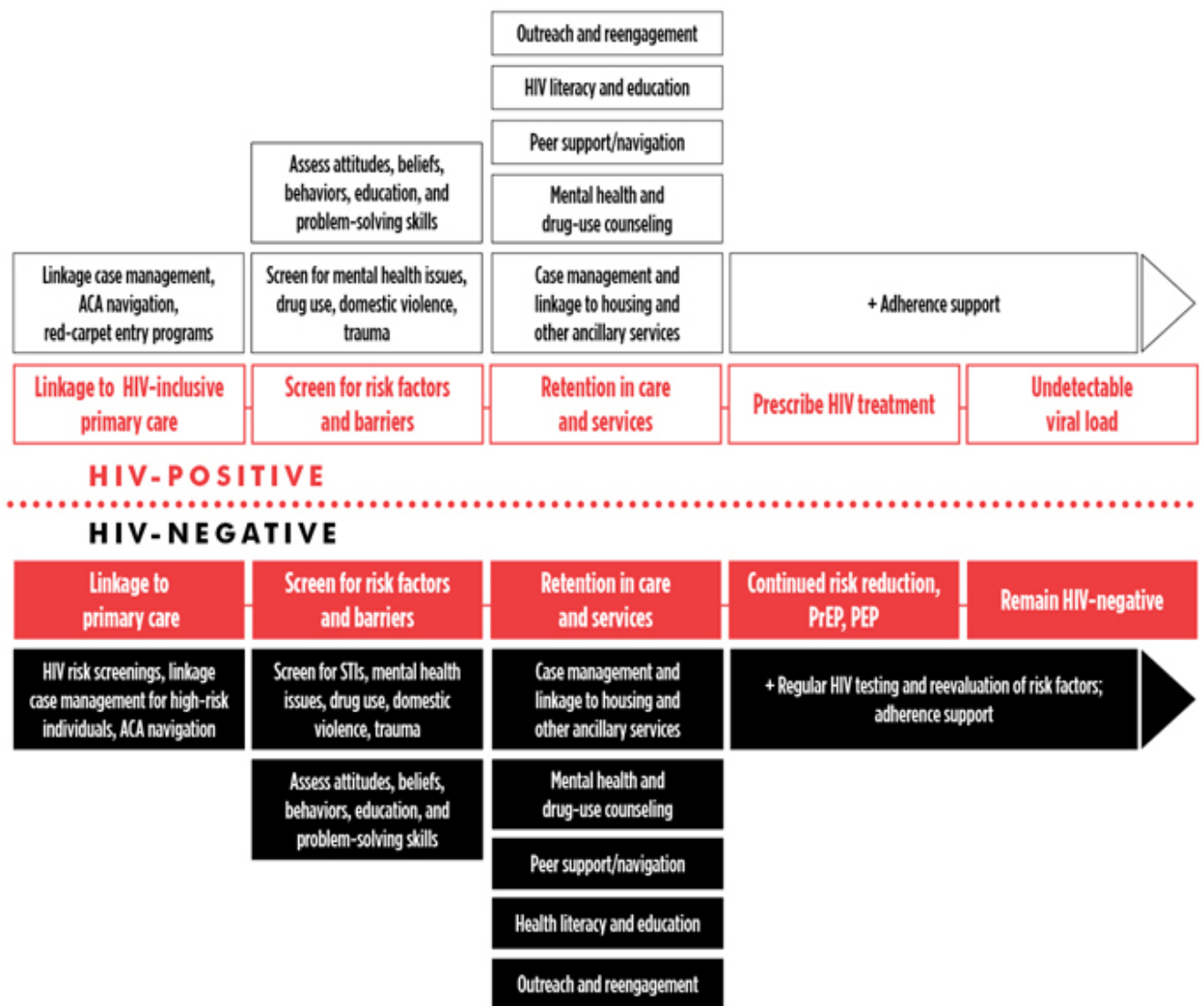
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