



2017-2021 INTEGRATED PLAN

2018 Integrated Prevention and Care Plan

Table of Contents	1
List of Figures	2
List of Appendices	3
Acknowledgements.....	4
Letter of Concurrence	5
Executive Summary.....	6
Introduction	8
Section I. Statewide Coordinated Statement of Need/Needs Assessment	11
A. Epidemiological Profile	11
B. HIV Care Continuum.....	15
C. Financial and Human Resources Inventory	19
D. Assessing Needs, Gaps, and Barriers	25
Section II. Integrated HIV Prevention and Care Plan	42
Integrated Goals, Objectives, Strategies, and Activities	42
Section III. Monitoring and Improvement.....	61
Monitoring and Evaluating Goals and Objectives	61
Conclusion.....	62

List of Figures

Figure 1	Chicago Eligible Metropolitan Area	11
Figure 2	Scale of Illinois Poverty, 2014.....	12
Figure 3	HIV Infections by Year of Diagnosis and Selected Demographic Characteristics, Chicago EMA, 2010-2014	13
Figure 4	People Living with HIV Infection in 2013, Chicago EMA	14
Figure 5	2016 HIV Care Continuum, Chicago EMA	15
Figure 6	2016 HIV Care Continuum, City of Chicago	16
Figure 7	2016 HIV Care Continuum among Black MSM, Chicago EMA	17
Figure 8	2016 HIV Care Continuum among Hispanic MSM, Chicago EMA.....	18
Figure 9	2016 HIV Care Continuum among Cisgender Black Women, Chicago EMA	19
Figure 10	Preliminary Provider Assessment, Chicago EMA, 2016	20
Figure 11	The average distance traveled to medical facilities and the range of miles traveled by people living with HIV between patient zip code and facility zip code within the counties of the Chicago EMA	22
Figure 12	2019 CDPH Anticipated HIV Funding for External Contractors	23
Figure 13	HIV Prevention, Care and Treatment, and Housing Service Needs and Gaps	31
Figure 14	Barriers to HIV Prevention, Care and Treatment, and Housing Services.....	31
Figure 15	Strategies and Solutions to Address HIV Prevention, Care and Treatment, and Housing Needs and Barriers	33
Figure 16	Community Forum and Focus Group Locations and Participant Information	38
Figure 17	CDPH/CAHISC ARV Pathway.....	55
Figure 18	2019 <i>HIV Services Portfolio</i> Funding Opportunities, Funding Amounts, and Funding Sources	60

List of Appendices

Appendix 1	Chicago EMA HIV/AIDS Profile	64
Appendix 2	City of Chicago HIV/STI Surveillance Report	96
Appendix 3	Integrated Plan Work Plan	150
Appendix 4	Chicago EMA HIV Resources Inventory	163
Appendix 5	Workforce Assessment – Chicago	177
Appendix 6	Chicago Area HIV Integrated Services Council – <i>HIV Services Portfolio</i> Committee Feedback	192
Appendix 7	Partners List.....	197

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Special thanks goes to past and present CAHISC community co-chairs who guided the process that yielded this document.

- Roman Buenrostro
- Peter McLoyd
- Kathryn Mercado
- Nicole Seguin

This plan is dedicated in loving memory of Betty Smith, Founding Executive Director of South Side Help Center, Dan Bigg, Founding Executive Director of the Chicago Recovery Alliance, and Marcia Lipetz, former Executive Director of the AIDS Foundation of Chicago. We lost them this year, but their leadership and contributions to HIV live long.



Chicago Area HIV Integrated Services Council

September 10, 2018

George Hill, M.Ed.
Project Officer
Centers for Disease Control and Prevention

Luigi Procopio, II
Public Health Analyst/Program Officer
Health Resources and Services Administration

Dear Mr. Hill and Mr. Procopio,

The Chicago Area HIV Integrated Services Council (CAHISC) concurs with the submission of the Integrated HIV Prevention and Care Plan 2017-2021. This document has been developed by the Chicago Department of Public Health (CDPH) in collaboration with CAHISC to comply with the guidance set forth by the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

CDPH and CAHISC have worked closely over the last six years to develop an integrated planning process that gathers input from community and provider stakeholders and people living with and vulnerable to HIV to assess needs and to develop a portfolio of HIV services that will meet these needs. The plan thoroughly describes this process and proposes a plan for implementing services that will best integrate the resources available to the Chicago Eligible Metropolitan Area (EMA) to meet these needs.

As described in the plan, CAHISC will closely monitor implementation of the HIV Services Portfolio and work with CDPH to continue to strengthen approaches to meet HIV prevention, care and treatment, and housing needs of members of the Chicago community. As Co-Chairs and representatives of the CAHISC, we look forward to working with CDPH to meet the goals and objectives stated in the plan.

Sincerely,

Kathryn Mercado

Community Co-Chair

Nicole Seguin

Community Co-Chair

Jorge Cestou

Governmental Co-Chair

Executive Summary

Chicago Integrated HIV Prevention and Care Plan, 2017–2021

Implementing an Actionable Model of Services

The Chicago Department of Public Health (CDPH) in collaboration with the Chicago Area HIV Integrated Services Council (CAHISC) has developed the Integrated HIV Prevention and Care Plan (Integrated Plan) for the Chicago Eligible Metropolitan Area (EMA). The plan has been developed according to joint guidance issued by the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). The Chicago EMA, which includes the City of Chicago and nine surrounding counties, participated in the development of the State Wide Coordinated Statement of Need (SCSN), in partnership with the Illinois Department of Public Health. The SCSN was developed to provide a collaborative mechanism to identify and address the most significant HIV needs of people living with HIV and to maximize coordination, integration, and effective linkages across all Ryan White HIV/AIDS Programs. The Integrated Plan promotes collaboration and coordination in the use of HIV surveillance and needs assessment data to inform HIV prevention and care program planning, resource allocation, evaluation, and quality improvement efforts to meet all HIV prevention and care needs.

The Integrated Plan is built on a solid foundation of collaboration with stakeholders across the EMA. The Integrated Plan is a joint effort of CDPH and CAHISC, a diverse and representative planning body that includes people living with HIV, community-based organizations, service providers, and representatives of highly impacted communities.

The Chicago EMA has organized the Integrated Plan according to goals defined by the National HIV/AIDS Strategy (NHAS).

Goal #1: Reduction of New HIV Infections

Goal #2: Increased Access to Care and Improved Health Outcomes for People Living with HIV

Goal #3: Reduction of HIV-Related Disparities and Health Inequities

Goal #4: A More Coordinated Response to HIV in the Chicago EMA and within the State of Illinois

The Integrated Plan has also adopted the vision of *Getting to Zero: A Framework to Eliminate HIV in Illinois* (GTZ). Getting to Zero refers to both HIV prevention and care goals to be addressed through the use of antiretroviral medications (ARV): zero new HIV infections and zero people living with HIV who are not receiving treatment. Plan objectives are set to accomplish GTZ goals:

1. Increase by 20 percentage points the number of people living with HIV who are virally suppressed and
2. Increase by 20 percentage points the number of people vulnerable to HIV infection who use pre-exposure prophylaxis (PrEP).

The Integrated Plan consists of the following sections:

- Introduction and Overview – This section provides a summary of the Integrated Plan’s development, intent, and a description of the geographic areas and populations affected by HIV in the EMA.
- The SCSN – This section provides a detailed overview of the HIV epidemic in Illinois and the EMA, a description of the HIV financial and workforce resources in Illinois, and a comprehensive assessment of HIV prevention, care, and treatment needs.

- The Integrated Plan – This section identifies SMART objectives, strategies, activities, and metrics to successfully accomplish the vision of Getting to Zero by implementing the *HIV Services Portfolio*.
- Monitoring and Improvement – This section describes how CDPH will monitor and evaluate the implementation of prevention and care activities and how these address the SMART objectives defined in the Integrated Plan. This section will also provide ongoing assessment and improvement to guide the incremental development of a new model of services to meet the goals and vision of the Integrated Plan.
- Conclusion

CAHISC and CDPH have identified four essential components of a high-impact model of services to be implemented through the Integrated Plan.

1. *Healthcare Access*. Increase access to both HIV treatment and PrEP, along with supportive services, for people living with and vulnerable to HIV. Enhance coordination among service providers to increase the likelihood people have every opportunity to benefit from services.
2. *Health Equity*. Invest resources to address root causes of health disparity, including systemic racism. Invest in communities most impacted by HIV to create opportunities and reduce marginalization.
3. *Housing*. Increase access to housing for persons living with and vulnerable to HIV.
4. *How-to*. Raise awareness, educate, and promote healthy behaviors in communities most impacted by HIV. Link persons living with and vulnerable to HIV to needed HIV services.

These components will be implemented through several programmatic funding opportunities which will provide an enhanced opportunity to integrate funding, resources, and services for HIV prevention, care, housing, and essential supportive services.

Introduction

The Integrated HIV Prevention and Care Plan: 2017-2021 (Integrated Plan) for the Chicago Eligible Metropolitan Areas (EMA) describes our ongoing efforts to reduce new HIV infections and ensure that everyone living with HIV has the opportunity for high quality healthcare and quality of life. Integrated HIV prevention and care planning enables the EMA to develop and implement a collaborative, efficient, and effective response to HIV in our region and to create opportunities for innovation in HIV prevention, care and treatment, and housing.

The Chicago EMA, which includes the City of Chicago and nine surrounding counties, actively participated in the development of the Statewide Coordinated Statement of Need (SCSN) which provides a collaborative mechanism to identify and address the most significant HIV needs of people living with and vulnerable to HIV and to maximize coordination, integration, and effective linkages across HIV prevention, care and treatment, and housing. The Integrated Plan is a joint effort of the Chicago Department of Public Health (CDPH) and the Chicago Area HIV Integrated Services Council (CAHISC), a diverse and representative planning body that includes people living with and vulnerable to HIV, community-based organizations, healthcare providers, and others.

The Chicago EMA has organized our Integrated Plan according to goals defined by the National HIV AID Strategy (NHAS).

Goal #1: Reduction of New HIV Infections

Goal #2: Increased Access to Care and Improved Health Outcomes for Persons Living with HIV

Goal #3: Reduction of HIV-Related Disparities and Health Inequities

Goal #4: A More Coordinated Response to HIV in the Chicago EMA and within the State of Illinois

To strengthen the focus on treatment as prevention and pre-exposure prophylaxis (PrEP), both of which emerged after NHAS was written, the Integrated Plan has adopted the vision of [Getting to Zero: A Framework to Eliminate HIV in Illinois](#). Getting to Zero refers to both achieving zero new HIV infections and zero people living with HIV who are not receiving treatment. Integrated Plan objectives and strategies are set to accomplish Getting to Zero goals:

1. To increase by 20 percentage points the number of people living with HIV who are virally suppressed and
2. To increase by 20 percentage points the number of people vulnerable to HIV infection who use PrEP.

The commitment to Getting to Zero comes at a critical time in the history of the HIV epidemic in the Chicago EMA. After years of plateau, we are seeing notable progress diagnosing infections and ensuring newly diagnosed persons are linked to care quickly. In 2016, the City of Chicago diagnosed only 839 new HIV infections, the fewest in a single year since 1990. Of those, 80 percent were linked to medical care within one month, and more than 90 percent within one year. In the Chicago EMA, 1,312 new HIV infections were diagnosed in 2016, 80 percent were linked to care within one month, and almost 94 percent were linked to care within one year.

Despite our success, certain groups continue to represent a disproportionate share of new HIV diagnoses: men, 20-29 year olds, non-Hispanic Blacks, and gay, bisexual, and other men who have sex

with men (MSM).¹ Further, we continue to face challenges keeping people in care and successfully using antiretroviral medication (ARV) for treatment. Only 60 percent of people living with HIV in Chicago accessed care in 2016, only 40 percent were in care consistently², and less than half achieved viral suppression. In the EMA, only 65 percent of people living with HIV accessed care in 2016, 44 percent were in care consistently, and just 50 percent were virally suppressed. For individuals vulnerable to HIV infection, conservative estimates suggest that only 10 percent of the 30,000 individuals eligible for PrEP in the State of Illinois are using it.³ In order to accelerate progress toward the ambitious goals set forth in the Getting to Zero framework, we must strengthen activities and services that are working and initiate new approaches to expand access, fill critical gaps, and recruit more customers into services.

Over the last two years, CDPH, in collaboration with CAHISC, hosted numerous forums, consultations, meetings, and other feedback-gathering conversations with stakeholders. Through this engagement emerged a comprehensive *HIV Services Portfolio*, or the collection of all HIV services that must work together to reduce HIV infections and increase quality of life for those living with and vulnerable to HIV. These engagements helped us learn what works, where challenges exist, and how we can push our system to accelerate progress toward ending the epidemic. Key take-aways from these engagements include:

- Individuals who receive Ryan White services see positive health outcomes. CDPH data indicate between 70-80 percent of these individuals achieve viral suppression. However, only about 50 percent of people living with HIV are enrolled in Ryan White. For individuals vulnerable to HIV infection, no similar system exists so there must be increased access to both clinical and non-clinical supportive services for more people, extending the benefits of this combination of services to persons vulnerable to HIV.
- Similarly, individuals who receive Housing Opportunities for Persons with AIDS (HOPWA) services see positive health outcomes. CDPH data indicate that nearly 70 percent of these individuals achieve viral suppression. Like healthcare, many persons living with and vulnerable to HIV do not have access to supportive housing services. There must be increased access to housing for more people, extending the benefits of housing to persons vulnerable to HIV.
- Individuals are often faced with navigating complicated systems of healthcare, supportive services, and housing on their own, particularly if they do not receive Ryan White and/or HOPWA services. Mechanisms are needed to better coordinate delivery of comprehensive services to increase the likelihood that people living with and vulnerable to HIV have every opportunity to benefit from the services that are available.
- Individuals are complex and face many life circumstances that can lead to poor health outcomes, including HIV infection. To promote population-level health, we must invest resources in tackling root causes of health disparity, including systemic racism, and in communities most impacted by HIV to create opportunities and power in groups that have been long-marginalized by prevailing systems.

¹ Chicago Department of Public Health. HIV/STI Surveillance Report 2017. Chicago, IL: City of Chicago, December 2017.

² Individuals who had at least two care visits between January 1 and December 31, 2016, at least 91 days apart.

³ Livak B, Michaels S, Green K, Nelson C, Westbrook M, Simpson Y, Prachand N, Benbow N, Schneider JA. Estimating the number of young Black men who have sex with men (YBMSM) on the south side of Chicago: Towards HIV elimination within US urban communities. *Journal of Urban Health*. 2013 Dec; 90(6): 1205-1213. PMID: PMC3853168

- Smaller organizations are essential to reaching and serving highly marginalized populations in communities where individuals live, work, and play. Future funding opportunities must embrace the value of smaller, non-clinical organizations.
- Chicago has had a long history of successfully implementing HIV services. Future funding must strive to preserve what is working, as it moves to accelerate progress toward Getting to Zero.
- Chicago must embrace [Undetectable = Untransmittable](#), which means service providers must follow current science which clearly states that people living with HIV who are virally suppressed cannot transmit HIV to their sexual partners.

These and other insights have been incorporated into the development of the *HIV Services Portfolio*. In the *HIV Services Portfolio*, activities and services are organized into a comprehensive, coordinated system of care that focuses on supporting successful ARV use for both individuals and populations living with and vulnerable to HIV. CAHISC and CDPH identified four focus areas in the *HIV Services Portfolio* that create a high-impact model of service delivery that we believe offers the best chance of achieving Getting to Zero goals.

1. *Healthcare Access*. We must increase access to both HIV treatment and PrEP, integrated with supportive services, for people living with and vulnerable to HIV. We must enhance coordination among service providers to increase the likelihood people have every opportunity to benefit from services.
2. *Health Equity*. We must invest resources to address root causes of health disparity, including systemic racism. We must invest in communities most impacted by HIV to create opportunities and reduce marginalization.
3. *Housing*. We must increase access to housing for persons living with and vulnerable to HIV.
4. *How-to*. We must raise awareness, educate, and promote healthy behaviors in communities most impacted by HIV. We must ensure persons living with and vulnerable to HIV reach and are able to use the HIV services they need.

The *HIV Services Portfolio* will be implemented through multiple funding opportunities, which are described later in the Integrated Plan. These funding opportunities represent the first integrated allocation of HIV prevention, care and treatment, and housing funding in the EMA.

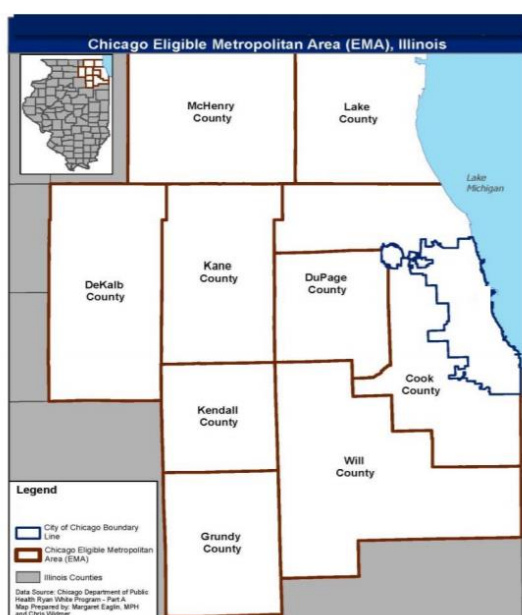
Section I. Statewide Coordinated Statement of Need/Needs Assessment⁴

A. Epidemiological Profile

Geographic Region

The Chicago EMA is located in the northeastern corner of Illinois and is comprised of nine counties: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry, and Will. See Figure 1. The estimated population in 2012 was 8.7 million people who represent 66 percent of the population of the State of Illinois. The Chicago EMA encompasses 5,046 square miles and reflects urban, suburban, and rural communities. Chicago, the largest urban center in the EMA, is the nation's third largest city. Ninety-four percent of EMA residents live in urban areas and in the smaller cities in the collar counties, two percent in suburban areas, and four percent in rural areas. In 2015, there were 38,314 people living with HIV in Illinois, 30,165 living in the EMA, and 23,824 living in the City of Chicago.

Figure 1. Chicago Eligible Metropolitan Area



According to the United States (U.S.) Census Bureau (2015), the estimated racial and ethnic composition of Illinois residents in 2014 was 62.3 percent White, 14.7 percent Black, 16.7 percent Hispanic or Latino, 5.3 percent Asian, 0.6 percent American Indian and Alaskan Native, 0.1 percent Native Hawaiian or other Pacific Islander, and 1.8 percent identified as two or more races. In 2014, 23.2 percent of Illinois residents were younger than 18 years, 13.9 percent were 65 years or older, and almost 51 percent were cisgender female.

Socio-demographics

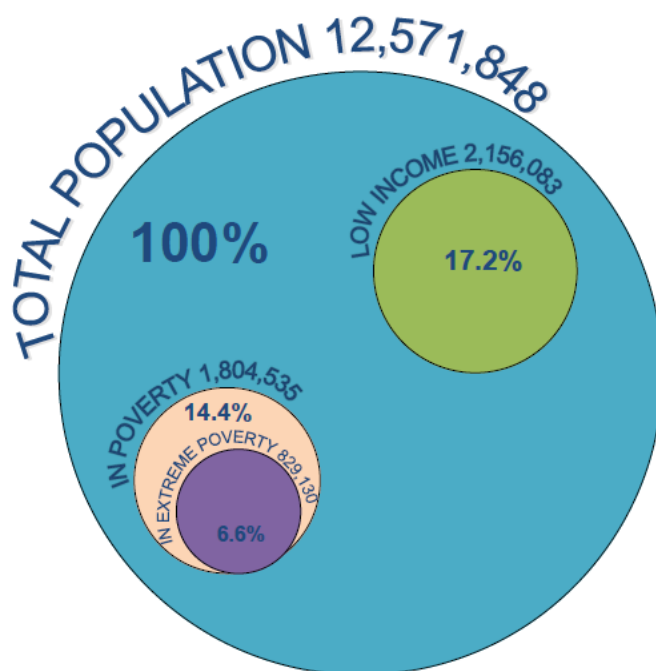
The U.S. Census Bureau calculates poverty rates according to household income by family size and family age composition. From 2010-2014, 14.4 percent of Illinois residents were living below the federal

⁴ For consistency, and to support statewide integration of HIV planning efforts, data and information from the [Illinois Integrated HIV Prevention and Care Plan](#) was used to complete parts of this section. Where appropriate, narrative is verbatim.

poverty level. Poverty rates in Illinois have stayed at or above 10 percent since 1980 and have generally followed national poverty trends.

The complex social, behavioral, environmental, educational, and economic dimensions of poverty are drivers of HIV in the hardest-hit communities in Illinois. Poverty creates serious obstacles to HIV prevention and a lack of opportunities that can mitigate risk-taking behaviors. Figure 2 from the Social Impact Research Center's 2016 *Report on Illinois Poverty* depicts the percentage of Illinoisans who were low-income, living in poverty, and living in extreme poverty in 2014. The 12 Illinois counties that were home to 77 percent of Illinoisans living in poverty in 2011 also accounted for 91 percent of all people living with HIV in the state that year. Those same 12 counties also reported high degrees of unaffordable housing, contributing to housing instability.

Figure 2: Scale of Illinois Poverty, 2014



According to the U.S. Census Bureau, data on health insurance coverage collected through multiple surveys, including the Current Population Survey's (CPS) Annual Social and Economic Supplement, the percent of the Illinois population without health insurance in 2014 was 11.1 percent. The uninsured rate in the state varied from 11.9 percent to 14.8 percent between 2000 and 2012. The uninsured rate in Illinois was consistently lower than the national rate over this time period.

HIV Burden

In the Chicago EMA in 2014, most new HIV diagnoses occurred among cisgender males (1,157/1,370 or 84 percent), non-Hispanic Blacks (684/1,370 or 50 percent), and gay, bisexual, and other MSM (1,040/1,370 or 76 percent). See Figure 3 for more information about new HIV diagnoses in 2014 and HIV diagnosis trends between 2010 and 2014.

Figure 3: HIV Infections by Year of Diagnosis and Selected Demographic Characteristics, Chicago EMA, 2010-2014 (as of 12.28.2015)

Table 1. HIV Infections* by Year of Diagnosis and Selected Demographic Characteristics, Chicago EMA, 2010-2014 (as of 12/28/2015)

	Year of Diagnosis									
	2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%
Sex										
Male	1,198	81.7%	1,154	81.6%	1,224	82.8%	1,225	82.9%	1,157	84.5%
Female	268	18.3%	260	18.4%	255	17.2%	253	17.1%	213	15.5%
Race/Ethnicity ^										
Black, non-Hispanic	769	52.5%	713	50.4%	748	50.6%	745	50.4%	684	49.9%
White, non-Hispanic	318	21.7%	257	18.2%	314	21.2%	329	22.3%	323	23.6%
Hispanic	279	19.0%	316	22.3%	333	22.5%	321	21.7%	305	22.3%
Other¶	100	6.8%	128	9.1%	84	5.7%	83	5.6%	58	4.2%
Transmission Group										
Male Sex w/ Male	962	65.6%	960	67.9%	1,061	71.7%	1,087	73.5%	1,040	75.9%
Injection Drug Use	118	8.0%	83	5.9%	61	4.1%	50	3.4%	50	3.6%
MSM and IDU§	41	2.8%	49	3.5%	36	2.4%	33	2.2%	31	2.3%
Heterosexual	338	23.1%	315	22.3%	292	19.7%	286	19.4%	242	17.7%
Other¶	8	0.5%	7	0.5%	28	1.9%	22	1.5%	8	0.6%
Age Category†										
< 13	6	0.4%	3	0.2%	14	0.9%	9	0.6%	7	0.5%
13-19	74	5.0%	86	6.1%	91	6.2%	68	4.6%	76	5.5%
20-29	475	32.4%	480	33.9%	505	34.1%	577	39.0%	565	41.2%
30-39	383	26.1%	328	23.2%	375	25.4%	348	23.5%	317	23.1%
40-49	314	21.4%	297	21.0%	273	18.5%	264	17.9%	233	17.0%
50-59	166	11.3%	164	11.6%	157	10.6%	156	10.6%	122	8.9%
60+	48	3.3%	56	4.0%	64	4.3%	56	3.8%	50	3.6%
Total	1,466	100.0%	1,414	100.0%	1,479	100.0%	1,478	100.0%	1,370	100.0%

*Note: Groups may not total 100% due to rounding; values <0.5 are rounded to zero. 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 12/28/2015. ^Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. §Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NTR. †Age at time of diagnosis.*

After years of plateau, notable progress has been made diagnosing infections. In 2016, the City of Chicago diagnosed 839 new HIV infections, the fewest in a single year since 1990. In the Chicago EMA, 1,312 new HIV infections were diagnosed in 2016.

In the Chicago EMA in 2014, most people living with HIV diagnoses were cisgender males (23,795/29,973 or 79 percent), non-Hispanic Blacks (14,553/29,973 or 49 percent), and gay, bisexual, and other MSM (17,969/29,973 or 60 percent). See Figure 4 for more information about new HIV diagnoses in 2014.

Figure 4: People Living with HIV Infection in 2013, Chicago EMA (as of 12.28.2015)

Table 2. People Living with HIV Infection (PLWH)* in 2013, Chicago EMA (as of 12/28/2015)

		Black, NH		White, NH		Race/Ethnicity ^A Hispanic		Other, NH		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
Males	Mode of Transmission										
	Male Sex w/Male	6,823	66.7%	6,413	84.1%	3,584	75.3%	1,148	77.8%	17,969	75.5%
	Injection Drug Use	1,592	15.6%	234	3.1%	428	9.0%	86	5.8%	2,340	9.8%
	MSM and IDU [§]	782	7.6%	379	5.0%	320	6.7%	134	9.1%	1,616	6.8%
	Heterosexual	885	8.6%	184	2.4%	384	8.1%	96	6.5%	1,548	6.5%
	Other [¶]	151	1.5%	58	0.8%	41	0.9%	12	0.8%	262	1.1%
	Age category[†]										
	< 13	40	0.4%	3	0.0%	6	0.1%	1	0.1%	50	0.2%
	13-19	135	1.3%	11	0.1%	24	0.5%	5	0.3%	175	0.7%
	20-29	1,783	17.4%	391	5.1%	567	11.9%	169	11.5%	2,910	12.2%
	30-39	1,818	17.8%	1,005	13.2%	1,169	24.6%	316	21.4%	4,308	18.1%
	40-49	2,523	24.7%	2,401	31.5%	1,608	33.8%	478	32.4%	7,010	29.5%
	50-59	2,700	26.4%	2,422	31.7%	979	20.6%	378	25.6%	6,479	27.2%
	60+	1,234	12.1%	1,036	13.6%	405	8.5%	128	8.7%	2,803	11.8%
Total Males		10,233	100.0%	7,629	100.0%	4,758	100.0%	1,475	100.0%	23,795	100.0%
Females	Mode of Transmission										
	Injection Drug Use	1,132	26.2%	227	33.0%	162	17.2%	79	27.1%	1,599	25.6%
	Heterosexual	3,023	70.0%	432	62.9%	748	79.6%	199	68.4%	4,402	70.6%
	Other [¶]	165	3.8%	28	4.1%	30	3.2%	14	4.8%	237	3.8%
	Age category[†]										
	< 13	31	0.7%	6	0.9%	5	0.5%	7	2.4%	49	0.8%
	13-19	98	2.3%	7	1.0%	12	1.3%	5	1.7%	122	2.0%
	20-29	502	11.6%	40	5.8%	78	8.3%	20	6.9%	640	10.3%
	30-39	881	20.4%	105	15.3%	220	23.4%	63	21.6%	1,269	20.3%
	40-49	1,317	30.5%	218	31.7%	315	33.5%	85	29.2%	1,935	31.0%
	50-59	1,081	25.0%	215	31.3%	211	22.4%	78	26.8%	1,585	25.4%
	60+	410	9.5%	96	14.0%	99	10.5%	33	11.3%	638	10.2%
Total Females		4,320	100.0%	687	100.0%	940	100.0%	291	100.0%	6,238	100.0%
Total		14,553	48.6%	7,956	26.5%	5,698	19.0%	1,766	5.9%	29,973	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. *All persons diagnosed with HIV, from the beginning of the epidemic through 12/31/2012 and living through 12/31/2013, as of 12/28/2015. **Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender, independently of values using birth sex, total diagnoses values may differ slightly across tables. *Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. §Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NID. †Age at time of diagnosis.*

In both the city and EMA, certain groups continue to represent a disproportionate share of new HIV diagnoses and persons living with HIV: cisgender males; non-Hispanic Blacks; and gay, bisexual, and other men who have sex with men (MSM).⁵ Year over year, these designations consistently emerge as indicators of risk. Additional information about indicators of risk can be found in Section 1.B and 1.D. The current Chicago EMA HIV/AIDS Profile can be found in Appendix 1. The current City of Chicago HIV/STI Surveillance Report can be found in Appendix 2.

B. HIV Care Continuum

The HIV continuum of care is an important tool for monitoring progress and identifying opportunities for HIV prevention, care and treatment, and housing interventions, such as those presented in the *HIV Services Portfolio*. Since ensuring persons living with HIV are engaged in care is critical to both individual and population-level health, the continuum was developed to depict two paths: 1) the percentages of

⁵ Chicago Department of Public Health. HIV/STI Surveillance Report 2017. Chicago, IL: City of Chicago, December 2017.

newly diagnosed persons linked to HIV medical care over the course of one year and 2) the percentages of people living with HIV at specific levels of care engagement and viral suppression. In 2016 in Chicago, 80 percent of persons newly diagnosed with HIV were linked to care within one month and more than 90 percent within one year. In the Chicago EMA, 80 percent were linked to care within one month and almost 94 percent within one year.

For individuals in Chicago diagnosed with HIV through 2015 and living with HIV in 2016, 60 percent had accessed care (having at least one medical visit in 2016), and 40 percent were considered to be retained in care (having at least two medical visits in 2016). In the Chicago EMA, 65 percent of people living with HIV accessed care in 2016, and 44 percent were in care consistently.

Reaching viral suppression for individuals living with HIV is essential to living a healthy life and to reducing the likelihood HIV will be transmitted to others. For individuals diagnosed with HIV through 2015 and living with HIV through 2016, only 48 percent of individuals in Chicago and 50 percent of individual in the Chicago EMA were considered to be virally suppressed (<200 copies/ml). These findings reinforce the importance of high-impact, coordinated services, such as those in the *HIV Services Portfolio*. The data represented in the continuum further highlight the need for increased attention on services that assist individuals living with HIV to become virally suppressed. See Figure 5 for the Chicago EMA continuum of care and Figure 6 for the City of Chicago continuum of care.

Figure 5: 2016 HIV Care Continuum, Chicago EMA (as of 04.10.2018)

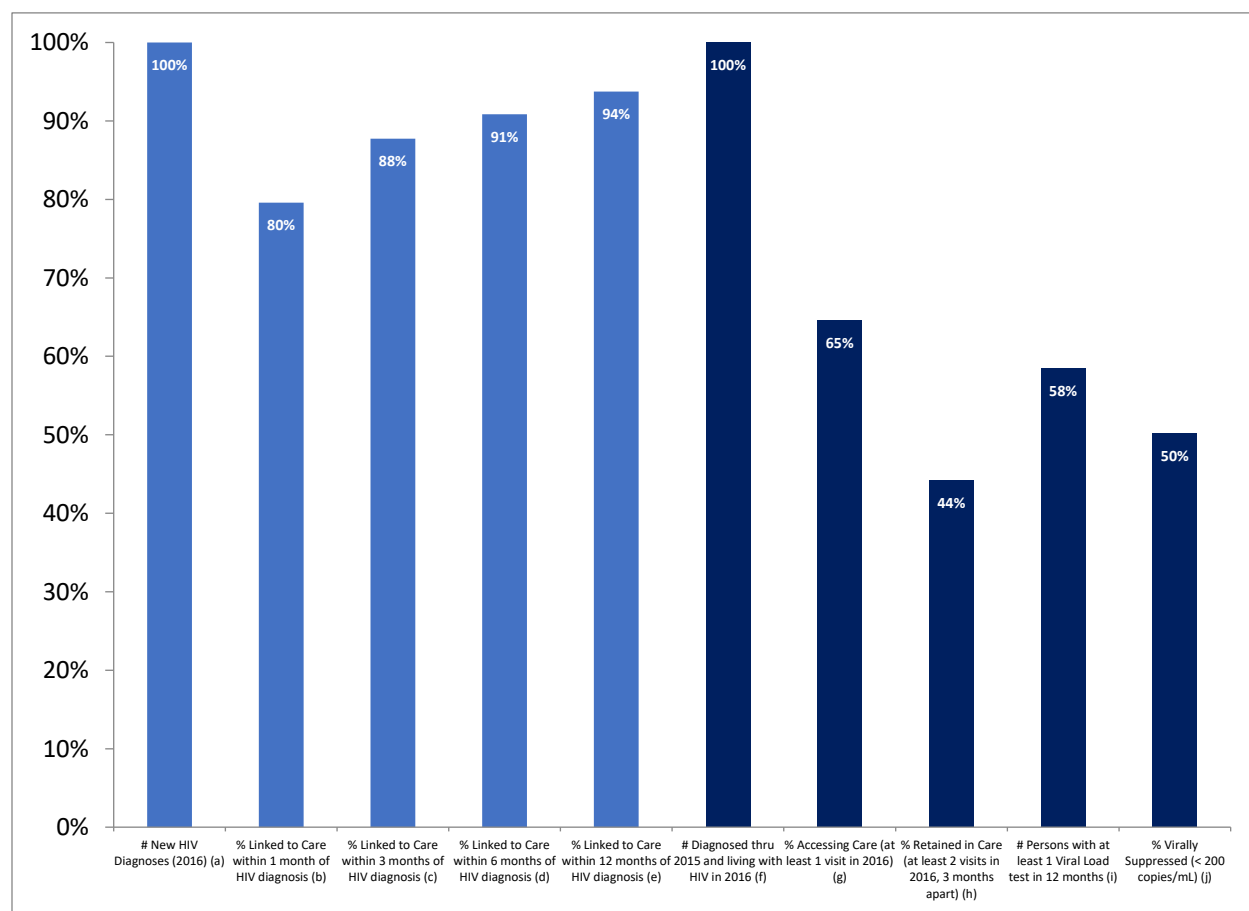
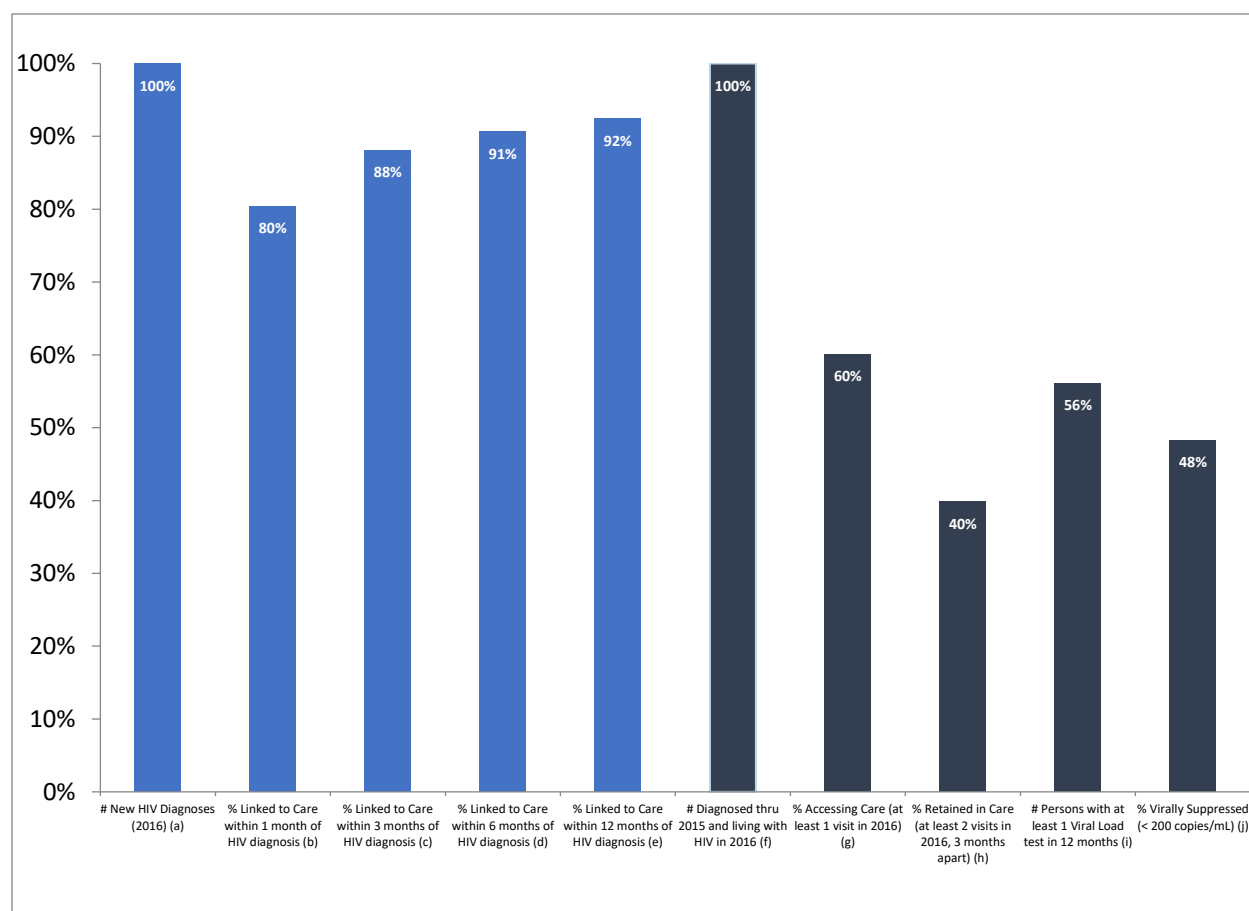


Figure 6: 2016 HIV Care Continuum, City of Chicago (as of 04.10.2018)



While HIV affects people of all ages, races, ethnicities, and genders, surveillance data collected over the years indicate the greatest impact occurs among specific populations in the Chicago EMA. Moving forward through the *HIV Services Portfolio*, prioritizing prevention, care and treatment, and housing services among these populations will allow us to focus resources and increase impact. CDPH continues to strive to serve all individuals affected by HIV; however, CDPH has chosen to prioritize three populations for increased emphasis: Black gay, bisexual, and other MSM; Latino gay, bisexual, and other MSM; and cisgender Black heterosexual women. In 2016, Black gay, bisexual, and other MSM represented 30 percent of all new HIV diagnoses (388/1,312); Latino gay, bisexual, and other MSM represented 15 percent (196/1,312); and Black women represented five percent (68/1,312).

When looking to each priority population's continuum of care, Latino gay, bisexual, and other MSM are linked to care within 30 days more often than Black gay, bisexual, and other MSM and Black women (84 percent, 79 percent, and 81 percent, respectively). However, within one year, more than 95 percent of all three groups had been linked. All three group access care similarly, with 69 percent of Black gay, bisexual, and other MSM; 68 percent of Latino gay, bisexual, and other MSM; and 66 percent of Black women having had at least one visit in 2016. Latino gay, bisexual, and other MSM were retained in care more often than Black gay, bisexual, and other MSM and Black women (50 percent, 45 percent, and 44 percent, respectively) and were virally suppressed more often (58 percent, 50 percent, and 47 percent, respectively). See Figure 7 for the continuum of care among Black gay, bisexual, and other MSM. See

Figure 7: 2016 HIV Care Continuum among Black MSM, Chicago EMA (as of 04.10.2018)

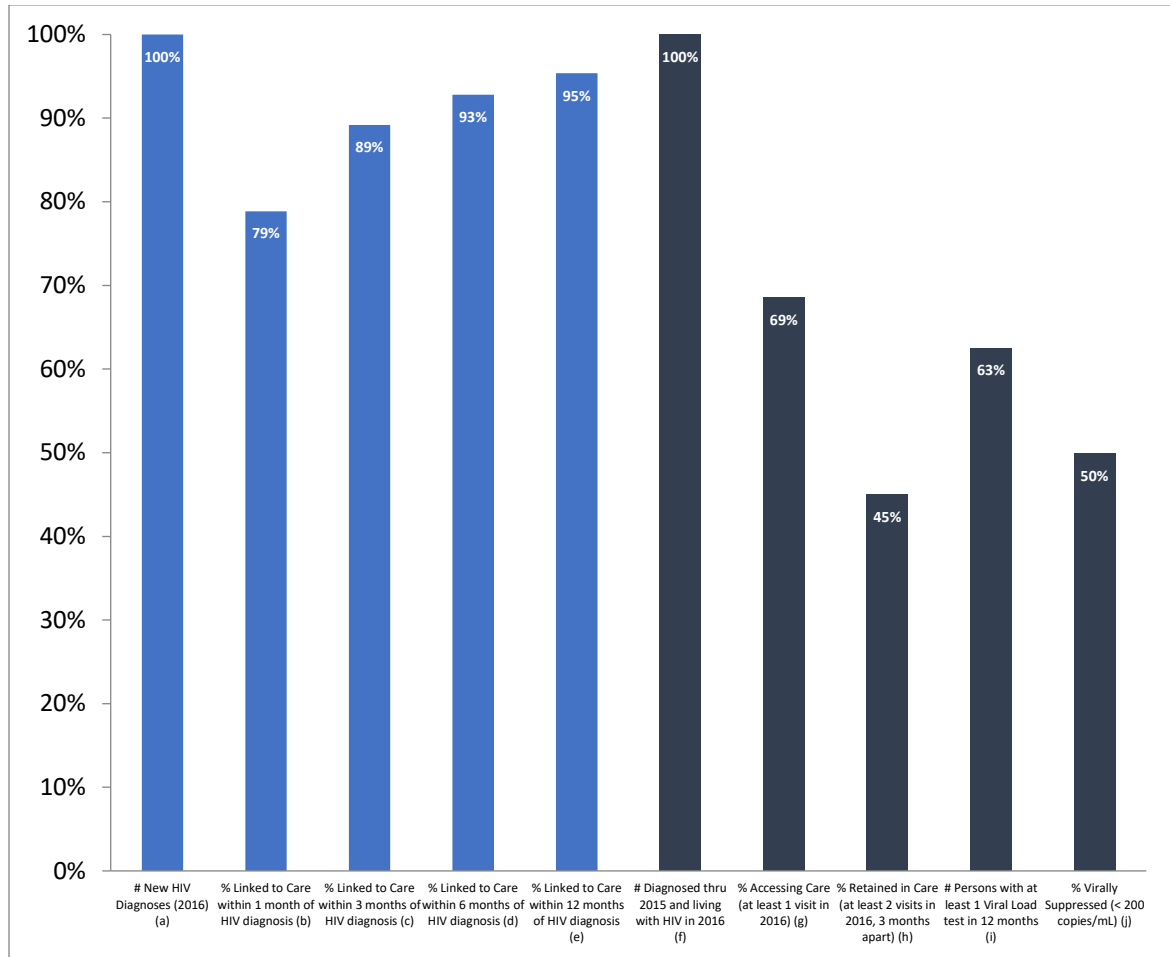


Figure 8: 2016 HIV Care Continuum among Hispanic MSM, Chicago EMA (as of 04.10.2018)

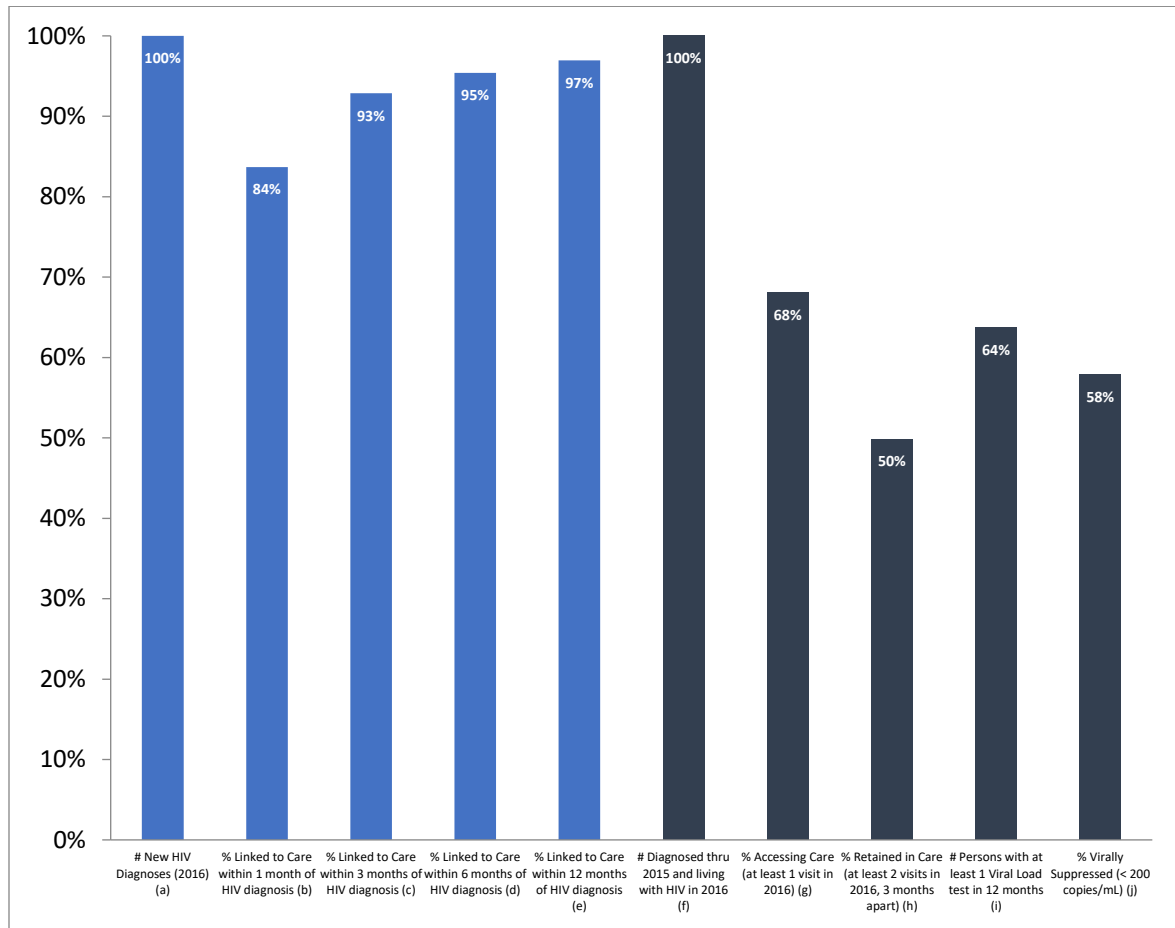
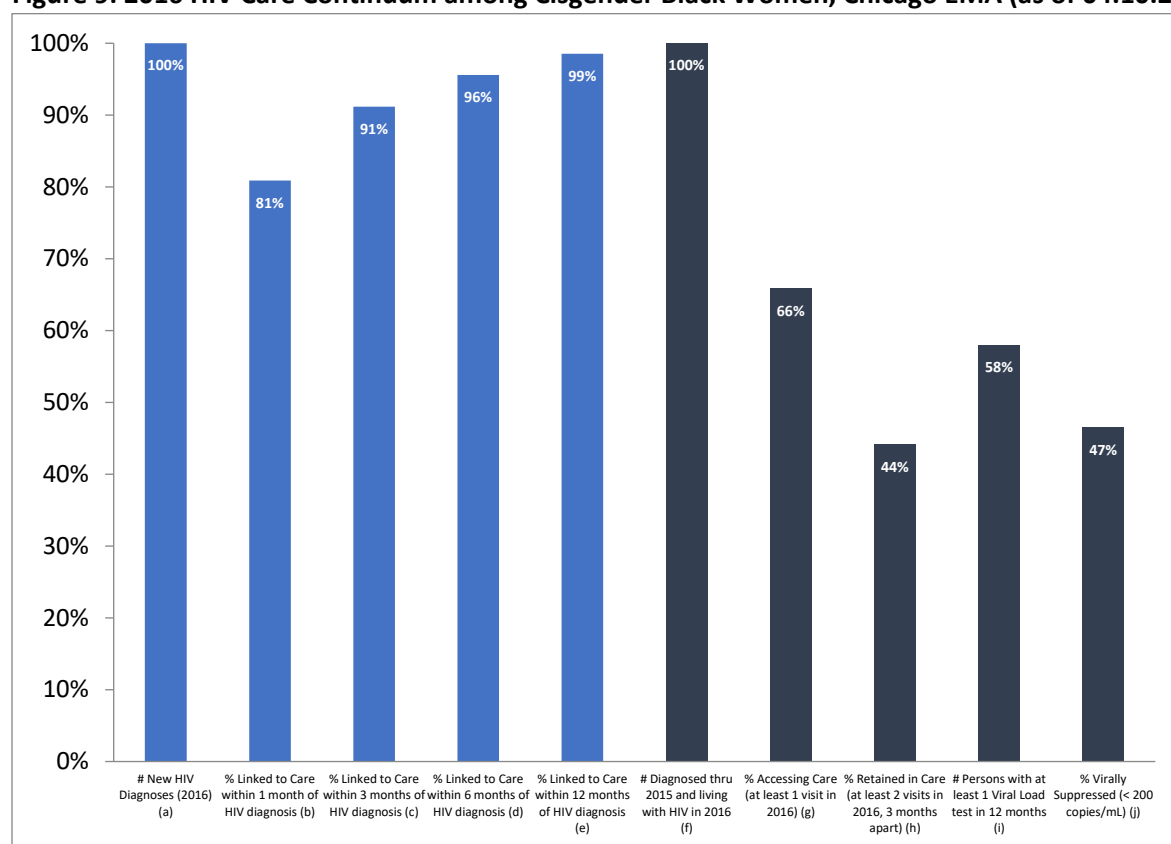


Figure 9: 2016 HIV Care Continuum among Cisgender Black Women, Chicago EMA (as of 04.10.2018)



Information provided through care continua is vital to planning efforts, program development, and resource allocation. Data indicate a significant need for providing enhanced services after initial linkage, as all population groups experience barriers to accessing and engaging care and achieving viral suppression.

HIV care continua were used in the development of the *HIV Services Portfolio*. As described in Section II of this document, the *HIV Services Portfolio* maps strategies directly to the continuum of care, with direct focus on initial linkage, engagement/retention, ARV use, and viral suppression. The *HIV Services Portfolio* also acknowledges the health disparities that exist for some populations. Accordingly, the *HIV Services Portfolio* prioritizes work to build health equity and reduce health disparity; implement critical supportive services, including housing; and promote greater awareness of and access to HIV services that are available in the Chicago EMA. The Integrated Plan Work Plan in Appendix 3 provides detailed activities, data indicators, and data targets that aim to improve engagement and outcomes at each stage of the continuum.

C. Financial and Human Resources Inventory

The Chicago EMA HIV Resources Inventory table is found in Appendix 4. It includes public and private funding sources for HIV prevention, care and treatment, and housing services; the dollar amount and percentage of total available funds in fiscal year 2016 for each category; how the resources are being used to deliver services; and the HIV care continuum steps impacted.

HIV Workforce Capacity

The HIV workforce in the Chicago EMA encompasses clinical health care providers, allied health professionals, and other licensed providers; community health workers and patient navigators; and other HIV-specific and non-HIV-specific providers. CDPH worked with the Midwest AIDS Training and Education Center (MATEC) to enumerate, define, and describe the HIV workforce in the EMA. Appendix 5 provides a copy of the preliminary workforce assessment for the City of Chicago developed by MATEC. A similar assessment was developed for the State of Illinois which includes information for regions seven and eight which comprise the nine counties of the EMA outside of Chicago.

Preliminary findings include the following:

- A total of 169 providers/facilities reported CD4/VL values.
- Most zip codes (86 percent) had providers that reported CD4/VL values. (Note: zip code 60660 had a prevalence of 785, but no reporting providers.)
- Eighteen community health centers (CHCs) in the City of Chicago are providing HIV primary care.
- Six CHCs in EMA counties are providing HIV primary care.
- All CHCs are in or close to zip codes with high reported HIV prevalence.

As the MATEC assessment is still in its preliminary stages, other attempts have been made to further describe the current state of the HIV workforce in the EMA. The following narrative is a summary of these assessments.

CDPH, AIDS Foundation of Chicago (AFC) Staff, and CAHISC Membership Survey 2016

Management Synergistics Inc., a CDPH-contracted consultant, conducted a survey of program staff at CDPH and AFC who were involved with coordinating and assessing provider services and needs. CAHISC members who were aware of providers outside of Ryan-White-funded services also provided input. Figure 10 summarizes the results.

FIGURE 10. Preliminary Provider Assessment, Chicago EMA, 2016

Provider Type	Number of Providers	Primary Funding Source
Licensed Providers	200	Part A
Case Managers	70	Part A, Part B
Community Health Workers	50	Part A
Paraprofessionals	250	Part A
Medical Benefits Coordinators	3	Part B
Certification Specialists	2	Part B
Resource Specialists	3	Part A
Retention Specialists	4	Part B

Survey of HIV Knowledge among Non-Medical Workforce: Black AIDS Institute, 2012-2014

A national survey was conducted among more than 3,600 non-medical participants to identify gaps in knowledge regarding HIV science and treatment, to evaluate familiarity with biomedical interventions, and to identify factors affecting HIV knowledge. Nationally, respondents, on average, answered only 63 percent of the questions correctly. In an Illinois State breakout, the average response was only slightly better. Ninety-one percent of respondents in Illinois were from Chicago. Blacks, in both the national and

state results, scored lower than their White counterparts. These results raise questions concerning the health science literacy of the workforce and its implications for reducing infections and improving care and treatment across the continuum and PrEP use. HIV care relies heavily upon the human touch of clinical and non-clinical staff. The more educated the staff are, the better equipped they will be when explaining HIV disease and the sequence of necessary clinical events for successful treatment. They will also be able to encourage the prevention of new infections through biomedical interventions, i.e., PrEP, and be able to clearly describe the importance of effective treatment as prevention.

Currently, Chicago outperforms the national percentage of retaining people living with HIV in care, on antiretroviral therapy, and achieving viral suppression. If these results are the outcome of a workforce with low health literacy, it is fair to assume greater outcomes can be achieved by a highly health literate workforce. There is great opportunity in the Chicago EMA to enhance training through a collaboration of MATEC, Ryan White Quality Management Learning Collaboratives (funding by CDPH and convened by the Public Health Institute of Metropolitan Chicago), local Ryan-White-funded Medical Case Manager training and technical assistance programming (funded by CDPH and provided by AFC), local CDC-funded evaluation providers (funded by CDPH and provided by Northwestern University), national CDC-funded Capacity Building Assistance (CBA) providers, and the internal CDPH HIV/STI CBA team. In 2019, these entities will collaborate to provide low, medium, and high-intensity trainings to the medical and non-medical workforce, using data from the Black AIDS Institute Survey as a base line. Additional information about current efforts can be found later in the Integrated Plan (under *A Plan for Needed Resources and Services*).

Work Force Shortages

A shortage of available medical and support resources exists throughout the state, and these shortages are exacerbated by a perceived lack of cultural competence throughout much of both the overall healthcare system and the HIV prevention and care services system.

Workforce shortages and their impact on the system were a common thread that ran throughout the 2012-2014 stakeholder engagement meetings and the needs assessment activities that took place at the 2015 integrated planning meetings of the State's Joint Illinois HIV Planning Group and Ryan White Advisory Group. The shortages most frequently identified included the following:

- Physician knowledge about HIV best practices and standards of care, such as treatment adherence, retention in care, PrEP, post-exposure prophylaxis (nPEP), and non-occupational PEP (nPEP);
- Obstetricians and gynecologists and other women-focused healthcare providers with knowledge about HIV;
- Behavioral healthcare providers, including mental health and substance use disorder counselors and care providers;
- A perceived lack of cultural competence throughout much of both the overall healthcare system and the HIV prevention and care services system;
- Lesbian, gay, bisexual, transgender, and queer (LGBTQ) providers, particularly transgender-friendly providers who are knowledgeable of issues specific to transgender health;
- Dentists, oral surgeons, and other oral healthcare providers; and

- Physicians, dentists, and other healthcare providers in some areas willing to accept new Medicaid patients or Medicaid at all.

The negative impact of these shortages is further complicated by the location of services and distances persons living with HIV must travel to receive care. People living with HIV, medical case managers, and other stakeholders who have participated in needs assessment activities identified transportation as a major barrier to HIV care services. To further assess this, the median distance traveled by HIV patients to medical facilities was estimated. Included in this analysis were people living with HIV whose current address was in the Chicago EMA and who had a reported lab test (CD4, VL, or genotype test) or an adult or pediatric case report in 2015 through May 2016. To be included in the analysis, both the zip code of the current residence and the zip code of the medical facility must have been reported, as these were used to estimate distance traveled. Median distance rather than average distance was used to account for outliers. The final sample size for the analysis was 6,503, which included 6,215 people living with HIV residing in Cook County, which includes the City of Chicago. Figure 11 summarizes the results.

FIGURE 11. The average distance traveled to medical facilities and the range of miles traveled by people living with HIV between patient zip code and facility zip code within the counties of the Chicago EMA

County	Number of People Living with HIV	Average Distance	Median	Range
Cook	6215	7.5	4.7	249.8
DeKalb	16	39.6	45.6	52
DuPage	108	10.7	6.7	31.3
Grundy	0			
Kane	37	19.6	14.4	43.8
Kendall	0			
Lake	55	29.2	29.8	65.5
McHenry	14	35.5	40.0	51.7
Will	58	20.7	22.8	71.6

There was a shared sense in each of the needs assessment activities that women, people of color, and transgender individuals did not have access in many areas to physicians, nurses, case managers, and other healthcare and social service providers who are sensitive and respectful and practice in a culturally responsive way. More and better pre-service and in-service training was proposed as a solution, as was diversifying the HIV workforce.

Participants also recommended training in HIV best practices and standards of care for physicians and other healthcare providers. Physicians in private practice and staff in private clinics and hospitals were especially in need of training related to HIV awareness, routine HIV testing and reporting, and linking newly diagnosed patients to care.

The Department of Health and Human Services Health Resources and Services Administration (HRSA) monitoring standards require that Medicaid-eligible services must be provided by Medicaid-certified providers. This has resulted in a decrease in the number of healthcare providers willing to serve Ryan White clients. In addition, the low Medicaid reimbursement rate and the tardiness of reimbursements

have caused many healthcare providers to discontinue Medicaid certification or refuse to take new clients.

These workforce shortages and limitations have a serious impact on the service delivery system and access to quality care for people living with and vulnerable to HIV. They interfere with routine HIV testing and reporting of new diagnoses, reduce the number of people who are linked to care, discourage people from staying in care, limit access to highly effective antiretroviral therapy, and, by failing to support adherence, reduce the number of people who are virally suppressed.

Funding Source Interaction

The Chicago EMA is challenged by having to achieve the NHAS and Getting to Zero goals with diminished funding. The EMA recently lost 2.5 million dollars in Centers for Disease Control and Prevention (CDC) HIV Prevention funding due to a shifting in regional priorities at the federal level. This created a significant gap in services that identify persons living with HIV who are unaware of their status, out-of-care persons living with HIV who can benefit from re-engagement in care, and persons vulnerable to HIV who can benefit from PrEP.

Fortunately, the Chicago EMA has had an integrated HIV prevention, care and treatment, and housing planning council since 2013. A central advantage of the integrated planning process, and the resulting Integrated Plan, is that it has created a foundation for leveraging different funding sources to maximize continuity of prevention, care and treatment, and housing services in the EMA. CAHISC and CDPH committed to finding ways to address the significant CDC funding reduction, promote funding and service integration, while, at the same time, adhering to CDC, HRSA, and HOPWA programmatic requirements and guidelines.

For the first time, CAHISC engaged in a Priority Setting and Resource Allocation (PSRA) process that took into consideration all funds received by CDPH. Figure 12 provides a summary. Their final decisions included integrated funding recommendations that both minimized the impact of CDC's HIV Prevention funding reduction and promoted priority outcomes through the integration of services. More information about CDPH's integrated *HIV Services Portfolio* is provided in Section II of this document.

FIGURE 12: 2019 CDPH Anticipated HIV Funding for External Contractors (All Sources)

Funding Source	Funding Amount
Corporate	\$3,100,000
CDC – HIV Prevention	\$2,650,000
CDC – STI Prevention	\$300,000
HRSA – RWA	\$21,413,000
HRSA – RWMAI	\$2,100,000
HUD – HOPWA	\$7,078,000
Total	\$36,641,000

CDPH also works closely with the Illinois Department of Public Health (IDPH) to coordinate investments in HIV services in the Chicago EMA. Agency leadership teams hold regular calls and meet in person at least annually to provide updates, problem solve, and strategize. Each agency shares funding information, including, but not limited to, requests for proposals, information about contractors, and planning group products. The State's Ryan White Part B/ADAP Director is a member of CAHISC, and

CAHISC has a standing seat on the Illinois HIV Integrated Planning Council. CDPH and IDPH AIDS Directors co-convene Illinois Getting to Zero.

A Plan for Needed Resources and Services

The new *HIV Services Portfolio* restructures services and service delivery models to more efficiently and effectively focus resources on outcomes that lead to reduced HIV transmission and fewer new infections. Specifically, the *HIV Services Portfolio* aligns funding to promote the use of ARV for treatment of persons living with HIV and PrEP for persons vulnerable to HIV. The portfolio identifies four areas for investment: healthcare, housing, health equity, and how-to (i.e., ensuring people know what is available and how to access needed services). A thorough description of the *HIV Services Portfolio* is provided in Section II of this document.

In addition to the *HIV Services Portfolio*, CDPH has identified training, technical assistance, and capacity building as areas for increased resources. CDPH will take the following steps to maintain or expand these services.

Case Management Training and Services Coordination: The EMA has a well-developed and centrally coordinated HIV case management system managed by AFC. AFC conducts regular trainings for case managers to increase their efficiency and effectiveness in assisting clients with navigating services, including gaps and barriers. Regular trainings are also conducted on specific issues regarding HIV knowledge and, in the future, will increasingly emphasize best practices in support of the *HIV Services Portfolio*.

CDPH Capacity Building Assistance Team: To prepare providers for the transition to the *HIV Services Portfolio* and to assure understanding and competence in the support and administration of prevention, care and treatment, and housing strategies, CDPH recently re-instituted a Capacity Building Assistance Team. The team will provide directly, or through CDC-funded CBA providers, organizational development support to enhance agency performance via:

- People Strategies – Attracting, retaining, and engaging organization stakeholders.
- Process Strategies – Understanding and using processes to promote continuous quality improvement.
- Planning Strategies – Ensuring organizations are able to adapt to changes and new approaches to HIV services.

MATEC Provider Training: As the regional AIDS Education and Training Center, MATEC offers ongoing provider education efforts, such as the HIV Inter-professional Education Project (HIPEP) and the Clinician Scholars Program. These programmatic activities specifically aim to prepare the next generation of skilled and dedicated HIV practitioners. Moving forward, MATEC will continue to support these programs.

HIPEP is a regional collaborative that includes six university-based inter-professional education programs. HIPEP works with these programs to develop, implement, and evaluate inter-professional team-based training programs for health professions students. The goal is to prepare a future workforce that is ready and able to optimize care and positive health outcomes for persons living with HIV.

The MATEC Clinician Scholars Program is a 12-month training program specifically designed for minority or predominately minority-serving, front-line clinical care providers, including physicians, physician assistants, nurse practitioners, and pharmacists, who are interested in the diagnosis, treatment, medical management, and prevention of HIV.

D. Assessing Needs, Gaps, and Barriers

The Chicago EMA has been engaged in an ongoing effort to determine HIV service needs, gaps, and barriers since the beginning of the epidemic. CDPH has worked collaboratively with CAHISC to comprehensively assess the impact of the epidemic across the continuum of care. 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 treatment, and housing. The involvement and leadership provided by CDPH and CAHISC in these activities has helped ensure that the goals and objectives of the Chicago EMA *HIV Services Portfolio* and Integrated Plan address the needs of diverse populations and geographic areas affected by the epidemic.

The Needs Assessment Process

Between 2012 and 2017, members of CAHISC and representatives of CDPH conducted locally focused needs assessment activities and actively collaborated with IDPH in the development of the SCSN. The SCSN can be accessed on the IDPH [website](#). Findings from these needs assessment activities drove the development of the *HIV Services Portfolio*. Needs assessment activities include:

- Needs assessment for the 2014-2018 Chicago EMA Unified Plan (2012-2013)
- IDPH SCSN activities (2012-2016)
- Mobilization for Action through Planning and Partnerships (MAPP) (2015 -2016)
- CAHISC-sponsored community forums on the key components of the HIV Services Portfolio (2017)
- CAHISC-sponsored forums with underserved and vulnerable populations (2017)
- CDPH-sponsored community development focus groups with underserved and vulnerable populations (2017)

Needs Assessment for the 2014-2018 Chicago EMA Unified Plan (2012-2013)

The *2014-2018 Chicago-Area Unified Plan* was developed through the active participation of CAHISC working with CDPH to develop an integrated and collaborative planning process. In 2012, CAHISC formed three working committees to focus on specific areas defined in the continuum of care model.

- Primary Prevention and Early Intervention
- Linkage and Retention to Care
- Anti-retroviral Therapy and Viral Suppression

Each committee included community members, stakeholders, and participant representatives from CDPH staff. The committees met monthly to review data presented by CDPH highlighting information specific to each CAHISC committee's area of the continuum. In addition to these data, CAHISC committees reviewed 1) prevention programs, 2) service utilization, 3) Ryan White client-level data, 4)

published literature and local reports, and 5) local resource inventories. The committees then identified needs and service gaps in the continuum that were specific to their area of concentration and formulated recommendations to guide the development of the *2014-2018 Chicago Area HIV Unified Plan's* goals and objectives.

In summarizing findings across the continuum, common service needs, gaps, and barriers were identified and include:

- ARV for both treatment and PrEP must be available to people living with HIV and persons vulnerable to HIV infection.
- Social determinants of health for those living with and vulnerable to infection are the same and present common barriers to prevention, care and treatment, and housing.
- Essential supportive services, including case management, mental healthcare, substance use disorder counseling and treatment, and housing must be available to both persons living with and vulnerable to HIV to assure successful engagement in HIV treatment and PrEP.
- High-impact prevention and culturally responsive care must be targeted and accessible to communities most vulnerable to HIV.
- Transportation services must be developed to increase access for individuals living in remote areas of the EMA that are far from services and without public transportation.
- HIV stigma is a barrier to treatment and PrEP and must be addressed in highly impacted communities and in service institutions caring for people living with HIV.
- Services and data systems must be more coordinated and integrated to better facilitate comprehensive prevention and care services.

IDPH SCSN Activities (2012-2016)

IDPH, with guidance and support from its Integrated Planning Steering Committee, used a multi-step process, multiple strategies, and a broad range of data sources and informants to identify the HIV prevention and care needs of people living with and vulnerable to HIV. Members of CAHISC and representatives from CDPH were involved in both regional and statewide activities. Activities include:

- Review of quantitative and qualitative data
- Perinatal case reviews
- Integrated planning meetings notes
- Provider surveys
- Statewide integrated planning meetings of the Joint Illinois HIV Planning Group/Ryan White Advisory Group
- Ryan White and HOPWA client satisfaction surveys
- MSM of Color Workgroup notes
- Youth seminar notes and survey
- SCSN regional stakeholder engagement meetings
- Regional high-risk focus groups community forums

Findings from these activities provide a comprehensive description of needs, gaps, and barriers to be addressed in providing HIV services to people in the State of Illinois and the Chicago EMA. While some barriers are not currently experienced in the Chicago EMA, many were useful in the development of the *HIV Services Portfolio*. A summary of findings follows.

Service Needs

Perinatal: Data reviewed showed consistent trends of pregnant women not disclosing their HIV status to medical providers, contributing to late entry into care and/or delayed interventions. Of 97 cases reviewed, 73 percent received limited or no prenatal care, and 78 percent reported one or more of the following co-occurring issues: substance use disorders, homelessness, incarceration, domestic violence, and mental illness.

Youth: Survey results indicated that there were high levels of awareness and knowledge among respondents. Most agreed that young people would access services if they knew where to get them, and the majority reported being comfortable disclosing their risk for HIV and sexually transmitted infections (STI). Only 31 percent reported that their doctor or nurse talked to them about prevention of HIV and STI at most or all visits. Participants identified social media as the most helpful source for getting information and about HIV and STI. Focus groups and exhibitor booths at schools and youth events were identified as the best way to gather youth input about HIV and STI prevention.

Gay, Bisexual and other MSM: The Illinois State MSM of Color Workgroup made the following recommendations to improve HIV outcomes:

- Develop a framework for the health of gay, bisexual, and other MSM.
- Promote leadership and representation of gay, bisexual, and other MSM of color in planning and evaluation bodies.
- Identify qualified providers who are culturally competent and sensitive to health care needs of gay, bisexual, and other MSM of color.
- Strengthen the infrastructure for referrals provided to immigrant gay, bisexual, and other MSM, especially in rural settings.
- Establish a comprehensive, constructive, and positive anti-stigma and anti-discrimination campaign inclusive of gay, bisexual, and other MSM of color.
- Engage LGBTQ leaders and affinity groups on college campuses in evidence-based interventions to empower gay, bisexual, and other MSM of color.

HIV Services Clients: Needs assessment data from 2015-2016 Ryan White, prevention, and HOPWA client satisfaction surveys assessed client perception of core services and needs. Key findings included: more than two-thirds of respondents in 2015 indicated an interest in PrEP, though more than 80 percent of respondents in 2016 reported having little or no knowledge of PrEP; and there is a lack of interest in and low rates of STI and hepatitis screening and vaccination for hepatitis A (HAV), hepatitis B (HBV), and human papilloma virus (HPV). These findings indicate a clear need for the integration of PrEP awareness and comprehensive sexual health into HIV prevention and care services.

SCSN Regional Meeting and Focus Group Participants: Service needs most frequently identified by key stakeholders in the engagement meetings, representatives of priority populations in the focus groups, and participants in the joint Illinois HIV Planning Group/Ryan White Advisory Group integrated planning meetings were the following:

- HIV specialty care.
- Primary care.

- Dental/oral healthcare.
- Transportation.
- Comprehensive risk counseling.
- HIV testing.
- PrEP, PEP, and nPEP.
- Diffusion of CDC-supported effective interventions for specific populations.
- Support groups, including youth groups.
- Comprehensive, developmentally appropriate sexuality education for youth, including school-based programs.
- Mental healthcare/behavioral healthcare.
- Help with substance use disorders including treatment, syringe exchange, and other harm reduction services.
- Condom availability.
- HIV education tailored to people who are homeless.
- Job training for people with substance use disorders, and persons who are formerly incarcerated.

Ryan White Case Managers in the Chicago EMA: This survey assessed training needs of case managers. High priority rankings for training included HIV and housing, self-care/preventing burnout, benefits and entitlements, crisis interventions, and medication adherence.

Service Gaps

Across all SCSN needs assessment activities, including those conducted in the Chicago EMA, the most frequently identified prevention, care, housing, and support services gaps include:

- There are geographic areas with very few or no prevention programs.
- PrEP, PEP, and nPEP are not widely available.
- Testing is not readily available in some areas.
- Ryan White A and B services are not available in all areas.
- Primary care providers able to provide HIV care are not available in all areas.
- Some areas do not have access to infectious disease specialists.
- Dental care, including oral surgery, is not available in all areas.
- Mental healthcare/behavioral healthcare services are not available in all areas.
- Substance use disorder treatment and services are not available in all areas.
- Support groups for specific populations are not available in all areas.
- Re-entry programs for persons who are formerly incarcerated are not available in all areas.
- Transportation.
- Housing assistance of all kinds.
- Safe, decent, and affordable housing.
- Culturally competent providers knowledgeable about HIV.
- Providers willing to accept Medicaid and/or new Medicaid patients.

Barriers to HIV Prevention and Care Services

Through the previously described needs assessment process and activities, people living with HIV, representatives of vulnerable communities, program planners, and community-based providers and organizations identified a range of barriers to HIV prevention, care and treatment, and housing services in the jurisdiction. Many of the social and structural barriers identified are rooted in complex, persistent social injustices.

Social and Structural Barriers:

- HIV-related stigma and discrimination.
- Stigma and discrimination against LGBTQ individuals.
- Stigma and discrimination against people who inject drugs.
- Too few partnerships with faith-based organizations and the faith-based community.
- Long distances between the clients and needed services.
- Public transportation patterns that do not match client needs.

Legislative and Policy Barriers:

- Restrictive laws and policies that promote stigma and discrimination and interfere with outreach and tracking.
- The changing healthcare coverage landscape.
- Political barriers around the previous lack of an Illinois State budget, which has been inhibiting prevention services by community-based organizations and health departments.
- Reimbursement structures in the healthcare system that disincentivize private provider participation in planning and other collaboration.

Health Department Barriers:

- Staff turnover throughout the system.
- Restrictive and overly narrow scopes in IDPH-issued HIV grants.
- Restrictions that prevent funds being used for certain needed services such as testing and education.
- Structures for allocating state and federal funding that inhibit collaboration and encourage destructive competition, silos, and territoriality.
- Policies that put smaller and newer organizations at a competitive disadvantage.
- Slow and late payments from the state.
- Funds that don't always follow the epidemic.
- Too few training opportunities.

Program Barriers:

- Inadequate and unpredictable funding.
- Limited infrastructure capacity including too few staff for the workload.
- Too few staff from communities most affected by HIV, and staff lacking in cultural competence.
- Waiting lists for some services.
- Inadequate training for staff in vital topic areas such as cultural competence; PrEP, PEP, and nPEP; social media strategies; and evidence-based practices.

Service Provider Barriers:

- Lack of diversity among prevention, care, and clinical providers at all levels.
- Lack of cultural competence among organizations and providers.
- Clinical challenges including the complexity of HIV care.
- Lack of knowledge about PrEP, PEP, and nPEP.
- Too few well-qualified providers in rural, distance-isolated, and remote areas.
- Long waiting times to see certain providers, such as infectious disease specialists, in some areas.
- High staff turnover.
- Difficulty engaging health and medical institutions and providers in HIV planning and other collaborative efforts.
- Difficulty engaging the corrections system and providers in HIV prevention and care planning.

Client Barriers:

- Poverty, socioeconomic status.
- Unemployment.
- No transportation.
- Homelessness and housing instability.
- Difficulty navigating the healthcare and social services system.
- Fears about disclosing HIV status.
- Low self-esteem and internalized limitations.
- Substance use.
- Incarceration.
- Co-morbidities such as mental health conditions, hepatitis.

Mobilizing for Action through Planning and Partnerships (MAPP) (2015 -2016)

In late 2015, CAHISC began conducting a comprehensive community health assessment using the MAPP process. A component of MAPP, the Community Themes and Strengths Assessment (CTSA), was conducted to identify the needs, gaps, and barriers for HIV prevention, care and treatment, and housing services in the EMA. The CTSA was a collaborative process that gathered stakeholder feedback through community forums and group discussions at multiple CAHISC events throughout 2015 and 2016. Methods of data collection included facilitated group discussions, panel discussions, community member testimonies, and anonymous surveys.

The CTSA provides a description of needs, gaps, and barriers according to impacted populations which enhance the findings of the IDPH SCSN by providing a targeted focus on the Chicago EMA. CDPH and CAHISC reviewed feedback from the CTSA to inform the development of the *HIV Services Portfolio*. CTSA findings are summarized in the following figures (Figure 13 – Services Needs and Gaps, Figure 14 – Barriers, and Figure 15 – Strategies and Solutions).

FIGURE 13: HIV Prevention, Care and Treatment, and Housing Service Needs and Gaps (MAPP)

Population	Services Needs and Gaps
Black persons	<ul style="list-style-type: none"> • Older Black men living with HIV who identify as heterosexual have no sense of belonging among HIV communities. • Limited LGBTQ programming for Black youth on the south side of Chicago.
Persons vulnerable to HIV	<ul style="list-style-type: none"> • High service needs for people who are vulnerable to HIV, including limited opportunities for supportive housing, services for substance use disorders, and mental healthcare.
Persons who are formerly incarcerated	<ul style="list-style-type: none"> • Continuity of care post-release is needed.
Latino/a/x persons	<ul style="list-style-type: none"> • No support groups for monolingual Spanish speakers. • No marketing or public announcements on the Spanish stations.
Transgender persons	<ul style="list-style-type: none"> • Employment is needed. • Population is still misidentified as gay, bisexual, and other MSM. • There is inadequate collection of demographic information on gender, sex, and sexuality to count and meet the needs of transgender populations. • There is lack of coverage of transgender-related healthcare and lack of integration with HIV care.
Women	<ul style="list-style-type: none"> • Housing is needed, including strategies for self-advocacy. • Childcare is needed. • There are no support groups specifically for females. • There is no acknowledgment of women's role in the home and the lack of support women have.

FIGURE 14: Barriers to HIV Prevention, Care and Treatment, and Housing Services (MAPP)

Population	Barriers
Black persons	<ul style="list-style-type: none"> • There is a distrust of the medical system. • Peer models are great for conversation, but they do not get people into clinics. • There is stigma related to HIV testing. • Providers only care about HIV status – “They do not ask about the things I care about.”
Asian persons	<ul style="list-style-type: none"> • There are language barriers with healthcare providers. • There are three main providers in Chinatown, but doctors barely spend five minutes with patients. • Providers will never bring up sexual health, mental health, substance use.
Survivors of domestic violence (DV)	<ul style="list-style-type: none"> • There are barriers to contacting and helping DV victims – controlling nature of relationships creates communication problems. • There are barriers to obtaining housing.
Persons who experience homelessness	<ul style="list-style-type: none"> • They do not have active phones to receive calls to remind them of appointments. • Transportation costs are a barrier.

	<ul style="list-style-type: none"> • Mental health issues and loss of providers create barriers. • Stigma related to mental health issues creates barriers. • When persons experiencing homelessness are kicked out, there are fewer places for them to go. • Affordable housing/single-room occupancies are closing. • “Survival” instinct is a strength but also a barrier, as focus on survival can lead to unhealthy behaviors. • This population may be used to doing things the “hard” way. • Some would rather be homeless.
Latino/a/x persons	<ul style="list-style-type: none"> • Appointments often conflict with work. • There are competing priorities. • “Hetero” Latinos do not want to let their partners near HIV tables due to stigma. • Populations may trust the system but do not have access (geographic or conflicts at work). • Language/comprehension is a barrier. • Providers need competency in prescribing in a way that people understand, because some folks are taking meds inappropriately.
Transgender persons	<ul style="list-style-type: none"> • Transgender individuals that were formerly homeless: primarily housing people on south side due to fair market, but do not want to see south side providers because north side has stronger reputation.
Women	<ul style="list-style-type: none"> • Women do not see themselves as target of efforts or at risk. • There is a lack of social support for particular HIV-positive communities (e.g., heterosexual women of color). • There is not enough housing for women and children. • There is not enough affordable childcare. • It is harder for women to have their voice heard as consumer. • Other obligations prevent participation in planning and advocacy groups. • Few are able to self-advocate and ask for assistance and wait too long to ask.
Women of Color	<ul style="list-style-type: none"> • There is a difference between women “asking for help” versus women labeled as “welfare queens.” • There is layering of stigmas. • There are fewer places to ask on the south side of Chicago. • Resources are not distributed equally across city. More resources are needed where advocates live. • Women need to know you can ask, find time to ask, and find the right place to ask. • Intersectionality must be considered.
Youth	<ul style="list-style-type: none"> • Unemployment is a barrier. • Young people do not feel welcome at planning body meetings. • There is a higher incidence of violence and incarceration. • Peer pressure and unprotected sex puts young people at risk.

The CTSA process also gathered input from participants on ways in which barriers and needs for certain populations might be addressed in further planning and programming efforts.

FIGURE 15: Strategies and Solutions to Address HIV Prevention, Care and Treatment, and Housing Needs and Barriers (MAPP)

Population	Strategies and Solutions
Survivors of DV	<ul style="list-style-type: none"> • Implement cultural competence training. • Acknowledge "saving face" and dealing with DV in context of different cultures. • Look at outcomes. • Implement public education about DV, ensuring awareness is informed by data. • Implement sensitivity training for providers/advocates. • Commit to implementing trauma informed care.
Women	<ul style="list-style-type: none"> • Identify housing specifically for women and children. • Get them off the street and out of violent situations. • Increase the number of affordable units in Chicago. • Identify funders interested in intersections of DV and single mothers. • Show the impact of stable housing.
Transgender persons	<ul style="list-style-type: none"> • Educate medical students about transgender cultural competence and transgender medical care. • Change our paperwork and data reporting systems to be more inclusive and count transgender populations. • Conduct clinical research on hormone replacement therapy and other transition-related care. • Stop talking to transgender individuals about HIV only. • Provide housing.

Assessing Needs for the *HIV Services Portfolio* (2017)

In 2017, CAHISC held internal discussions within its working sub-committees and convened community forums to discuss the newly proposed *HIV Services Portfolio*. Feedback from these discussions and forums was reviewed and, wherever possible, incorporated into the final *HIV Services Portfolio*.

CAHISC Committee Review of Portfolio Components

In March 2017, the new integrated HIV services model was confirmed as the *HIV Services Portfolio*. The CAHISC Steering Committee initiated a plan for sub-committees to review the individual portfolio components at monthly meetings where discussions would be led by CDPH staff, CAHISC members, or outside content experts. The following five components were reviewed.

- Population Centered Health Homes (PCHH)
- Community development
- Marketing
- Housing
- Services for persons who use drugs

This review process continued through all the three sub-committees each month, followed by summary presentations at monthly CAHISC full body meetings through November 2017. A detailed description of committee feedback is included in Appendix 6. The following recommendations emerged.

General

- A phased-in pilot, of at least a couple of different models, will allow evaluation and assessment of the feasibility and success of PCHH to meet the needs of the EMA.
- CAHISC should carve out a percentage of our Ryan White and prevention allocation for this pilot.
- Ensure there is a tracking/data system across agencies in the PCHH.
- Ensure there is case management system integration into PCHH.
- CDPH should spell out how the contracting is going to work and that there be clear expectations for contracting and subcontracting.
- CDPH will elaborate on how partnerships are built.
- CAHISC should be a part of the evaluation process or receive regular evaluation reports.
- CDPH should provide clarity on how case management will be handled in this new model and how existing case management will be integrated into the PCHH.
- CAHISC values the current Ryan White model for coordinated case management and wants it to be included in the PCHH model.
- Assure connection to housing assistance.

Geographical equity recommendations:

- Have a combination with a minimum of five PCHHs in the south, north, and west corridors and a sufficient amount in the collar counties.
- There should be combination of clinical and non-clinical health homes.
- Have a minimum of one collaboration between a university, a community-based organization, and a public health service provider.
- Avoid creating a PCHH that would reinforce isolation due to stigma.
- There should be a requirement for PCHHs to work in collaboration with other PCHHs.

Social and racial equity recommendations:

- One PCHH in each geographic area should be minority-based.
- Each one of the selected PCHHs must participate in capacity building services that include cultural sensitivity and undoing racism.
- Each PCHH should have continual capacity building throughout the life cycle of the PCHH funding.

Evaluation recommendations:

- Each organization should be required to submit a quality improvement/quality assessment plan.
- Each organization should have a community advisory board representing of the population they are working with.

CAHISC-sponsored Community Forums on the Key Components of the HIV Services Portfolio

Four community forums were convened to present components of the *HIV Services Portfolio* and gather needs assessment information. The following is a summary of findings and additional information can be found in Figure 16.

Population Centered Health Homes (February 16, 2017): A key concern was that changes would disrupt the existing system of care and negatively affect relationships with current providers. There had not been enough representation of providers and delegate agencies in the development of the PCHH component and that the details of transportation and flexible medical appointment scheduling had not been adequately discussed. Participants were concerned that services need to be based on the needs of the individual and that participating agencies need the freedom to be client-centered.

Community Development (February 23, 2017): Participants emphasized that this component offered a chance to think “outside of all of the boxes of HIV-related services” and to involved broad-based community leadership in developing an approach that addresses how structural determinants intersect with HIV, which create barriers to achieving viral suppression and PrEP adherence.

Marketing and Services for Persons who Use Drugs Health (April 19, 2017): This discussion centered on issues of stigma and the need for increased resources applied to both Marketing and Services for Persons who Use Drugs. The group emphasized the need to approach services from a comprehensive perspective that included increased access to medical care, mental healthcare, supportive services, and housing.

Housing (May 24, 2017): Discussion concerned existing structural barriers to housing access and comprehensive services including long wait periods for application approval, a lack of client-centered supports within facilities, restrictions on treatment access in housing facilities (eligibility tied to enrollment in specific services provided by facility instead of allowing linkage to existing care relationships), and that maintaining housing should not be solely based on the ability of the individual to adhere to treatment. There was also strong support that housing/support services should be developed for youth and persons vulnerable to HIV.

CAHISC-sponsored Forums with Underserved Communities

In 2017, CAHISC convened community forums with historically underserved communities. The following is a summary of findings and additional information can be found in Figure 17.

Collar Counties at Open Door (June 21, 2017): Participants emphasized the importance being known by their provider, rather than just being treated by their provider. These relationships should not be disrupted by new model. The need for bilingual services, and associated issues of stigma and racism, impact access to service and support in suburban and rural areas of the collar counties. There are fewer providers, more diffusely located, which emphasizes the need that service be client-centered and co-located.

Youth Focus (July 19, 2017): Participants emphasized the need for more providers who were experienced and interested in caring for youth and familiar with LGBTQ youth. These services need to be provided in safe, confidential environments supported by transportation and childcare with access to real-time services specializing in youth, including youth who use drugs. Stigma experienced by youth should be given an enhanced consideration in marketing efforts and service provision.

Pregnant and Parenting Women (August 18, 2017): A woman's HIV and general healthcare is often not her first priority. Children, food, housing, family, isolation, abuse, mental health concerns, work, and stigma often compete with her ability to care for herself. Providers need to provide trauma-informed services to women that acknowledge previous traumatic experiences and recognize its effects on relationships and outcomes. Medical services need to consider the needs of a woman's children regardless of HIV status. Childcare and coordination of pediatric care appointments would increase a mother's ability to be adherent to her own treatment. Participants spoke of the inconsistency of provider sensitivity to competing family concerns and many reported that they had been "kicked out of care" for not being compliant. Structural barriers and other issues could possibly be addressed by the Community Development component of the *HIV Services Portfolio*.

Community Development Focus Groups

In 2017, four Community Development focus groups were convened with communities most vulnerable to HIV infection and poor HIV health outcomes. The conversations focused on structural and institutional barriers to the successful use of ARV for HIV treatment and PrEP. Feedback from the focus groups was used to develop the Community Development component of the *HIV Services Portfolio*. Feedback also informed other components of the portfolio. Additional focus group information can be found in Figure 17.

Cisgender Black Heterosexual Women (May 30, 2017 and June 20, 2017): Services need be trauma-informed and support women coming out of incarceration. There are not enough services for cisgender Black women, and those that do exist are not well-known or easy enough to access. Stigma, safety, isolation, and confidentiality all need to be considered. Peer supports are helpful. Providers need to recognize and address that healthcare is not the only priority facing women. Peer support and access to housing are essential to achieving treatment outcomes.

Black Gay, Bisexual, and other MSM (May 30, 2017 and June 13, 2017): Healthcare access is limited by a lack of culturally responsive providers and transportation to those that exist. Unaddressed behavioral health needs often compete or conflict with medical care. Trauma experienced as an adult or as a child and race-based trauma were specifically raised as concerns in receiving competent care. Confidentiality regarding HIV status and sexual orientation needs to be considered in creating a trauma-informed environment. Comprehensive health services are lacking outside of the Ryan White system. There needs to be a range of outreach and adherence-focused interventions for Black gay, bisexual, and other MSM. Participants recommended provider training and quality monitoring to help develop and foster welcoming, responsive person-centered care and trauma-informed services.

Latino Gay, Bisexual, and other MSM (April 4, 2017): Participants receiving services from five agencies serving Latino populations across the EMA identified the following barriers preventing Latinos from accessing HIV care and PrEP. There is a lack of culturally and linguistically appropriate marketing materials that are presented in a sensitive and non-invasive way. This is impacted by the current political climate which has increased fears that seeking HIV information or access will threaten immigration and documentation status. Marketing and access need to consider targeting special interests among Latinos who do not identify as Latino gay, bisexual, and other MSM but whose high-risk sexual activity occurs through other community gathering spaces. Latino gay, bisexual, and other MSM face specific cultural stigma within their communities, and participants felt that there should be more access through neutral

spaces, less identified as LGBTQ or HIV-oriented. At the same time, there are not enough healthcare facilities that are bilingual/bicultural with providers and service staff that understand HIV and Ryan White and provide integrated services. There need to be community-oriented service sites that consider the time constraints imposed on Latino clients by work schedules and transportation and offer legal services to help deal with HIV and immigration issues. PrEP and sexual activity needs to be addressed in a culturally specific way for Latinos to combat community homophobia and stigma that is a barrier to access.

Participants also identified strengths and opportunities in addressing these challenges. There are existing community spaces like ALMA, NEXOS, VivesQ, Orgullo en Accion, United Latino Pride, and Generation L that can serve as a foundation for the development of effective community services for Latinos that emphasize both clinical and cultural aspects to care. These centers can promote mentorship and peer involvement to encourage individuals to be advocates for themselves. Latinos are very community-minded, and Latino gay, bisexual, and other MSM support one another having created their own sense of community based on common language, culture, and family experience. This capacity will enhance community development to address HIV effectively.

Transgender Persons (June 30, 2017): Participants identified and discussed challenges presented by five social determinants of health in assuring access to ARV for HIV PrEP and treatment.

- Adverse life events, trauma, and violence: Public violence/assault leads to trauma, murdering trans women of color, family acceptance/rejection, domestic abuse/partners restricting and controlling hormone access, misogyny, difficulties with the transition process, and discrimination.
- Poor access to and quality of healthcare: Mis-gendering, outing, lack of access to affirming care, lack of competence/sensitivity, ignorance, and structural barriers must be taken into consideration. [CDPH] should have all HIV service providers use trans-affirming paperwork and work to minimize the disconnect between the client and paperwork, i.e., practitioners need to read the paperwork clients fill out and address them accordingly. Other issues include expenses, restriction to Medicaid, and the current climate to access healthcare.
- Social exclusion and social isolation: Family acceptance/rejection is a very real concern. Marketing messages tell you there is something wrong with you which leads to isolation. Hormone reactions can lead a person to become emotional. Sexual and romantic relationships can exacerbate exclusion and perceptions of desirability. Invisibility equals safety.
- Housing instability: Housing is expensive, and there are not enough subsidies. There is discrimination, regardless of public or private housing. Eligibility, immigration status, and safety are concerns. There is no trans-affirming housing and no trans-specific integrated services.
- Under- and unemployment/poverty: There are no trans-affirming employment opportunities, which creates economic disparities. The rate of unemployment is four times higher for trans persons. There is no equity. [Some trans persons do] not have enough skills to be successful. There is a need for trans-umbrella embracing/affirming services. There is no current structure to have trans-affirming programs.

Participants recommended having multi-tiered approaches to:

- Educate the trans community on benefits, existing protections, and or opportunities, and
- Educate the general population about trans community inclusion and its protections and benefits.

FIGURE 16: Community Forum and Focus Group Locations and Participant Information

Date of Event	Event Name	Location	Number of Participants	Participant Characteristics
February 16, 2017	Community Forum: Population Centered Health Home	Southside of Chicago West Point Baptist Church	45	65% Cis Female 80% Black 10% White 10% Latino(a)
March 23, 2017	Community Forum: Community Development	South Suburban EMA First United Methodist Church	20	70% Cis Female 90% Black 10% White
April 4, 2017	Focus Group: Latino Gay, Bisexual, and other MSM	Downtown Chicago CDPH	6	100% Cis Male 100% Latino/a
April 19, 2017	Community Forum: Marketing and Drug User Health	Westside of Chicago Above and Beyond Family Center	20	90% Cis Female 80% Black 20% Latino/a
May 24, 2017	Community Forum: Housing	Northside of Chicago Heartland Housing	15	70% Cis Female 65% Black 25% White 10% Latino/a
May 30, 2017	Focus Group: Cisgender Black Heterosexual Women (session 1)	Downtown Chicago CDPH	16	100% Cis Female 100% Black
May 30, 2017	Focus Group: Black Gay, Bisexual, and other MSM (session 1)	Downtown Chicago CDPH	15	100% Cis Male 100% Black
June 13, 2017	Focus Group: Black Gay, Bisexual, and other MSM (session 2)	Downtown Chicago CDPH	8	100% Cis Male 100% Black
June 20, 2017	Focus Group: Cisgender Black Heterosexual Women (session 2)	Downtown Chicago CDPH	5	100% Cis Female 100% Black
June 21, 2017	Community Forum: EMA Collar County	West Suburban EMA Open Door Clinic	23	50% Cis Female 20% Black 50% White 30% Latino/a
June 30, 2017	Focus Group: Trans Persons	CDPH	8	100% Trans Female Race/ethnicity not collected
July 19, 2017	Community Forum: Youth	Southside of Chicago Access Center for Discover Learning Center	30	25% Cis Female 25% Trans Female 50% Cis Male 81% Black 19% Unknown 50% < 24 years
August 18, 2017	Community Forum: Pregnant / Parenting Women	Downtown Chicago Perinatal AIDS Chicago Prevention Initiative	20	100% Cis Female 45% Black (U.S.) 38% Black (foreign-born) 2% White 12% Latina 3% Unknown 27% Pregnant

Addressing Needs, Gaps, and Barriers

To address needs, gaps, and barriers in services, and in conjunction with needs assessment activities, CDPH and CAHISC constructed iterative versions of the *HIV Services Portfolio*, incorporating feedback as it became available. The final *HIV Services Portfolio* was presented to CAHISC in January 2018. In July 2018, CAHISC completed its PSRA process which allocated funding to the portfolio. For the first time, CAHISC considered all funding sources referenced in Figure 12 during PSRA. The PSRA vote included allocations across all fund sources. More information about CDPH's integrated *HIV Services Portfolio* is provided in Section II of this document.

In conjunction with the development of the *HIV Services Portfolio*, CDPH and CAHISC community leadership actively participated in the development of *Getting to Zero: A Framework to Eliminate HIV in Illinois*. In July 2016, a small group of HIV stakeholders met to explore what it would take to radically change the course of the epidemic. Getting to Zero refers to both HIV prevention and care: zero new HIV infections and zero people living with HIV who are not receiving treatment. To achieve this vision, the focus must be on outcomes that provide the greatest potential and impact for reducing HIV transmission, i.e., successful use of ARV medications for HIV treatment and PrEP. The Affordable Care Act, PrEP, and HIV treatment provide an opportunity to develop a new portfolio of programs that will effectively target the people vulnerable to and living with HIV and optimize responses to address identified service needs, gaps, and barriers, and address health disparities that affect everyone regardless of HIV status. The *HIV Services Portfolio* and the Integrated Plan have adopted the vision and outcomes of Getting to Zero.

Data: Access, Sources, and Systems

CDPH has dedicated HIV/STI surveillance, prevention, care and treatment, and housing programs that work together to collect, monitor, and analyze data. This data is used for planning programs, allocating resources, and other kinds of decision making related to monitoring HIV/STI disease trends, identifying vulnerable populations, monitoring health outcomes for people living with HIV, identifying strategies to engage people living with and vulnerable to HIV, and providing access to and evaluating HIV prevention, care and treatment, and housing services.

The CDPH HIV/STI Bureau Surveillance, Epidemiology, and Research Team conducts core surveillance activities in conjunction with IDPH including reporting confirmed diagnoses of HIV disease to CDC and collecting demographic characteristics, transmission category, initial immune status, and ongoing viral load and CD4 counts.

Data Sources

A variety of data sources were used to develop the *HIV Services Portfolio* and Integrated Plan.

HIV Surveillance: The Chicago EMA is included in the IDPH/CDC surveillance system for tracking HIV prevalence and incidence in Illinois established in 1981. The system has developed mandated name-based reporting of people living with HIV by healthcare providers within seven days of diagnosis. The HIV case definition requires confirmed HIV infection with either clinical conditions that meet the

definition, or severe immune suppression. In January 2006, Illinois re-adopted a name-based HIV reporting system, which has improved HIV surveillance data quality and database linkages.

The Enhanced HIV/AIDS Reporting System (eHARS): In June 2009, eHARS was successfully implemented in Illinois. Data from multiple documents are entered for each case, and those documents are linked with a unique identification number. Implementation of eHARS has enabled the CDPH and IDPH HIV surveillance programs to gather and store more information from birth certificates, death certificates, and laboratory reports than was possible with the previous system. eHARS is supported primarily by federal funding from the CDC.

Medical Monitoring Project (MMP): The Medical Monitoring Project is a CDC-funded supplemental surveillance project designed to learn about the experiences and needs of people living with HIV. MMP monitors progress and identifies areas for improvement in delivery of HIV care, treatment, and prevention interventions. For each MMP data collection cycle, the population of reference is persons living with HIV, 18 and older, who received outpatient HIV medical care. To recruit study participants, CDPH identifies a representative sample of persons living with HIV in the City of Chicago from eHARS. CDPH then contacts all sampled persons.

MMP staff invite each selected patient to participate in a face-to-face or telephone interview, with questions concerning their medical history, use of medical and social services, and risk behaviors. Trained MMP abstractors then collect additional information from the patient's medical chart, which complements data from the interview.

National HIV Behavioral Surveillance (NHBS): In 2003, CDC created NHBS for conducting behavioral surveillance among people vulnerable to HIV infection. Surveillance is conducted in rotating annual cycles in three different vulnerable populations: gay, bisexual, and other MSM; people who inject drugs; and heterosexuals at increased risk for HIV infection. Before each NHBS cycle, formative research is conducted to learn about the populations and to help with sampling procedures. Trained interviewers in all NHBS jurisdictions use a standardized anonymous questionnaire to collect information on HIV-related risk behaviors, HIV testing, and use of HIV prevention services. HIV testing is also offered to all participants.

Chicago is the only city in Illinois that receives funding to conduct these activities. Data collected include national and metropolitan statistical area specific data on behavioral risks for HIV, HIV testing behaviors, access to and use of prevention services, and HIV testing results. NHBS data are used by CAHISC to provide a behavioral context for trends seen in HIV surveillance data, especially data trends specific to the Chicago EMA.

Perinatal HIV Exposure Reporting: The Illinois Perinatal HIV Prevention Act mandates that healthcare providers provide every pregnant woman who has an unknown HIV status with HIV counseling and recommend HIV testing as soon as possible. The Act stipulates that if a pregnant woman with an undocumented HIV result refuses an HIV test her newborn will be tested, unless there are documented religious objections.

Since 2004, the Pediatric AIDS Chicago Prevention Initiative (PACPI) has coordinated the collection of perinatal testing data from Illinois hospitals. Hospitals are required monthly to report a summary of all rapid tested and known HIV-positive women delivering at their facility. PACPI collects both fax and email reports from hospitals, and this data is shared monthly with the CDPH and IDPH.

The PACPI Enhanced Case Management program has transitioned from using the ClientTrack database to the Provide® database to allow for integrated data capture and customized reporting.

STI Reporting: Individuals who test positive for chlamydia, gonorrhea, or syphilis are reported to CDPH by healthcare providers, public and private clinics, and laboratories. Gonorrhea and chlamydia are reported directly into the Illinois National Electronic Disease Surveillance System, and syphilis is reported into the Chicago Health Information System. Information on STI infections is important in planning for HIV prevention and care, as rectal gonorrhea and syphilis are indicators for risk of HIV infection and for referral to PrEP.

Vital Statistics Reporting: The National Center for Health Statistics (NCHS) receives information on births and deaths in the U.S. through a program of voluntary cooperation with state government agencies, such as state health departments and state offices of vital statistics, called the Vital Statistics Cooperative Program. Reporting is nearly 100 percent complete for births and deaths. HIV may be underreported as an underlying or contributory cause of death on certificates if infection status at death is unknown. State statutes related to confidentiality of HIV data have resulted in problems with HIV being reported to NCHS as the underlying cause of death. IDPH provides CDPH with this information.

U.S. Census Data: Comprehensive data is retrieved from the U.S. Census Bureau website on demographic characteristics of the U.S. population including population size, family structure, educational attainment, income level, housing status, and the proportion of people who live at or below the poverty level. The Census Bureau produces and publishes annual estimates of the population for the nation, states, counties, state/county equivalents, and Puerto Rico.

Ryan White HIV/AIDS Program Data: The Ryan White CAREware database includes information on all individuals receiving assistance through programs funded through the Ryan White HIV/AIDS Program. Information is collected from service providers throughout the EMA and includes demographic and risk information for each client, eligibility verification data, types of services received, date and quantity of services received, cost of these services, and other pertinent information, including a history of substance use disorders or mental health treatment, veteran status, and current pregnancy status.

Inferences drawn from Ryan White data cannot be generalized to all persons living with HIV, since the data collected are selective of people who (1) know their HIV status, (2) are not eligible for health coverage through private insurance or Illinois Medicaid, (3) are currently seeking care and treatment services from providers funded through Ryan White Part A, and (4) are financially eligible to receive services. In 2019, CDPH will begin using the Provide® system to align data collection with IDPH Part B.

HIV Prevention Program Data: CDPH routinely collects data from City of Chicago HIV prevention providers, including HIV screening, linkage to care, condom distribution, and PrEP promotion.

Information collected from service providers includes data on demographics, risk, sexual health, and other pertinent client information.

Behavioral Risk Factor Surveillance System: BRFSS is a CDC-funded, state-based random-digit-dialed telephone survey of adults that monitors state-level prevalence of behavioral risks associated with premature morbidity and mortality. Respondents to the BRFSS questionnaire are asked about their personal health behaviors and health experiences. A sexual behavior module, first added in 1994, asks adults (aged 18–65 years) about several risk behaviors including number of sex partners, condom use, and treatment for STI. Data from the BRFSS survey are population based. Therefore, estimates about testing attitudes and practices can be generalized not only to individuals vulnerable to HIV infection, but also to the adult population of a state.

Youth Risk Behavior Survey: YRBS monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the U.S. Topics include nutrition, tobacco use, alcohol and other drug use, physical activity, injuries, and sexual behavior resulting in STIs and pregnancy. The Illinois YRBS is conducted every two years and provides data representative of ninth through twelfth grade students in high schools throughout the state.

Desired Data

More comprehensive, up-to-date, client-level data on medical appointments, labs visits, and ARV use would be useful in efforts to enhance and strengthen the *HIV Services Portfolio*, particularly data on PrEP use. This would require having data sharing agreements in place with third party public and private insurers, laboratories, and pharmacies. As part of Integrated Plan implementation, CDPH will collaborate with IDPH to identify strategies to gather and analyze these data. This will provide a more accurate picture of successes, challenges, and efforts still needed within specific geographic regions and population groups to achieve the goals of NHAS and Getting to Zero.

Section II: Integrated HIV Prevention and Care Plan

Integrated Goals, Objectives, Strategies, and Activities

To promote alignment with other jurisdictional plans, the Integrated Plan organizes its goals, objectives, strategies, and activities to follow NHAS goals:

Goal #1: Reduction of New HIV Infections

Goal #2: Increased Access to Care and Improved Health Outcomes for People Living with HIV

Goal #3: Reduction of HIV-Related Disparities and Health Inequities

Goal #4: A More Coordinated Response to HIV in the Chicago EMA and within the State of Illinois

In addition to support for NHAS, the Integrated Plan has adopted the vision and outcomes of Getting to Zero. This is necessary as the NHAS was formulated before a focus on treatment as prevention and PrEP was widely accepted as viable and effective. Plan objectives are set to accomplish Getting to Zero outcomes:

- To increase by 20 percentage points the number of people living with HIV who are virally suppressed and

- To increase by 20 percentage points the number of people vulnerable to HIV infection who use PrEP.

CDPH worked closely with CAHISC to create the *HIV Services Portfolio* in order to achieve the goals outlined in the NHAS and Getting to Zero. CDPH and CAHISC recognized the activities and services that are working in the Chicago EMA must be strengthened and new approaches to expand access, fill critical gaps, and recruit more customers into services must be initiated. To accomplish this, activities and services were organized into a comprehensive, coordinated system of care that focuses on supporting successful ARV use for both individuals and populations and for both people living with and vulnerable to HIV. CAHISC and CDPH identified four components in the *HIV Services Portfolio* that represent a high-impact model of service delivery.

1. Healthcare Access. Increase access to both HIV treatment and PrEP, integrated with supportive services, for people living with and vulnerable to HIV. Enhance coordination among service providers to increase the likelihood people have every opportunity to benefit from services.

Initiatives under healthcare include:

- a. *Population Centered Health Homes (PCHH)* ensure people have access to and use high-quality comprehensive healthcare for HIV treatment and PrEP, including integration of supportive services, such as case management, care navigation and coordination, and behavioral health.
- b. *PCHH for Persons Living with HIV who have Complex Medical/Behavioral Needs* ensure people receive all services provided through PCHH and services to enhance engagement of individuals who are chronically disconnected from care and/or who have chronically high HIV viral loads.
- c. *Essential Supportive Services* ensure people not engaged in the healthcare system have access to high-quality comprehensive supportive services, such as mental health and substance use disorder treatment. Through addressing non-medical needs, people can be successfully linked to healthcare services for HIV care and treatment and PrEP.
- d. *HIV Primary Care* ensures people who do not need supportive services have access to primary care services for HIV care and treatment and PrEP.
- e. *Targeted HIV Screening and Linkage to Care* ensures people are provided opportunities to learn their HIV status and are linked to or re-engaged in appropriate services, including HIV care and treatment and PrEP.
- f. *HIV Screening in Healthcare Settings* ensures people who do not routinely access HIV services are provided opportunities to learn their HIV status through hospitals and other non-HIV healthcare institutions so they can be linked to or re-engaged in appropriate services, including HIV care and treatment and PrEP.
- g. *Legal, Food, and Financial Assistance* ensures people have access to legal, food, and financial supports, including emergency financial support and transportation, to reduce barriers to accessing healthcare.
- h. *Medical Case Management* ensures people living with HIV are provided intensive, one-on-one support to increase successful engagement in healthcare, including HIV care and treatment and viral suppression.

2. Health Equity. Invest resources to address root causes of health disparity, including systemic racism. Invest in communities most impacted by HIV to create opportunities and reduce marginalization.
 - a. *Community Development* addresses the intersections of HIV and other community needs and social determinants of health, such as mental health, substance use, trauma and violence, and access to healthcare. Through Community Development, communities will identify problems and identify structural and institutional-level solutions.
 - b. *Services for Persons who Use Drugs* leverages HIV resources to help address the opioid epidemic by responding to the leading health needs of persons who inject drugs, including HCV, overdose, and substance use disorders.
3. Housing. Increase access to housing for persons living with and vulnerable to HIV.
 - a. *Housing for Persons Living with HIV* will increase access to housing for people living with HIV to remove barriers to accessing healthcare and to promote HIV care and treatment.
 - b. *Housing for Persons Vulnerable to HIV* will invest in housing options for HIV-vulnerable PrEP users to remove barriers to accessing healthcare and to promote PrEP adherence.
4. How-to. Raise awareness, educate, and promote healthy behaviors in communities most impacted by HIV. Link persons living with and vulnerable to HIV to needed HIV services.
 - a. *Marketing* will develop and deploy cohesive and consistent HIV/STI health marketing campaigns that increase knowledge and promote the value of HIV services.
 - b. *Resource Coordination* will provide information, real-time advice, and direct linkage to HIV services for both persons living with and vulnerable to HIV.

The *HIV Services Portfolio* will be implemented through several programmatic funding opportunities which provide an enhanced opportunity to integrate funding, resources, and services for HIV prevention, care and treatment, housing, and essential support. The following objectives and strategies will guide the implementation process.

Objectives and Strategies

The four Integrated Plan goals follow NHAS and will be achieved through corresponding SMART—specific, measurable, achievable, realistic, and time-phased—objectives, strategies, and activities. See Appendix 3 for the companion work plan.

Goal #1: Reduce New HIV Infections

- Objective 1.1: Systematically collect, analyze, interpret, and disseminate HIV and STI data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response.
 - Strategy 1.1.1: Maintain collection and use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan for an implement services.
 - Activity 1.1.1.1: Maintain the enhanced HIV/AIDS Reporting System (eHARS) in order to monitor trends in HIV infection and describe demographic and geographic distribution of HIV in Chicago.

- Activity 1.1.1.2: Maintain collection of MMP, NHBS, and STI surveillance in order to understand correlates of HIV risk and HIV health outcomes.
- Objective 1.2: By December 2021, lower the annual number of new HIV infections in the Chicago EMA by 25 percent, from 1,312 to 984.
 - Strategy 1.2.1: Increase the number of persons living with HIV who are aware of their HIV status.
 - Activity 1.2.1.1: By March 2019, establish 3-5 Targeted HIV Screening and Linkage to Care programs to provide 6,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons to care within 30 days. Link 60% of previously diagnosed persons who are out of care back to care within 3 months.
 - Data Target: Annually, provide 6,000 HIV tests.
 - Data Target: Annually, identify approximately 90 new HIV diagnoses (1.5% seroprevalence).
 - Data Target: Annually, link at least 90% of newly diagnosed persons to care within 30 days (81).
 - Data Target: Annually, identify approximately 200 previously diagnosed persons who are out of care.
 - Data Target: Annually, re-engage at least 60% of out-of-care persons in care within 3 months (120).
 - Activity 1.2.1.2: By March 2019, establish 3-5 Essential Supportive Services programs to provide 6,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons who are out of care back to care within 30 days. Link 60% of previously diagnosed persons to care within 3 months.
 - Data Target: Annually, provide 6,000 HIV tests.
 - Data Target: Annually, identify approximately 90 new HIV diagnoses (1.5% seroprevalence).
 - Data Target: Annually, link at least 90% of newly diagnoses persons to care within 30 days (81).
 - Data Target: Annually, identify approximately 200 previously diagnosed persons who are out of care.
 - Data Target: Annually, re-engage at least 60% of out-of-care persons in care (120).
 - Activity 1.2.1.3: By March 2019, establish 10-15 Population Centered Health Homes (PCHH) to provide 54,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons to care within 30 days. Link 60% of previously diagnosed persons who are out of care back to care within 3 months.
 - Data Target: Annually, provide 54,000 HIV tests.

- Data Target: Annually, identify approximately 810 new HIV diagnoses (1.5% seroprevalence).
- Data Target: Annually, link at least 90% of newly diagnosed persons to care within 30 days (729).
- Data Target: Annually, identify approximately 400 previously diagnosed persons who are out of care.
- Data Target: Annually, re-engage at 60% of out-of-care persons in care (240).
- Activity 1.2.1.4: By March 2019, establish 1 HIV Screening in Healthcare Settings program to provide 84,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons to care within 30 days. Link 60% of previously diagnosed persons who are out of care back to care within 3 months.
 - Data Target: Annually, provide 84,000 HIV tests.
 - Data Target: Annually, identify approximately 84 new HIV diagnoses (0.1% seroprevalence).
 - Data Target: Annually, link at least 90% of newly diagnosed persons to care within 30 days (76).
 - Data Target: Annually, identify approximately 400 previously diagnosed persons.
 - Data Target: Annually, re-engage at least 60% of out-of-care persons in care (240).
- Strategy 1.2.2: By December 2021, increase by 20% the number of people vulnerable to HIV who use PrEP, from approximately 20% (6,000/30,000) to 40% (12,000/30,000).⁶
 - Activity 1.2.2.1: By March 2019, establish 10-15 Population Centered Health Homes (PCHH) to provide comprehensive clinical and essential supportive services for 13,750 persons who can benefit from PrEP. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.
 - Data Target: By December 2021, identify at least 13,750 HIV-negative individuals who are not currently using PrEP who are PrEP-eligible.
 - Data Target: By December 2021, refer at least 80% (11,000) to a PrEP prescriber.
 - Data Target: By December 2021, link at least 60% (8,250) to a PrEP prescriber.
 - Data Target: 4: By December 2021, prescribe PrEP to at least 50% (6,875).

⁶ Data estimates were defined using Project PrIDE (CDC PS 15-1502) preliminary evaluation outcomes. Data suggest 80% of individuals identified as PrEP candidates are referred to a prescriber, 60% are linked to a prescriber, and 50% are prescribed PrEP. Through our programs, we anticipate approximately 50% of those prescribed PrEP will initiate PrEP use. Therefore, across Strategies 1.3.1 - 1.3.4, approximately 5,750 individuals will initiate PrEP by 2021 (11,500 prescribed * 50% = 5,750 initiate PrEP).

- Activity 1.2.2.2: By March 2019, establish 3-5 HIV Primary Care programs to provide clinical services to 50 persons who can benefit from PrEP who do not need supportive services. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.
 - Data Target: By December 2021, identify at least 50 HIV-negative individuals who are not currently using PrEP who are PrEP-eligible.
 - Data Target: By December 2021, refer at least 80% (40) to a PrEP prescriber.
 - Data Target: By December 2021, link at least 60% (30) to a PrEP prescriber.
 - Data Target: By December 2021, prescribe PrEP to at least 50% (25).
- Activity 1.2.2.3: By March 2019, establish 3-5 Essential Supportive Services programs to provide non-clinical supportive services to 2,500 persons not engaged in healthcare that can benefit from PrEP. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.
 - Data Target: By December 2021, identify at least 2,500 HIV-negative individuals who are not currently using PrEP who are PrEP-eligible.
 - Data Target: By December 2021, refer at least 80% (2,000) to a PrEP prescriber.
 - Data Target: By December 2021, link at least 60% (1,500) to a PrEP prescriber.
 - Data Target: By December 2021, prescribe PrEP to at least 50% (1,250).
- Activity 1.2.2.4: By March 2019, establish 3-5 Targeted HIV Screening and Linkage to Care programs to provide linkage to PrEP to 2,500 persons who can benefit. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.
 - Data Target: By December 2021, identify at least 2,500 HIV-negative individuals who are not currently using PrEP who are PrEP-eligible.
 - Data Target: By December 2021, refer at least 80% (2,000) to a PrEP prescriber.
 - Data Target: By December 2021, link at least 60% (1,500) to a PrEP prescriber.
 - Data Target: By December 2021, prescribe PrEP to at least 50% (1,250).
- Activity 1.2.2.5: By March 2019, establish 1 HIV Screening in Healthcare Settings program to provide linkage to PrEP to 4,200 persons who can benefit. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.
 - Data Target: By December 2021, identify at least 4,200 HIV-negative individuals who are not currently using PrEP who are PrEP-eligible.

- Data Target: By December 2021, refer at least 80% (3,360) to a PrEP prescriber.
- Data Target: By December 2021, link at least 60% (2,520) to a PrEP prescriber.
- Data Target: By December 2021, prescribe PrEP to at least 50% (2,100).
- For efforts to reduce new HIV infections by increasing viral suppression among persons living with HIV, please see Goal #2, Objective 2.1.

Goal #2: Increased Access to Care and Improved Health Outcomes for People living with HIV/AIDS and those vulnerable to infection.

- Objective 2.1: By December 2021, increase by 20% the number of people living with HIV who are virally suppressed, from approximately 50% (~15,134/30,165) to 70% (~21,115/30,165).
 - Strategy 2.1.1: Increase access to HIV care and treatment for persons living with HIV.
 - Activity 2.1.1.1: By March 2019, establish 10-15 PCHH to provide comprehensive clinical and essential supportive services for 18,000 persons living with HIV. Achieve 81% viral suppression among the patient population.
 - Data Target: Annually, serve 18,000 persons living with HIV through PCHH.
 - Data Target: By December 2021, achieve 81% viral suppression among persons living with HIV who receive services through PCHH (14,580).
 - Activity 2.1.1.2: By March 2019, establish 3-5 HIV Primary Care programs to provide clinical services to 2,000 persons living with HIV who do not need supportive services. Achieve 81% viral suppression among the patient population.
 - Data Target: Annually, serve 2,000 persons living with HIV through HIV Primary Care programs.
 - Data Target: By December 2021, achieve 81% viral suppression among persons living with HIV who receive services through HIV Primary Care programs (1,620).
 - Activity 2.1.1.3: By September 2019, establish 1 Resource Hub to increase the number of people living with HIV who are provided information, real-time advice, and direct linkage to HIV clinical care services (including, but not limited to, services funded by CDPH).
 - Data Target: By March 2019, select a successful contractor to create the Resource Hub.
 - Data Target: By September 2019, launch Resource Hub.
 - Data Target: By December 2021, link X persons to PCHH and HIV Primary Care programs. (Actual baseline and target numbers are contingent on execution of new contracts for the Resource Hub beginning March 1, 2019.)

- Activity 2.1.1.4: By December 2019, develop and deploy a cohesive and consistent HIV/STI health marketing campaigns.
 - Data Target: By March 2019, select a successful contractor to create a plan for developing and deploying health marketing campaigns.
 - Data Target: By December 2019 and annually thereafter, launch at least two campaigns annually, at least one of which promotes ARV use for HIV treatment or PrEP.

Goal #3: Reduce HIV-Related Disparities and Health Inequities

- Objective 3.1: By December 2021, increase viral suppression among Black gay, bisexual, and other MSM from 50% to 55%.
 - Strategy 3.1.1: Examine and address root causes of disparities among Black gay, bisexual, and other MSM.
 - Activity 3.1.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of ARVs for HIV treatment and PrEP among Black gay, bisexual, and other MSM.
 - Data Target: 1 Community Development initiative initiated. Other activities and data targets are contingent on execution of new contracts for Community Development initiatives beginning March 1, 2019.
 - Activity 3.1.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including Black gay, bisexual, and other MSM, to support ARV use for HIV treatment.⁷
 - Data Target: Activities are contingent on execution of new contracts for Housing programs beginning March 1, 2019.
 - Activity 3.1.1.3: By March 2019, establish 1 Housing program to provide housing opportunities for persons vulnerable to HIV with an emphasis on Black gay, bisexual, and other MSM, to support ARV use for PrEP.
 - Data Target: Activities are contingent on execution of new contracts for Housing programs beginning March 1, 2019.
 - Activity 3.1.1.4: By July 2019, establish 2-3 PCHH for persons living with HIV who have complex medical and/or behavioral challenges (PCHH-Complex), including Black gay, bisexual, and other MSM, to support ARV use for HIV treatment.⁸

⁷ Housing programs for persons living with HIV will be funded through HOPWA funding. CDPH will fund a total of 20 Housing programs. We reference the same 20 programs multiple times, under Strategies 3.1.2, 3.2.2, 3.3.2, and 3.4.2, as many of these programs will serve members of the referenced priority populations.

⁸ PCHH-Complex will be funded through Ryan White Minority AIDS Initiative funding. CDPH will fund a total of 2-3 PCHH-Complex. We reference the same 2-3 programs multiple times, under Strategies 3.1.4, 3.2.3, 3.3.3, and 3.4.3, as many of these programs will serve members of the referenced priority populations.

- Data Target: 1 PCHH-Complex established. Other activities and data targets are contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019.
- Objective 3.2: By December 2021, increase viral suppression among cisgender Black heterosexual women from 47% to 52%.
 - Strategy 3.2.1: Examine and address root causes of disparities among cisgender Black heterosexual women.
 - Activity 3.2.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of ARVs for HIV treatment and PrEP among cisgender Black heterosexual women.
 - Data Target: 1 Community Development initiative initiated. Other activities and data targets are contingent on execution of new contracts for Community Development initiatives beginning March 1, 2019.
 - Activity 3.2.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including cisgender Black heterosexual women, to support ARV use for HIV treatment.
 - Data Target: Activities are contingent on execution of new contracts for Housing programs beginning March 1, 2019.
 - Activity 3.2.1.3: By July 2019, establish 2-3 PCHH-Complex, including cisgender Black heterosexual women, to support ARV use for HIV treatment.
 - Data Target: 1 PCHH-Complex established. Other activities and data targets are contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019.
- Objective 3.3: By December 2021, increase viral suppression among Latino gay, bisexual, and other MSM from 58% to 62%.
 - Strategy 3.3.1: Examine and address root causes of disparities among Latino gay, bisexual, and other MSM.
 - Activity 3.3.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of ARVs for HIV treatment and PrEP among Latino gay, bisexual, and other MSM.
 - Data Target: 1 Community Development initiative initiated. Other activities and data targets are contingent on execution of new contracts for Community Development initiatives beginning March 1, 2019.
 - Activity 3.3.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including Latino gay, bisexual, and other MSM, to support ARV use for HIV treatment.
 - Data Target: Activities are contingent upon execution of new contracts for Housing programs beginning March 1, 2019.

- Activity 3.3.1.3: By July 2019, establish 2-3 PCHH-Complex, including Latino gay, bisexual, and other MSM, to support ARV use for HIV treatment.
 - Data Target: 1 PCHH-Complex established. Other activities and data targets are contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019.
 - Objective 3.4: By December 2021, increase viral suppression among transgender persons who have sex with men.⁹
 - Strategy 3.4.1: Examine and address root causes of disparities among transgender persons who have sex with men.
 - Activity 3.4.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of ARVs for HIV treatment and PrEP among Transgender persons who have sex with men.
 - Data Target: 1 Community Development initiative initiated. Other activities and data targets are contingent on execution of new contracts for Community Development initiatives beginning March 1, 2019.
 - Activity 3.4.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including Transgender persons who have sex with men, to support ARV use for HIV treatment.
 - Data Target: Activities are contingent on execution of new contracts for Housing programs beginning March 1, 2019.
 - Activity 3.4.1.3: By July 2019, establish 2-3 PCHH-Complex, including Transgender persons who have sex with men, to support ARV use for HIV treatment.
 - Data Target: 1 PCHH-Complex established. Other activities and data targets are contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019.

Goal #4: A More Coordinated Response to HIV in the Chicago EMA and within the State of Illinois

- Objective 4.1: Improve administrative mechanisms within the CDPH to address changes in the delivery of HIV funding and services.
 - Strategy 4.1.1: Restructure the CDPH HIV/STI Bureau to reflect integration of HIV funding sources and services in the *HIV Services Portfolio*.
 - Strategy 4.1.2: Strengthen coordination across data systems and the use of data to improve health outcomes and monitor use of CDPH funds.
- Objective 4.2: Continue collaborative efforts with partners in the Chicago EMA and at the state and federal levels to improve the integration and effective delivery of HIV services.
 - Strategy 4.2.1: Continue close collaboration with CAHISC to monitor implementation and quality improvement of *HIV Services Portfolio*.

⁹ Viral Suppression among transgender persons who have sex with men is currently unknown. Investigation to determine this information is underway.

- Strategy 4.2.2: Continue participation in the planning and implementation of Getting to Zero for the State of Illinois.
 - Strategy 4.2.3: Coordinate Plan implementation and evaluation with IDPH.
- Objective 4.3: Increase HIV knowledge and reduce disparities in learning scores among the non-medical workforce using data from the Black AIDS Institute Survey as baseline (i.e., 63 percent overall score, 42 percent indicate that they are familiar with PrEP, and 41 percent are familiar with treatment as prevention; 13-16 percentage point gap between Whites and Blacks on all category scores).
 - Strategy 4.3.1: Collaborate with MATEC, AFC, Northwestern University, the Public Health Institute of Metropolitan Chicago, and CDC-funded CBA providers to provide low, medium, and high-intensity trainings to the non-medical workforce.

Activities and Metrics

Integrated Plan activities and metrics have been identified and are detailed in the work plan (Appendix 3). The work plan includes the timeframe, responsible parties, target population, data indicators, and data targets for each activity.

In addition to the activities and metrics, the Integrated Plan objectives and strategies will be guided by the following principles. Agencies participating in the implementation of the *HIV Services Portfolio* will be expected to demonstrate alignment by promoting organizational policies and practices that support these principles.

1. Getting to Zero – aligning with the State’s ending the HIV epidemic plan.
2. Undetectable = Untransmittable – following current science which tells us that people living with HIV who are virally suppressed cannot transmit HIV to their sexual partners.
3. Deconstructing racist systems – actively working to reframe and dismantle systems that perpetuate privilege, such as policies and practices that remove barriers to employment, retention, promotion, and staff development.
4. Trauma prevention and trauma-informed services – ensuring services are free of trauma.
5. Cultural responsiveness – ensuring services are culturally and linguistically appropriate.
6. Health equity in all communities – allocating resources and services to people and areas with the greatest need.

Data indicators

CDPH will monitor data indicators that are consistent with NHAS goals and the core indicators for Ryan White, CDC, and HOPWA, including the following:

- Number of HIV tests performed, by priority population
- Annual number of new HIV diagnoses, by priority population
- Disparities in the rate of new diagnoses
- Percentage of people living with HIV disease who know their serostatus
- Percentage of newly diagnosed people linked to clinical care within one month of diagnosis

- Percentage of previously diagnosed persons who are out of care who are relinked to care within three months
- Number of people linked and referred to PrEP, by priority population, including those testing HIV-negative through CDPH-funded programs
- Number of people prescribed PrEP
- Percentage of PLWH who are virally suppressed, by priority population
- Percentage of PLWH with sustained viral suppression, by priority population
- HIV transmission rate
- Number of infants born to untested mothers
- Percentage of RW clients retained in care
- Percentage of RW clients who are virally suppressed
- Percentage of HOPWA clients retained in care
- Percentage of HOPWA clients who are virally suppressed

Anticipated Challenges and Barriers

Current efforts are not sufficient to meet the vision of Getting to Zero in the next ten years. The service system must work more efficiently and effectively, expanding access to healthcare and services that support healthcare for more people living with and vulnerable to HIV. In establishing our *HIV Services Portfolio*, the Chicago EMA actively confronts the following challenges and barriers. Wherever possible, the portfolio seeks to mitigate these challenges.

- Though new HIV diagnoses have dropped, Getting to Zero requires that more people be virally suppressed and on PrEP. As currently constructed, the service delivery system cannot do this quickly enough. One primary cause: CDPH funding needs to be more fully invested in programs and services that lead to the use of ARVs for HIV treatment and PrEP.
- Less than half of people living with HIV are retained in care and virally suppressed. To get the benefits of U=U, services that help people connect to and stay engaged in healthcare need to be integrated across the continuum of care and sufficiently resourced and funded.
- Only about ten percent of people vulnerable to HIV are using PrEP. Current services and funding need to be redirected to increase this number.
- In 2018, the EMA received a \$2.5 million cut in CDC prevention funds which covered services for both people living with and vulnerable to HIV. This increases the urgency to improve the efficiency of the service structure.
- Restructuring services and altering current funding allocations has raised concern among those receiving and delivering services. CDPH and CAHISC have worked collaboratively to gather input from stakeholders and community members and have integrated that feedback into the *HIV Services Portfolio*. CDPH and CAHISC will continue to regularly engage stakeholders through implementation and evaluation of the *HIV Services Portfolio*.
- Service needs and gaps have been identified in suburban and rural areas of the EMA. CDPH and CAHISC must continue to work with IDPH to ensure the *HIV Services Portfolio* can be fully implemented throughout the entire nine counties of the Chicago EMA, including HIV prevention activities for which IDPH receives funding.

- Technical assistance and capacity building will be needed to assure that service providers can effectively respond to funding initiatives and implement and monitor services according to newly evolved criteria and procedures.
- Trans persons are critically underserved. Service needs for this population have been identified as a primary focus within Community Development projects. Where appropriate, services for transgender persons will be integrated in other portfolio components.
- On-going evaluation and quality management will need to be enhanced to provide on-going feedback as the *HIV Services Portfolio* is implemented

Partners and Participants

The development of the Integrated Plan is a joint effort by CDPH, CAHISC, other HIV prevention and care groups, community-based organizations and service providers, people living with HIV, individuals vulnerable to HIV, and other community stakeholders. These partners were essential to developing the *HIV Services Portfolio* which was used to guide the development of the Integrated Plan's objectives, strategies, and activities. These stakeholders will be equally important to Integrated Plan implementation and evaluation. Key partners in this effort included the following. A listing of additional partners can be found in Appendix 7.

CAHISC is a diverse and representative council providing input and review of integrated prevention, care and treatment, housing, and other HIV service concerns. CAHISC also includes a wide array of participants from service provider organizations. During the past two years, in anticipation of the *HIV Services Portfolio*, representatives of various stakeholder agencies attended CAHISC meetings as guest participants to provide input into the Plan.

AFC has been actively involved in HIV planning and service delivery since the beginning of the epidemic. AFC centrally coordinates and provides training to Parts A and B case managers, peer navigators, and other para-professionals assisting clients throughout the EMA. Through ongoing provider forums such as the Services Providers Council and Medical Advisory Group, they gather input from service providers on the current state of HIV care across the continuum and how to improve it. AFC has collaborated with CDPH and IDPH through CAHISC, the Illinois HIV Planning Group, Getting to Zero Illinois, and other planning efforts across the EMA.

Getting to Zero Illinois is an ongoing collaboration including city and state governments, health system stakeholders, elected officials, community-based organizations, consumers, and others convened by CDPH, IDPH, and AFC that has developed a framework to end the epidemic in Illinois by 2030. The focus is to increase the use of ARVs to suppress viral load among people living with HIV and as PrEP among persons vulnerable to HIV. Getting to Zero Illinois will recommend strategies to ensure collective efforts are as effective as possible and to bring additional resources to the table. Key Getting to Zero participants include:

- AFC
- Alexian Brothers Housing and Health Alliance
- Center on Halsted
- Chicago Black Gay Men's Caucus
- CDPH

- Howard Brown Health
- IDPH
- Illinois Public Health Association
- Lake County Health Department
- Northwestern University
- Ruth M. Rothstein CORE Center
- University of Chicago

People Living with HIV/AIDS and Community Engagement

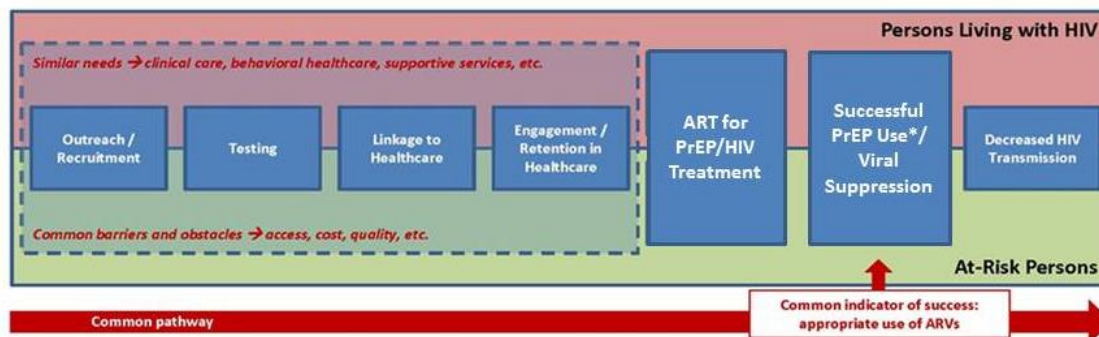
Since the beginning of the epidemic, HIV services planning in the Chicago EMA has been a collaborative process between CDPH, other public health authorities, and community groups and stakeholders. Input into the needs assessment process and service delivery has been coordinated through community councils and other stakeholder and consumer groups described above.

Leadership in this effort has been provided by CAHISC whose membership is representative and inclusive of all populations and geographic areas in the Chicago EMA. CAHISC bylaws ensure parity, inclusion, and representation on the council as required by HRSA and CDC. Ongoing recruitment efforts assure the development of a membership that meets these criteria. Specifically, 33 percent of the members must be people living with HIV and at least one of the CAHISC Community Co-chairs must be living with HIV. This has been effective in assuring the involvement of people living with HIV in needs assessment and planning efforts. Members of the council are also able to recruit the involvement of people living with HIV through their networks to provide further input through community forums and data gathering activities.

Developing a New *HIV Services Portfolio* to Address existing Service Needs, Gaps and Barriers

In conceptualizing the *HIV Services Portfolio*, CAHISC and CDPH focused on the central challenge of *rapidly expanding the number of persons who achieve viral suppression and successfully use PrEP by using current level or diminished resources*. CAHISC and CDCH recognized that successful ARV use requires a connection to the healthcare system, and individuals, regardless of HIV status, must walk through a series of common steps to be prescribed ARV and successfully use them. This is described as the ARV Pathway. Figure 17 illustrates the pathway.

Figure 17: CDPH/CAHISC ARV Pathway



To achieve the identified outcomes by rapidly expanding use of ARVs for HIV treatment and PrEP via the ARV Pathway, the approach must strengthen existing programs, services, and activities that effectively serve clients, while, at the same time, scaling back or stopping efforts that are not effective. Programs, services, and activities must also be organized into a comprehensive, coordinated system of care that focuses on supporting successful ARV use for both individuals and populations. This is the heart of the *HIV Services Portfolio*.

In late 2016, CDPH was eager to work with CAHISC to create a forward-thinking plan to reduce new HIV infections in the EMA. In hindsight, CDPH has identified critical oversights which delayed implementation efforts but increased CAHISC and community participation in the development and ownership of the planned *HIV Services Portfolio*.

Initially, CDPH didn't clearly delineate roles and responsibilities between CAHISC and CDPH and did not adequately acknowledge the ambiguity and anxiety created by the evolving development of the *HIV Services Portfolio*. CDPH had embraced an organic process and evolution of ideas but did not communicate clearly enough why they wanted to change the current service delivery system and what it would look like.

As the ideas were evolving and the shape of the *HIV Services Portfolio* changing, it was often very difficult for CAHISC members to explain what was evolving. As a result, CAHISC members and the council itself received criticism and pressure from communities, service providers, and agencies they represented about perceived threats to their current resources and the care they were providing and receiving. Incomplete information caused anxiety to turn to fear and anger toward both CDPH and CAHISC.

Honoring and responding to community feedback, CDPH and CAHISC agreed to extend planning conversations before making changes to the system, and all existing HIV prevention, care and treatment, and housing contracts were extended thru 2018 to provide additional time for gathering and incorporating community and stakeholder input. CDPH affirmed that the *HIV Services Portfolio* would be developed with guidance and direction from CAHISC and community members and organizations and acknowledged that many current services lead to positive outcomes and would be incorporated into the new portfolio. In 2017, CAHISC sponsored community forums and focus groups to gather and incorporate additional feedback. Information about and outcomes from these forums and focus groups can be found in Section I of the Integrated Plan.

2019 HIV Services Portfolio Funding

Once finalized, CDPH developed a funding rubric for the *HIV Services Portfolio* based on input from CAHISC and the 25 months of community engagement described in Section I of the Integrated Plan. Responding to the concerns of community participants, the *HIV Services Portfolio* preserves activities and services that are effective, while implementing new approaches that accelerate progress towards the goals of Getting to Zero. To further support the transition to the new *HIV Services Portfolio*, CDPH met with all of its current delegates/sub-recipients to discuss changes. CDPH was also able to provide funding to HIV prevention agencies to support infrastructure and capacity development to ready them for the transition to the *HIV Services Portfolio*.

PSRA Process: In 2018, CAHISC adapted its PSRA process mandated by Ryan White to align with the components of the *HIV Services Portfolio*. The PSRA process was conducted to allow maximum input from the entire body of CAHISC membership in order to determine how services would be prioritized and funding allocated.

For the first-time, CAHISC was asked by CDPH to consider all HIV services funding sources in the PSRA process. Ryan White funding will continue to support approved service categories, often already bundled in contracts or through partnerships, to not disrupt service delivery. Where possible, local and federal HIV and STI prevention funds will be integrated with Ryan White funds. This will support expanded access to PrEP by building on the comprehensive organizational backbone created by the Ryan White Program. Housing services for persons in HOPWA will likely look very similar to current services but will be more closely coordinated with all other HIV services. The integration of funding follows all funding criteria and restrictions of federal agencies overseeing HIV funding in the EMA, including HRSA (Ryan White Part A and MAI), CDC (HIV Prevention and STD Prevention), and HUD (HOPWA).

The 2019 HIV Services Portfolio includes four focus areas and several programmatic categories and funding opportunities. Figure 17 provides a summary of *HIV Services Portfolio* funding opportunities, available funding, and funding sources.

Healthcare Access

The Healthcare Access focus area is directed to preserving what works while enhancing new approaches. Ten Funding opportunities under Healthcare Access will support comprehensive, coordinated clinical and supportive services that promote the use of ARVs for HIV treatment and PrEP.

➤ Funding opportunity: PCHH

PCHH will provide comprehensive clinical and essential support services for persons living with and vulnerable to HIV. PCHH are modeled on services that have been developed in other Ryan White Programs and include existing Ryan White and prevention services. PCHH will prioritize comprehensive approaches to healthcare engagement, instead of siloed services and extend benefits to non-Ryan-White-eligible persons living with HIV and persons vulnerable to HIV infection. This will reduce barriers associated with healthcare navigation and promote patient choice and flexibility, in combination with other Healthcare Access funding opportunities.

PCHH will be required to provide services in each of the following categories: outreach and recruitment, HIV testing, linkage to healthcare, engagement/retention in healthcare, primary care and/or HIV-related medical care, medication adherence, STI screening and treatment, mental health services, substance use disorder services, and direct provision of or referral to employment assistance, nutrition services, vision services, oral healthcare, specialty medical care, and hormone therapy.

➤ Funding opportunity: PCHH for persons living with HIV who have complex medical/behavioral needs (PCHH-Complex)

PCHH-Complex will provide comprehensive clinical and essential support services for persons living with HIV who are chronically disconnected from care and/or who have chronically high HIV viral loads. PCHH-Complex will provide all services referenced under PCHH, along with services to better engage individuals with complex needs.

- Funding opportunity: Highly targeted HIV screening and linkage to care
Funds will provide highly targeted HIV screening and linkage to HIV treatment and PrEP via PCHH or other healthcare providers for newly diagnosed persons, previously diagnosed persons, and persons vulnerable to HIV.
- Funding opportunity: Essential supportive services
Funds will provide non-clinical essential support services for persons living and vulnerable to HIV. Services will support successful ARV use by connecting individuals to HIV PrEP or HIV treatment via PCHH or other healthcare providers. Essential Supportive Services will be required to provide services in each of the following categories: outreach and recruitment, HIV testing, linkage to healthcare, engagement/retention in healthcare, and direct provision of or referral to other needed supportive services, including STI screening and treatment, mental health services, substance use disorder services, and employment assistance.
- Funding opportunity: HIV primary care
Funds will provide primary care and/or HIV-related medical care, medication adherence, and STI screening and treatment for persons living with and vulnerable to HIV. Services will support ARV by providing direct HIV PrEP medical care and HIV medical care and treatment.
- Funding opportunity: Legal services
Funds will provide legal services for persons living with and vulnerable to HIV to support successful ARV use for HIV PrEP and HIV treatment.
- Funding opportunity: Foodbank
Funds will provide food to persons living with and vulnerable to HIV in support of successful ARV use for HIV PrEP and HIV treatment.
- Funding opportunity: Financial assistance
Funds will provide financial support (emergency financial, emergency housing, and transportation) for persons living with and vulnerable to HIV to support successful use of ARVs for HIV PrEP and HIV treatment.
- Funding opportunity: Medical case management
Funds will provide system-wide coordination of medical case management services for persons living HIV. Services will support successful ARV use by connecting individuals to HIV treatment via PCHH or other healthcare providers and supporting medication adherence.
- Funding opportunity: HIV screening in healthcare settings
The funding opportunity under HIV Screening in Healthcare Settings will implement routine, opt-out HIV screening in healthcare institutions.

Health Equity

The Health Equity focus area will examine root causes of HIV health disparity to create strategies that mitigate harms associated with institutional and structural barriers to healthcare with an emphasis on

ARV use for HIV treatment and PrEP. Six funding opportunities will support efforts to promote Health Equity.

Community Development

Funding opportunities under Community Development will address the intersections of HIV and social determinants of health in four highly impacted communities. An additional funding opportunity will support comprehensive evaluation of these initiatives. Community Development projects are to be designed to provide comprehensive HIV-related prevention services for people vulnerable to HIV through community-level HIV prevention activities. Funded projects must include partnerships between communities, community organizations or coalitions, and evaluators. Partnerships will assess root causes of HIV disparities caused by social determinants, seek solutions from community members to address root causes, develop systems-level interventions to reduce disparities at a population level, implement and evaluate interventions, and disseminate findings.

- Funding Opportunity: Black gay, bisexual, and other MSM
- Funding Opportunity: Latino gay, bisexual, and other MSM
- Funding Opportunity: Cisgender Black heterosexual women
- Funding Opportunity: Transgender persons
- Funding Opportunity: Evaluation

Services for Persons Who Use Drugs

Funds will support the delivery of health and harm reduction services for persons who use drugs, including, but not limited to, needle/syringe exchange, HIV and HCV testing and linkage to care, overdose prevention, and direct provision of or referral to primary medical care and other substance use disorder services. One funding opportunity will be released.

- Funding Opportunity: Services for Persons Who Use Drugs

Housing

Two Funding opportunities under Housing will provide housing for persons living with and vulnerable to HIV.

- Funding opportunity: Housing for persons living with HIV
- Funding opportunity: Housing for persons vulnerable to HIV

How-to

Marketing

A single funding opportunity under Marketing will develop and deploy cohesive and consistent HIV/STI health marketing campaigns. Funds will support development of brand/identity and one to two branded campaigns, annually, at least one of which will promote use of ARVs for HIV treatment and/or HIV PrEP.

- Funding opportunity: Marketing

Resource Coordination

A single funding opportunity under Resource Coordination will create a comprehensive resource center that provides information about and direct linkage to HIV services for people living with and vulnerable to HIV.

- Funding opportunity: Resource Coordination

Figure 18: 2019 *HIV Services Portfolio* Funding Opportunities, Funding Amounts, and Funding Sources

Funding Opportunity	Funding Amount	Funding Sources
HEALTHCARE ACCESS (HCA)		
HCA – PCHH	\$11,857,025	Ryan White Part A (RW-A), CDC HIV Prevention (CDC-HIV), CDC STD Prevention (CDC-STD), Corporate
HCA – PCHH-Complex	\$2,100,000	Ryan White Minority AIDS Initiative
HCA – Targeted Screening/Linkage	\$800,000	RW-A
HCA – Essential Support	\$1,348,075	RW-A, CDC-HIV
HCA – Primary Care	\$700,000	RW-A, Corporate
HCA – Legal	\$875,000	RW-A, Corporate
HCA – Food	\$975,000	RW-A, Corporate
HCA – Financial Assistance	\$1,050,000	RW-A, Corporate
HCA – MCM	\$4,557,900	RW-A, Corporate
HIV Screening in Healthcare	\$1,000,000	RW-A, Corporate
HEALTH EQUITY		
Community Development	\$1,200,000	CDC-HIV
Services for Persons who Use Drugs	\$800,000	Corporate
HOUSING		
Housing PLWH	\$6,078,000	HOPWA
Housing Vulnerable	\$750,000	Corporate
HOW-TO		
Marketing	\$1,000,000	RW-A, CDC-HIV, CDC-STD, Corporate
Resource Coordination	\$1,550,000	RW-A, CDC-HIV, HOPWA
Total	\$36,641,000	

Section III: Monitoring and Improvement

The Integrated Plan will serve as a guide to implementing services that effectively address the identified needs of those impacted by HIV. The Integrated Plan will align services and resources to meet the goals of NHAS and the vision of Getting to Zero. Integrated Plan implementation will not only involve CDPH and CAHISC, but community partners and stakeholders who provide HIV prevention, care and treatment, and housing services throughout the Chicago EMA. Successful implementation requires careful CDPH monitoring, with continued oversight by the CAHISC, and regular advice from other stakeholders. CDPH will continue to work with and participate in the activities of these planning and advisory groups to engage them in Integrated Plan implementation, update them on progress, solicit their advice, and use their feedback to make improvements as necessary to respond needs and barriers.

Monitoring and Evaluating Goals and Objectives

Implementation of the Integrated Plan's goals and objectives will be monitored through regular reports to CAHISC, and progress toward achieving the objectives will be evaluated annually for both process and outcomes. To support implementation of the *HIV Services Portfolio*, CAHISC revamped its committee structure to match primary portfolio components – Healthcare Access, Community Development (Health Equity), and Housing. Similarly, CDPH is in the process of revamping its HIV/STI Bureau organizational structure to match these components, creating a Healthcare Access Team, a Community Development Team, and a Housing Team. Leadership from these three teams serve as liaisons to respective CAHISC committees, creating an intentional and bidirectional process for providing information, receiving and responding to feedback, and incorporating feedback into the *HIV Services Portfolio*. Additionally, the Getting to Zero Illinois planning group has identified the same committee structure – Healthcare Access, Health Equity (Social Determinants of Health), and Housing, creating synergy in statewide HIV planning efforts.

Process and outcome evaluation will follow the data indicators and data targets described in the work plan (Appendix 3). Primary indicators include new HIV diagnoses, linkage to care, re-engagement in care, viral suppression, linkage/referral to PrEP, PrEP prescribing, and housing. Additional qualitative indicators will be collected through the Community Development projects.

Beginning in 2019, CDPH will begin collecting all Ryan White client level data electronically from subcontracted providers through the Provide® system. This will enable CDPH to better track persons living with HIV in the same system, rather than having multiple data systems that are unable to communicate with each other. Provide allows sub-contracted providers to input client and service utilization data directly into the system, which will provide CDPH with direct access to the data in real time. Through program entries into the data system, CDPH will track all HRSA-required measures, which will continue to be used for quality management. CD4 and viral load testing, client diagnosis, co-infections, and HAV/HBV vaccines are reported and monitored through the electronic data system, which allows CDPH to track and benchmark progress in the HIV care continuum. In addition to HRSA variables, CDPH may use Provide®, in conjunction with Evaluation Web and the Chicago Information Management System, to collect CDC- and HOPWA-required variables.

Additionally, CDPH will be awarding evaluation and quality management (QM) contracts through the *HIV Service Portfolio*. One contract will support evaluation of the Healthcare Access initiatives, including PCHH. The external evaluator will support the development of organizational logic models, evaluation plans, and evaluation tools. A second contract will support QM of CDPH-funded HIV services to ensure that services, across Ryan White, prevention, and housing, are implemented in a manner that leads to achievement of goals and provision of high quality services. A third contract will support program development and evaluation of the Community Development initiatives, including the development of a continuous quality improvement process to identify and address issues as the implementation proceeds. The contractors will meet with CDPH regularly to provide updates on factors that promote successful completion of objectives, strategies, and activities, and barriers that inhibit progress.

Using Data to Improve Health Outcomes

CDPH and CAHISC will continue to routinely review HIV/STI surveillance data, data from MMP and NHBS, and program evaluation data (client-level) to monitor Integrated Plan implementation and to track and improve health outcomes along the HIV care continuum. Monitoring those outcomes will allow CDPH to identify patterns of need, disparities, and other barriers to viral suppression and successful PrEP use. If there are significant shifts, objectives and strategies may be modified as necessary.

Improving health outcomes along the HIV care continuum will be grounded in the existing QM program and other quality improvement (QI) efforts. The Chicago Ryan White Part A QM Program includes the following key components:

- Involvement of people living with HIV in service evaluation.
- Collaboration with stakeholders on program initiatives.
- Analysis of performance and outcome data.
- Ongoing identification of quality improvement strategies.
- Monitoring standards of care and performance measures.
- Providing guidance and technical assistance.

As noted above, CDPH will be developing similar QM and QI efforts for services and activities funded through city corporate funds, CDC HIV and STD prevention funds, and HOPWA funds.

Conclusion

The Integrated Plan for the Chicago EMA is the product of several years of collaboration between CDPH and CAHISC to implement an integrated response to the epidemic. The Integrated Plan represents the leadership and vision of public and private HIV prevention, care and treatment, and housing stakeholders across the EMA and incorporates the experience and guidance of people living with and vulnerable to HIV and the communities most impacted by the epidemic.

The Integrated Plan responds to the guiding principles defined in NHAS and Getting to Zero Illinois in order to reduce new infections and increase access to care while addressing the disparities in resources and outcomes which exist in highly impacted communities and populations. The Integrated Plan describes the development and initiation of the *HIV Services Portfolio*, a new model of service delivery

designed to accelerate progress in efforts to reduce new HIV infections through integrating planning and funding for HIV prevention, care and treatment, and housing services.

The Integrated Plan describes the ongoing commitment and collaboration of CDPH and its community partners to assess the changing needs of the epidemic and adapt an integrated system of services to meet the increasing complexity of needs in an environment of diminishing resources. The Integrated Plan is developed with clear knowledge that innovation is necessary and needs to be evaluated and monitored on an ongoing basis. This Integrated Plan not only demonstrates the commitment of stakeholders within the EMA to develop an integrated response but also represents their ongoing commitment to collaboration that will assure that resources are focused where they are most needed and always in support of an end to the HIV epidemic.

2014

CHICAGO EMA HIV/AIDS PROFILE



Chicago Department of Public Health | HIV/STI Bureau
February 2016

Profile Information:

Chicago Department of Public Health. Chicago EMA HIV/AIDS Profile, 2014. Chicago, IL. 60604. 2/24/16.

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EMA as of 2014 vs NHAS 2020 Indicators [these are estimates, DO NOT CITE]

INDICATORS AT-A-GLANCE

	INDICATOR 1	Increase the percentage of people living with HIV who know their serostatus to at least 90 percent .
	INDICATOR 2	Reduce the number of new diagnoses by at least 25 percent .
	INDICATOR 3	Reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by at least 10 percent .
	INDICATOR 4	Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent .
	INDICATOR 5	Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent .
	INDICATOR 6	Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80 percent .
	INDICATOR 7	Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent .
	INDICATOR 8	Reduce the death rate among persons with diagnosed HIV infection by at least 33 percent .
	INDICATOR 9	Reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.
	INDICATOR 10	Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80 percent .

Indicator 1: Assume 84% of people with HIV know their status [estimated 5,700 undiagnosed individuals in EMA]. Would have needed to increase by 6% (2,143 individuals diagnosed) to reach 90% goal.

Indicator 2: On average: 1,370 to 1,441 new diagnoses in EMA for past 5 years [25% = 342 to 360]. Would have needed about 350 less new diagnoses.

Indicator 3: From National HIV Behavioral Surveillance (NHBS) MSM4 cycle: 52% of participants stated no condom use; 39% of participants stated used of alcohol and 3% of participants stated use of drugs during sex; 18% of participants had not been tested for HIV in the past 2 years.

Indicator 4: Currently, it takes 6 months to have 85% of new diagnosed in EMA linked into care.

Indicator 5: Currently at 43% retained. Would have needed 13,220 more individuals retained to reach 90% goal.

Indicator 6: Currently at 45% virally suppressed. Would have need 9,976 more individuals suppressed to reach 80% goal.

Indicator 7: No good estimate available

Indicator 8: A total of 1.4% of people living with HIV in the EMA in 2013 died.

Indicator 9: In EMA 2014: MSM 20x more diagnoses than IDU males and 18X more than Heterosexuals; young Black MSM 3.5x and 3x more diagnoses than young White MSM and young Hispanic MSM, respectively; Black females 7x more diagnoses than White females and 5x more than Hispanic females.

Indicator 10: Currently 38% of youth and 40% of IDU are virally suppressed. Would have needed 599 more young individuals and 1,394 IDU virally suppressed to reach 80% goal.

Notes on Methodology

Diagnoses data are presented through 2014. All AIDS and HIV data for 2014 are considered provisional. When interpreting data in this report, keep in mind that the eHARS database is updated continuously to reflect the most current and complete information on people infected and newly diagnosed with HIV or AIDS; data in this report were up-to-date as of 12/28/2015.

The “HIV Infection Diagnosis” data presented in this issue include 3 categories of diagnoses: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection with a later diagnosis of AIDS, and (3) concurrent diagnoses of HIV infection and AIDS. HIV cases include both laboratory-defined cases as well as HIV cases diagnosed by a physician without laboratory tests. AIDS represent a later stage in the HIV disease spectrum. Data from the HIV reporting system should be interpreted with caution. HIV surveillance reports may not be representative of all persons infected with HIV because not all infected persons have been tested. Rates and percentages based on twenty or fewer cases can vary widely just by random chance even when there is no meaningful statistical difference between measurements.

For surveillance purposes, HIV and AIDS cases are counted only once in a hierarchy of modes of transmission. Persons with more than one reported mode of transmission are classified in the transmission mode first in the hierarchy. The exception is men who have sex with men and also inject drugs, which has its own category. Persons whose transmission mode is classified as male-to-male sexual contact (MSM) include men who report sexual contact with other men and men who report sexual contact with both men and women. Persons whose mode of transmission is classified as heterosexual contact are persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injection drug user).

Because many cases of HIV infection and AIDS are initially reported without a defined mode of transmission, we use multiple imputation to assign a mode of transmission for these cases. Multiple imputation is a statistical approach in which each missing mode of transmission is replaced with a set of plausible values that represent the uncertainty about the true, but missing, value. The plausible values are analyzed by using standard procedures, and the results from these analyses are then combined to produce the final results. Multiple imputation is used by the Centers for Disease Control and Prevention (CDC) in their national HIV Surveillance Report.

Cases reported here are inclusive of those aged <13 yrs to those 60+ years. Case numbers less than 5 have not been suppressed in this report since it is inclusive of the entire EMA and the cases are not specifically identified by area.

Terminology Review

Rate = a measure of the frequency of an event occurring in a defined population in a defined time

Ex: The number of litters per 100,000 dogs in one year

Proportion = No time component

Ex: The number of dogs < 2 years old in Chicago/ Total number of dogs in Chicago

Ratio = Comparison

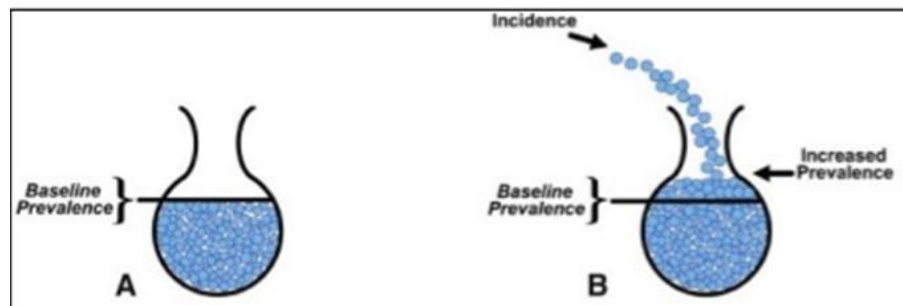
Ex: The number of female dogs in Chicago: the number of male dogs in Chicago

Incidence = measure of change from non-disease to disease (numerator) in a population at risk (denominator)

Ex: New cases of disease

Prevalence = static measure of proportion of a population that is diseased

Ex: Existing cases of disease

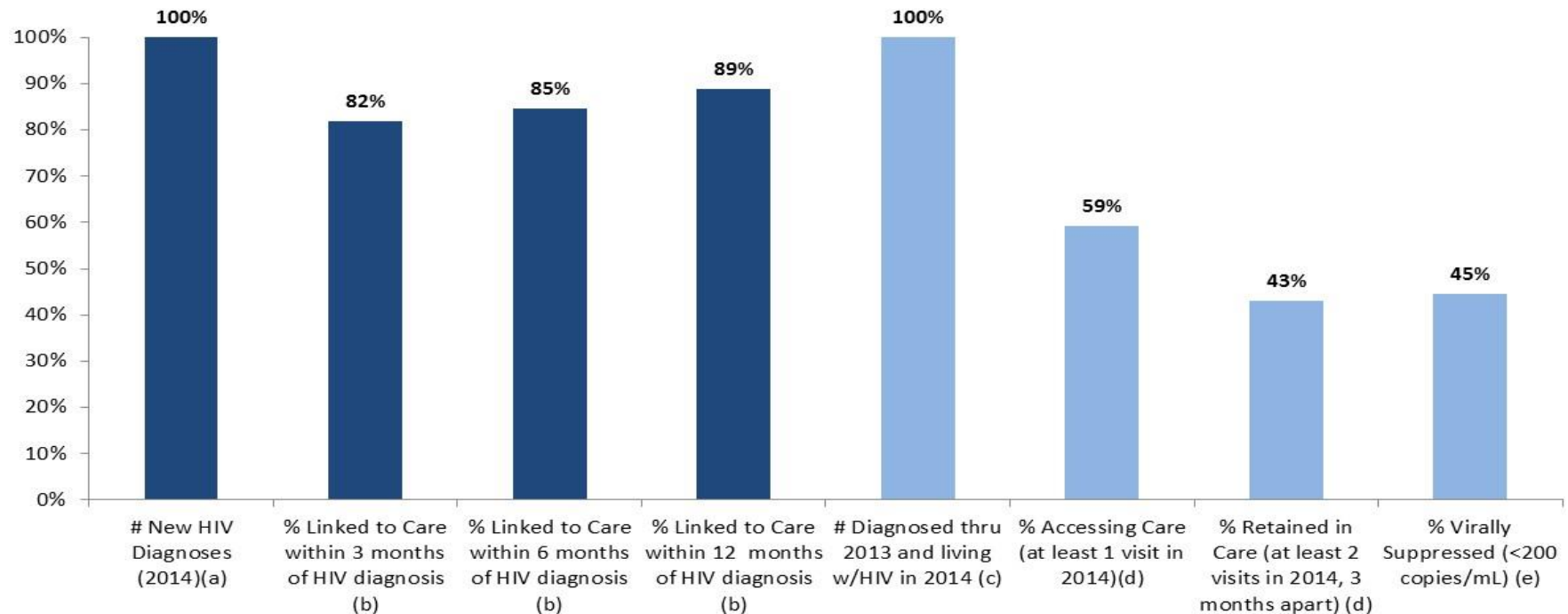


****Provisional Data ****

Enhanced HIV/AIDS Reporting System (eHARS) is constantly being updated.

The data you are seeing today were up to date **as of 12/28/2015**.

Figure 1. HIV Continuum of Care among Cases, Chicago EMA 2014 (as of 12/28/2015)



^aNumber of persons ≥13 years of age at diagnosis and diagnosed with HIV infection between 1/1/2014 and 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

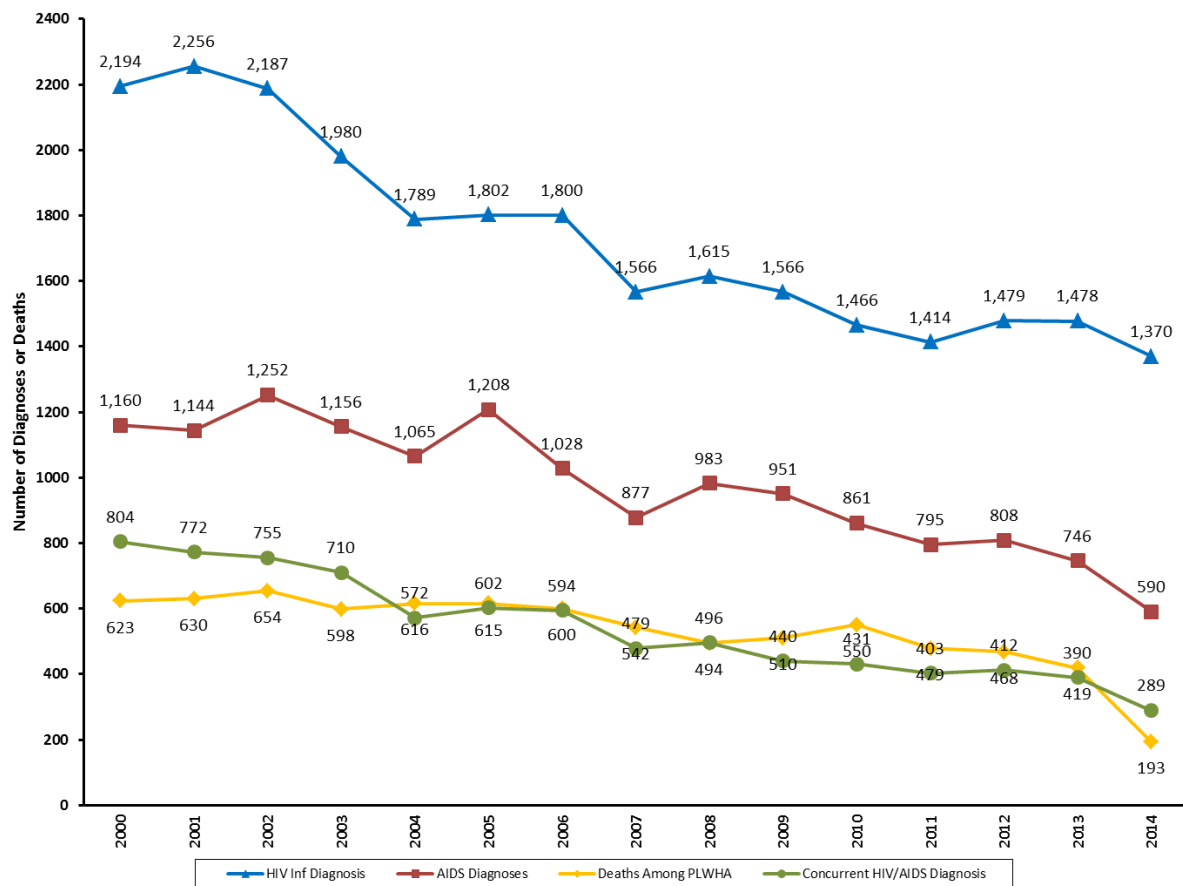
^bPercent of persons ≥13 years of age linked to care (at least one CD4 or VL) within 3, 6, and 9 months of HIV diagnosis among those diagnosed with HIV infection from 1/1/2014 to 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

^cNumber of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 or VL1 tables.

^dPercent of HIV-infected adults who have at least one or more care visit between January-December 2014; Percent of HIV-infected adults who have at least two or more care visit between January-December 2014, 3 months apart. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 table.

^ePercent of persons with HIV viral suppression among number of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, VL1 table.

Figure 2. People Diagnosed with HIV Infection, Chicago EMA, 2000-2014 (as of 12/28/2015)



Years of Note:

2006 = HIV name-based reporting

2012 = All CD4 and Viral Load labs became reportable

Table 1. HIV Infections* by Year of Diagnosis and Selected Demographic Characteristics, Chicago EMA, 2010-2014 (as of 12/28/2015)

	Year of Diagnosis									
	2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%
Sex										
Male	1,198	81.7%	1,154	81.6%	1,224	82.8%	1,225	82.9%	1,157	84.5%
Female	268	18.3%	260	18.4%	255	17.2%	253	17.1%	213	15.5%
Race/Ethnicity ^										
Black, non-Hispanic	769	52.5%	713	50.4%	748	50.6%	745	50.4%	684	49.9%
White, non-Hispanic	318	21.7%	257	18.2%	314	21.2%	329	22.3%	323	23.6%
Hispanic	279	19.0%	316	22.3%	333	22.5%	321	21.7%	305	22.3%
Other¶	100	6.8%	128	9.1%	84	5.7%	83	5.6%	58	4.2%
Transmission Group										
Male Sex w/ Male	962	65.6%	960	67.9%	1,061	71.7%	1,087	73.5%	1,040	75.9%
Injection Drug Use	118	8.0%	83	5.9%	61	4.1%	50	3.4%	50	3.6%
MSM and IDU§	41	2.8%	49	3.5%	36	2.4%	33	2.2%	31	2.3%
Heterosexual	338	23.1%	315	22.3%	292	19.7%	286	19.4%	242	17.7%
Other¶	8	0.5%	7	0.5%	28	1.9%	22	1.5%	8	0.6%
Age Category†										
< 13	6	0.4%	3	0.2%	14	0.9%	9	0.6%	7	0.5%
13-19	74	5.0%	86	6.1%	91	6.2%	68	4.6%	76	5.5%
20-29	475	32.4%	480	33.9%	505	34.1%	577	39.0%	565	41.2%
30-39	383	26.1%	328	23.2%	375	25.4%	348	23.5%	317	23.1%
40-49	314	21.4%	297	21.0%	273	18.5%	264	17.9%	233	17.0%
50-59	166	11.3%	164	11.6%	157	10.6%	156	10.6%	122	8.9%
60+	48	3.3%	56	4.0%	64	4.3%	56	3.8%	50	3.6%
Total	1,466	100.0%	1,414	100.0%	1,479	100.0%	1,478	100.0%	1,370	100.0%

Note: Groups may not total 100% due to rounding; values <0.5 are rounded to zero. 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 12/28/2015. ^Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. §Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NIR. †Age at time of diagnosis.

Table 1. HIV Infection Diagnoses* in 2014, Chicago EMA (as of 12/28/2015)

		Race/Ethnicity [^]									
		Black, NH		White, NH		Hispanic		Other, NH		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
Males	Mode of Transmission										
	Male Sex w/Male	472	88.9%	271	90.0%	254	92.0%	41	83.7%	1,040	89.9%
	Injection Drug Use	16	3.0%	7	2.3%	3	1.1%	1	2.0%	26	2.2%
	MSM and IDU [§]	10	1.9%	13	4.3%	6	2.2%	2	4.1%	31	2.7%
	Heterosexual	32	6.0%	8	2.7%	13	4.7%	5	10.2%	58	5.0%
	Other [¶]	1	0.2%	2	0.7%	0	0.0%	0	0.0%	3	0.3%
	Age category[†]										
	< 13	1	0.2%	1	0.3%	0	0.0%	0	0.0%	2	0.2%
	13-19	50	9.4%	4	1.3%	7	2.5%	4	8.2%	65	5.6%
	20-29	290	54.6%	90	29.9%	115	41.7%	23	46.9%	518	44.8%
	30-39	85	16.0%	80	26.6%	90	32.6%	12	24.5%	267	23.1%
	40-49	61	11.5%	67	22.3%	47	17.0%	6	12.2%	181	15.6%
	50-59	31	5.8%	42	14.0%	11	4.0%	3	6.1%	87	7.5%
	60+	13	2.4%	17	5.6%	6	2.2%	1	2.0%	37	3.2%
Total Males		531	100.0%	301	100.0%	276	100.0%	49	100.0%	1,157	100.0%
Females	Mode of Transmission										
	Injection Drug Use	17	11.1%	5	22.7%	2	6.9%	0	0.0%	24	11.3%
	Heterosexual	131	85.6%	17	77.3%	27	93.1%	9	100.0%	185	86.9%
	Other [¶]	5	3.3%	0	0.0%	0	0.0%	0	0.0%	5	2.3%
	Age category[†]										
	< 13	5	3.3%	0	0.0%	0	0.0%	0	0.0%	5	2.3%
	13-19	11	7.2%	0	0.0%	0	0.0%	0	0.0%	11	5.2%
	20-29	34	22.2%	4	18.2%	7	24.1%	2	22.2%	47	22.1%
	30-39	32	20.9%	7	31.8%	8	27.6%	3	33.3%	50	23.5%
	40-49	40	26.1%	5	22.7%	5	17.2%	2	22.2%	52	24.4%
	50-59	20	13.1%	6	27.3%	8	27.6%	1	11.1%	35	16.4%
	60+	11	7.2%	0	0.0%	1	3.4%	1	11.1%	13	6.1%
Total Females		153	100.0%	22	100.0%	29	100.0%	9	100.0%	213	100.0%
Total		684	49.9%	323	23.6%	305	22.3%	58	4.2%	1,370	100.0%

Note: Groups may not total 100% due to rounding; values <0.5 are rounded to zero. 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 12/28/2015. **Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender, independently of values using birth sex, total diagnoses values may differ slightly across tables. ^Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. §Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NIR. †Age at time of diagnosis.

Table 2. People Living with HIV Infection (PLWH)* in 2013, Chicago EMA (as of 12/28/2015)

		Race/Ethnicity [^]									
		Black, NH		White, NH		Hispanic		Other, NH		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
Males	Mode of Transmission										
	Male Sex w/Male	6,823	66.7%	6,413	84.1%	3,584	75.3%	1,148	77.8%	17,969	75.5%
	Injection Drug Use	1,592	15.6%	234	3.1%	428	9.0%	86	5.8%	2,340	9.8%
	MSM and IDU [§]	782	7.6%	379	5.0%	320	6.7%	134	9.1%	1,616	6.8%
	Heterosexual	885	8.6%	184	2.4%	384	8.1%	96	6.5%	1,548	6.5%
	Other [¶]	151	1.5%	58	0.8%	41	0.9%	12	0.8%	262	1.1%
	Age category[†]										
	< 13	40	0.4%	3	0.0%	6	0.1%	1	0.1%	50	0.2%
	13-19	135	1.3%	11	0.1%	24	0.5%	5	0.3%	175	0.7%
	20-29	1,783	17.4%	391	5.1%	567	11.9%	169	11.5%	2,910	12.2%
	30-39	1,818	17.8%	1,005	13.2%	1,169	24.6%	316	21.4%	4,308	18.1%
	40-49	2,523	24.7%	2,401	31.5%	1,608	33.8%	478	32.4%	7,010	29.5%
	50-59	2,700	26.4%	2,422	31.7%	979	20.6%	378	25.6%	6,479	27.2%
	60+	1,234	12.1%	1,036	13.6%	405	8.5%	128	8.7%	2,803	11.8%
Total Males		10,233	100.0%	7,629	100.0%	4,758	100.0%	1,475	100.0%	23,795	100.0%
Females	Mode of Transmission										
	Injection Drug Use	1,132	26.2%	227	33.0%	162	17.2%	79	27.1%	1,599	25.6%
	Heterosexual	3,023	70.0%	432	62.9%	748	79.6%	199	68.4%	4,402	70.6%
	Other [¶]	165	3.8%	28	4.1%	30	3.2%	14	4.8%	237	3.8%
	Age category[†]										
	< 13	31	0.7%	6	0.9%	5	0.5%	7	2.4%	49	0.8%
	13-19	98	2.3%	7	1.0%	12	1.3%	5	1.7%	122	2.0%
	20-29	502	11.6%	40	5.8%	78	8.3%	20	6.9%	640	10.3%
	30-39	881	20.4%	105	15.3%	220	23.4%	63	21.6%	1,269	20.3%
	40-49	1,317	30.5%	218	31.7%	315	33.5%	85	29.2%	1,935	31.0%
	50-59	1,081	25.0%	215	31.3%	211	22.4%	78	26.8%	1,585	25.4%
	60+	410	9.5%	96	14.0%	99	10.5%	33	11.3%	638	10.2%
Total Females		4,320	100.0%	687	100.0%	940	100.0%	291	100.0%	6,238	100.0%
Total		14,553	48.6%	7,956	26.5%	5,698	19.0%	1,766	5.9%	29,973	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. *All persons diagnosed with HIV, from the beginning of the epidemic through 12/31/2012 and living through 12/31/2013, as of 12/28/2015. **Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender, independently of values using birth sex, total diagnoses values may differ slightly across tables. ^Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. §Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NIR. †Age at time of diagnosis.

Table 3. AIDS* Cases in 2014, Chicago EMA (as of 12/28/2015)

		Race/Ethnicity [^]									
		Black, NH		White, NH		Hispanic		Other, NH		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
Males	Mode of Transmission										
	Male Sex w/Male	167	76.6%	81	83.5%	86	81.9%	19	65.5%	354	78.8%
	Injection Drug Use	18	8.3%	4	4.1%	6	5.7%	1	3.4%	28	6.2%
	MSM and IDU ^{\$}	8	3.7%	4	4.1%	5	4.8%	3	10.3%	21	4.7%
	Heterosexual	20	9.2%	8	8.2%	7	6.7%	6	20.7%	41	9.1%
	Other [¶]	4	1.8%	0	0.0%	1	1.0%	0	0.0%	5	1.1%
	Age category[†]										
	< 13	2	0.9%	0	0.0%	0	0.0%	0	0.0%	2	0.4%
	13-19	8	3.7%	1	1.0%	0	0.0%	0	0.0%	9	2.0%
	20-29	67	30.7%	12	12.4%	28	26.7%	7	24.1%	114	25.4%
	30-39	51	23.4%	13	13.4%	39	37.1%	9	31.0%	112	24.9%
	40-49	37	17.0%	34	35.1%	23	21.9%	6	20.7%	100	22.3%
	50-59	37	17.0%	25	25.8%	10	9.5%	7	24.1%	79	17.6%
	60+	16	7.3%	12	12.4%	5	4.8%	0	0.0%	33	7.3%
Total Males		218	100.0%	97	100.0%	105	100.0%	29	100.0%	449	100.0%
Females	Mode of Transmission										
	Injection Drug Use	23	22.1%	3	37.5%	4	20.0%	1	11.1%	31	22.0%
	Heterosexual	76	73.1%	5	62.5%	15	75.0%	7	77.8%	103	73.0%
	Other [¶]	5	4.8%	0	0.0%	1	5.0%	1	11.1%	7	5.0%
	Age category[†]										
	< 13	2	1.9%	0	0.0%	0	0.0%	0	0.0%	2	1.4%
	13-19	3	2.9%	0	0.0%	1	5.0%	1	11.1%	5	3.5%
	20-29	15	14.4%	0	0.0%	3	15.0%	0	0.0%	18	12.8%
	30-39	23	22.1%	2	25.0%	8	40.0%	3	33.3%	36	25.5%
	40-49	36	34.6%	0	0.0%	3	15.0%	2	22.2%	41	29.1%
	50-59	15	14.4%	6	75.0%	4	20.0%	2	22.2%	27	19.1%
	60+	10	9.6%	0	0.0%	1	5.0%	1	11.1%	12	8.5%
Total Females		104	100.0%	8	100.0%	20	100.0%	9	100.0%	141	100.0%
Total		322	54.6%	105	17.8%	125	21.2%	38	6.4%	590	100.0%

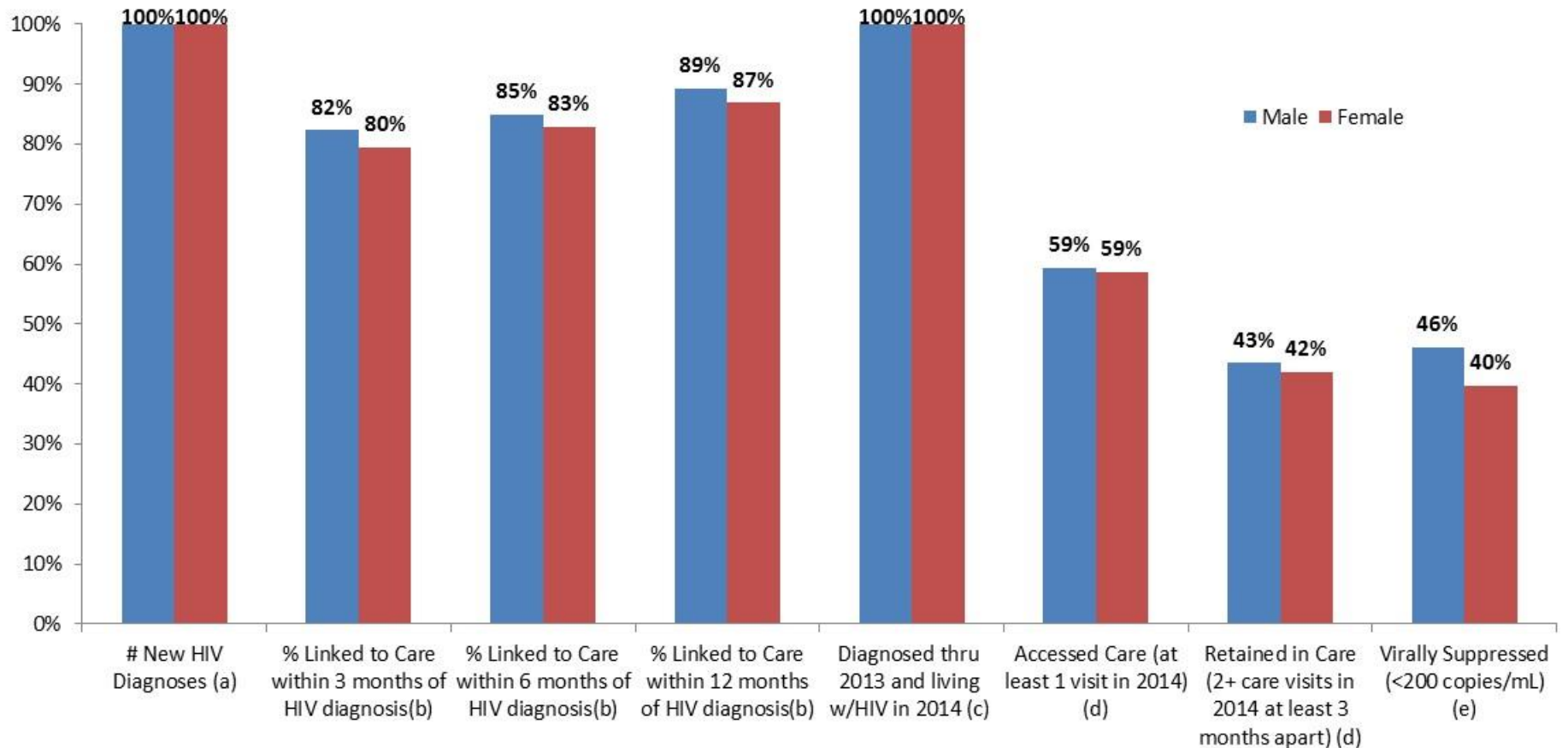
Note: Groups may not total 100% due to rounding; values <0.5 are rounded to zero. Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. *All persons diagnosed with AIDS, from the beginning of the epidemic through 12/28/15. **Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender, independently of values using birth sex, total diagnoses values may differ slightly across tables. ^Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. \$Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NIR. †Age at time of diagnosis.

Table 4. Concurrent* HIV/AIDS Cases in 2014, Chicago EMA (as of 12/28/2015)

		Race/Ethnicity [^]									
		Black, NH		White, NH		Hispanic		Other, NH		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
Males	Mode of Transmission										
	Male Sex w/Male	87	87.0%	44	77.2%	56	88.9%	10	76.9%	197	84.5%
	Injection Drug Use	6	6.0%	3	5.3%	1	1.6%	0	0.0%	9	3.9%
	MSM and IDU ^{\$}	1	1.0%	2	3.5%	2	3.2%	0	0.0%	5	2.1%
	Heterosexual	6	6.0%	8	14.0%	3	4.8%	3	23.1%	21	9.0%
	Other [¶]	1	1.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%
	Age category[†]										
	< 13	1	1.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%
	13-19	7	7.0%	1	1.8%	0	0.0%	0	0.0%	8	3.4%
	20-29	42	42.0%	10	17.5%	19	30.2%	4	30.8%	75	32.2%
	30-39	17	17.0%	11	19.3%	20	31.7%	7	53.8%	55	23.6%
	40-49	15	15.0%	17	29.8%	16	25.4%	2	15.4%	50	21.5%
	50-59	13	13.0%	11	19.3%	5	7.9%	0	0.0%	29	12.4%
	60+	5	5.0%	7	12.3%	3	4.8%	0	0.0%	15	6.4%
Total Males		100	100.0%	57	100.0%	63	100.0%	13	100.0%	233	100.0%
Females	Mode of Transmission										
	Injection Drug Use	5	13.2%	1	20.0%	0	0.0%	0	0.0%	7	12.5%
	Heterosexual	31	81.6%	4	80.0%	8	100.0%	5	100.0%	47	83.9%
	Other [¶]	2	5.3%	0	0.0%	0	0.0%	0	0.0%	2	3.6%
	Age category[†]										
	< 13	2	5.3%	0	0.0%	0	0.0%	0	0.0%	2	3.6%
	13-19	1	2.6%	0	0.0%	0	0.0%	0	0.0%	1	1.8%
	20-29	4	10.5%	0	0.0%	0	0.0%	0	0.0%	4	7.1%
	30-39	7	18.4%	2	40.0%	3	37.5%	1	20.0%	13	23.2%
	40-49	14	36.8%	0	0.0%	2	25.0%	2	40.0%	18	32.1%
	50-59	5	13.2%	3	60.0%	2	25.0%	1	20.0%	11	19.6%
	60+	5	13.2%	0	0.0%	1	12.5%	1	20.0%	7	12.5%
Total Females		38	100.0%	5	100.0%	8	100.0%	5	100.0%	56	100.0%
All HIV Infections in 2014		138	47.8%	62	21.5%	71	24.6%	18	6.2%	289	100.0%

Note: Groups may not total 100% due to rounding; values <0.5 are rounded to zero. Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. *Diagnoses represents people newly diagnosed with HIV and subsequently AIDS within a 12 month time period, through 12/28/2015. **Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender, independently of values using birth sex, total diagnoses values may differ slightly across tables. ^Multiple, non-Hispanic indicates more than one race identified; totals include cases with unknown race ethnicity. \$Men who have sex with men and inject drugs. ¶Includes perinatal transmission, blood transfusion, hemophilia, and NIR. †Age at time of diagnosis.

Figure 3. HIV Continuum of Care among Cases by Sex, Chicago EMA 2014 (as of 12/28/2015)



*Number of persons ≥13 years of age at diagnosis and diagnosed with HIV infection between 1/1/2014 and 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

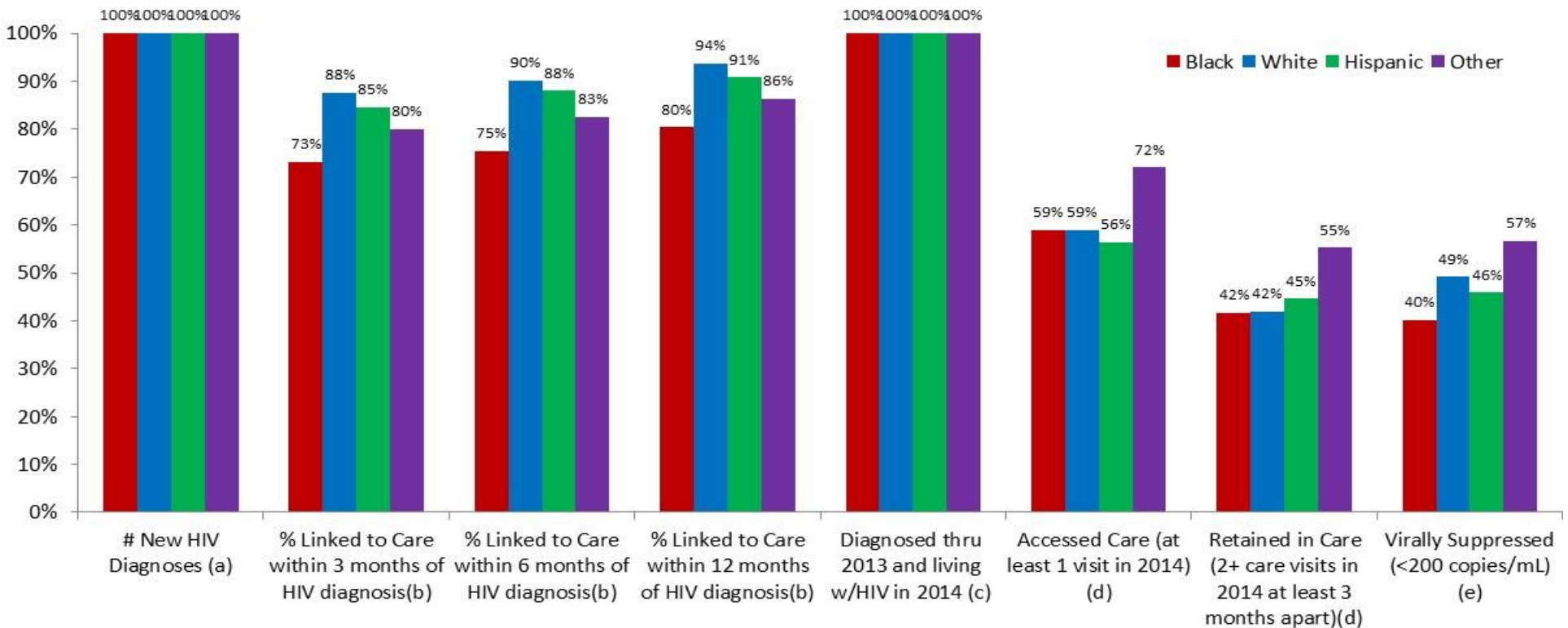
^bPercent of persons ≥13 years of age linked to care (at least one CD4 or VL) within 3, 6, and 9 months of HIV diagnosis among those diagnosed with HIV infection from 1/1/2014 to 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

^cNumber of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 or VL1 tables.

^dPercent of HIV-infected adults who have at least one or more care visit between January-December 2014; Percent of HIV-infected adults who have at least two or more care visit between January-December 2014, 3 months apart. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 table.

^ePercent of persons with HIV viral suppression among number of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, VL1 table.

Figure 4. HIV Continuum of Care among Cases by Race, Chicago EMA 2014 (as of 12/28/2015)



^aNumber of persons ≥13 years of age at diagnosis and diagnosed with HIV infection between 1/1/2014 and 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

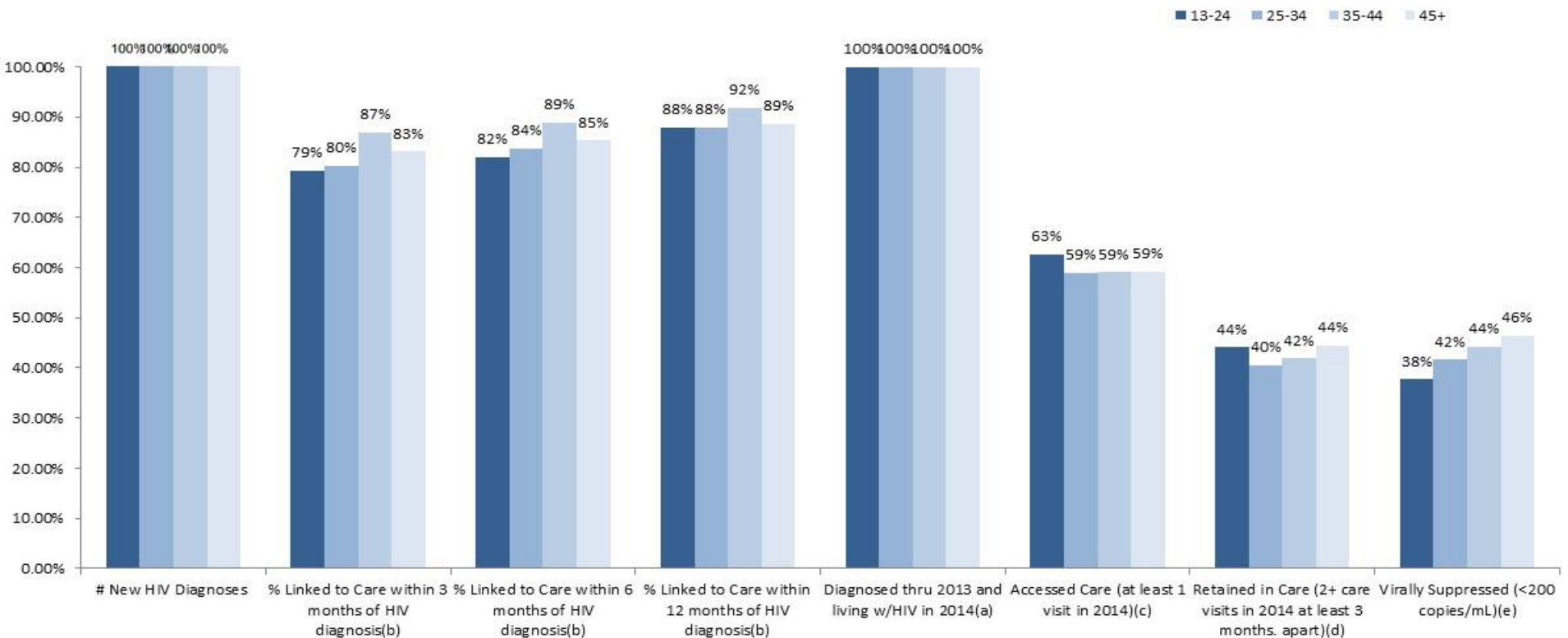
^bPercent of persons ≥13 years of age linked to care (at least one CD4 or VL) within 3, 6, and 9 months of HIV diagnosis among those diagnosed with HIV infection from 1/1/2014 to 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

^cNumber of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 or VL1 tables.

^dPercent of HIV-infected adults who have at least one or more care visit between January-December 2014; Percent of HIV-infected adults who have at least two or more care visit between January-December 2014, 3 months apart. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 table.

^ePercent of persons with HIV viral suppression among number of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, VL1 table.

Figure 5. HIV Continuum of Care among Cases by Age, Chicago EMA 2014 (as of 12/28/2015)



^aNumber of persons ≥13 years of age at diagnosis and diagnosed with HIV infection between 1/1/2014 and 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

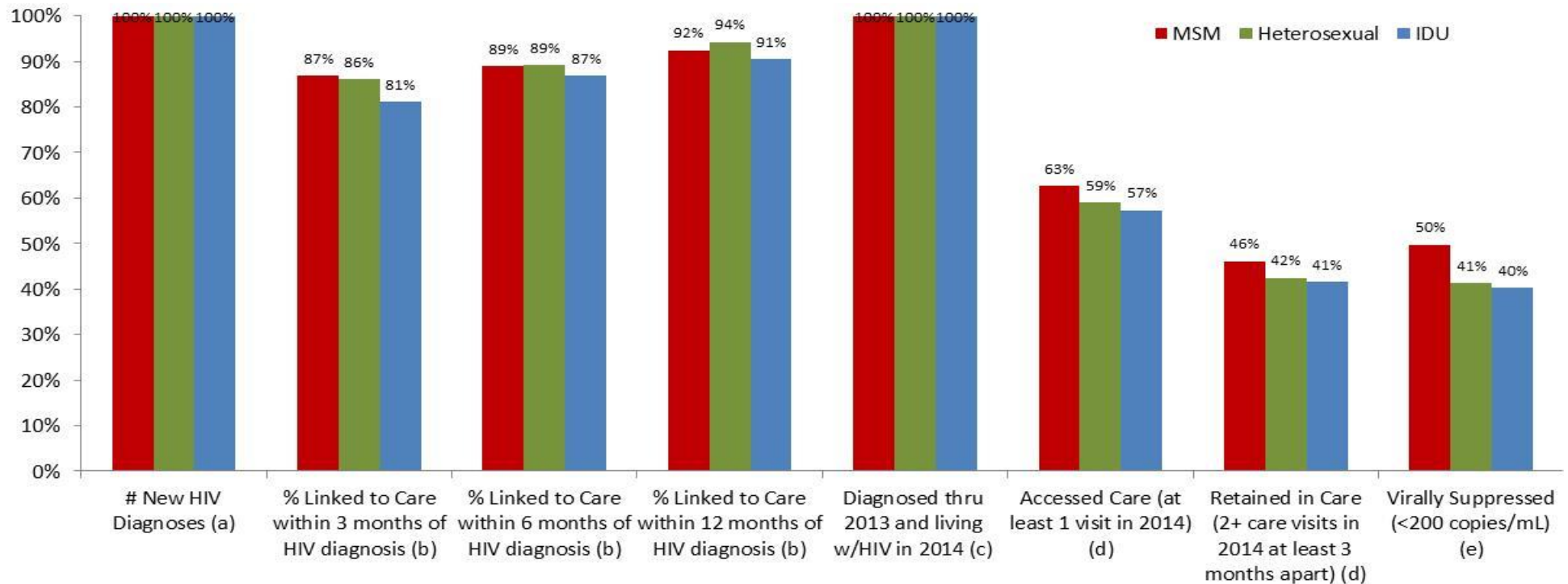
^bPercent of persons ≥13 years of age linked to care (at least one CD4 or VL) within 3, 6, and 9 months of HIV diagnosis among those diagnosed with HIV infection from 1/1/2014 to 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

^cNumber of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 or VL1 tables.

^dPercent of HIV-infected adults who have at least one or more care visit between January-December 2014; Percent of HIV-infected adults who have at least two or more care visit between January-December 2014, 3 months apart. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 table.

^ePercent of persons with HIV viral suppression among number of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, VL1 table.

Figure 6. HIV Continuum of Care among Cases by Transmission Group, Chicago EMA 2014 (as of 12/28/2015)



*Number of persons ≥13 years of age at diagnosis and diagnosed with HIV infection between 1/1/2014 and 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

^bPercent of persons ≥13 years of age linked to care (at least one CD4 or VL) within 3, 6, and 9 months of HIV diagnosis among those diagnosed with HIV infection from 1/1/2014 to 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Link1 table.

^cNumber of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 or VL1 tables.

^dPercent of HIV-infected adults who have at least one or more care visit between January-December 2014; Percent of HIV-infected adults who have at least two or more care visit between January-December 2014, 3 months apart. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, Care1 table.

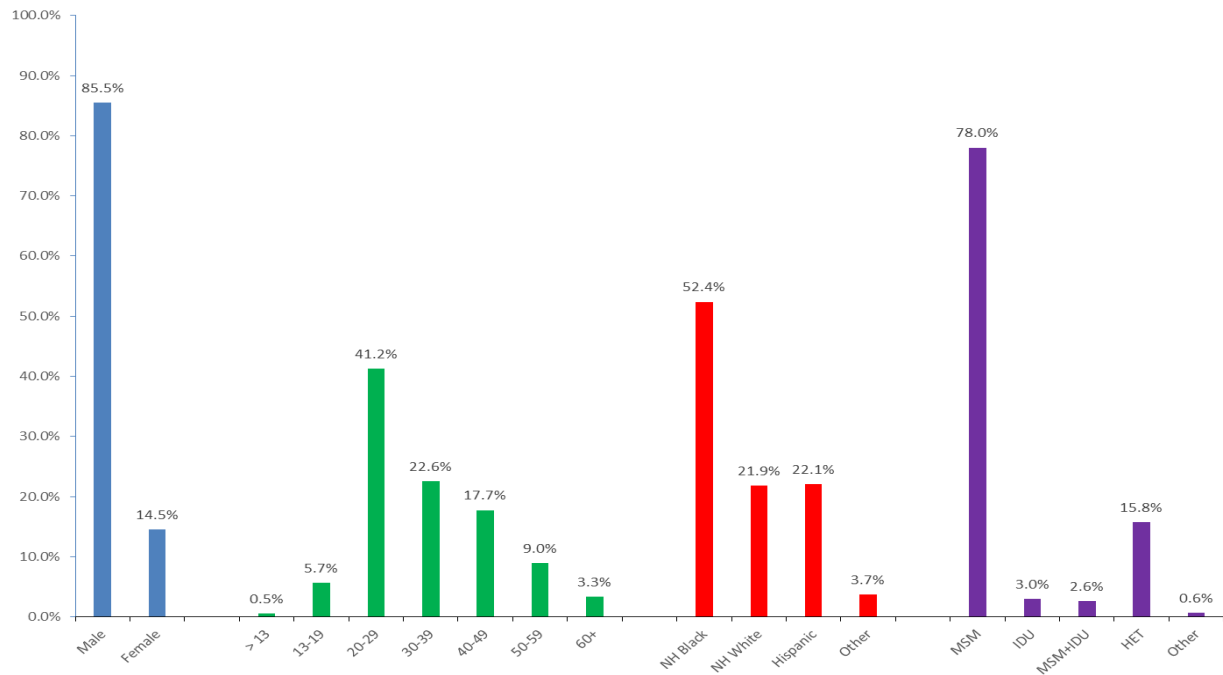
^ePercent of persons with HIV viral suppression among number of persons ≥13 years of age on 12/31/2013 diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014. Source: Chicago HIV/AIDS Reporting System (as of 12/28/2015). NHAS output, VL1 table.

EMA Area Specific Profiles

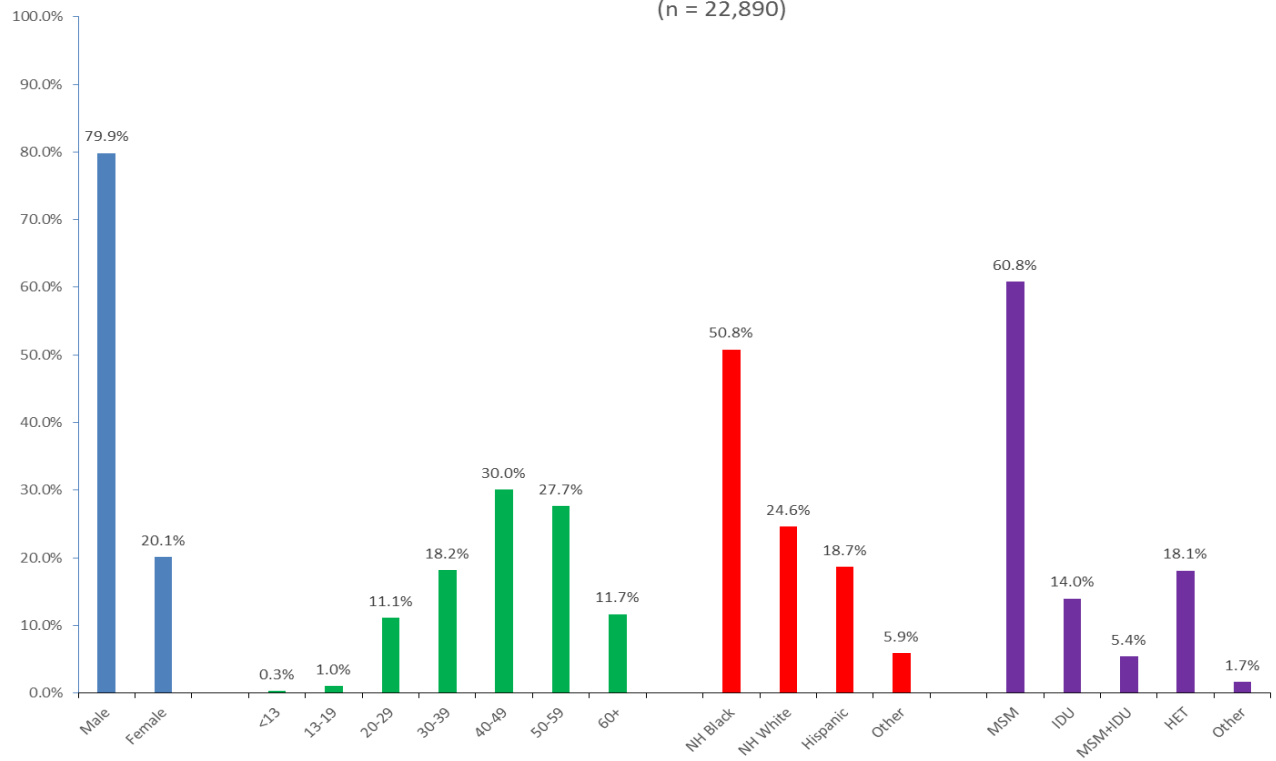
Note*: If any area had less than 15 cases reported for surveillance metric, a profile was not created. This is to ensure cases are un-identifiable.

City of Chicago

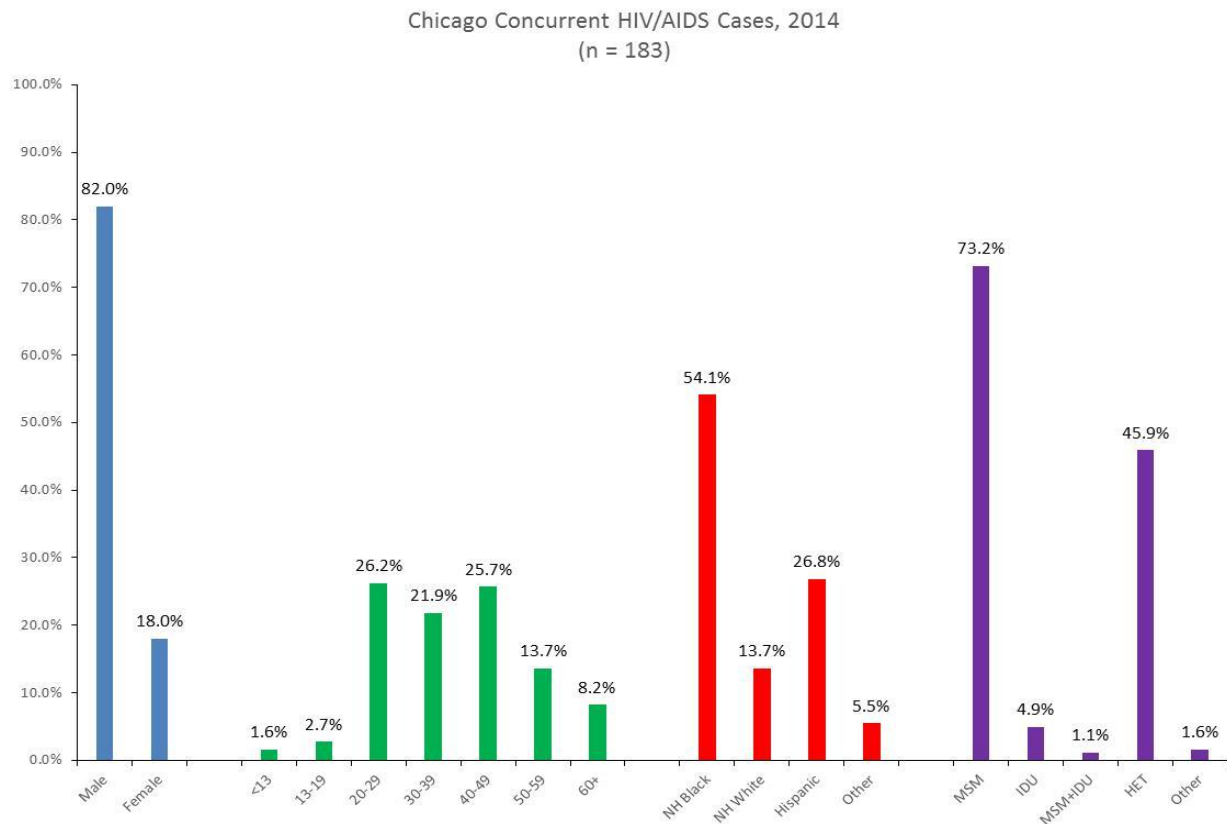
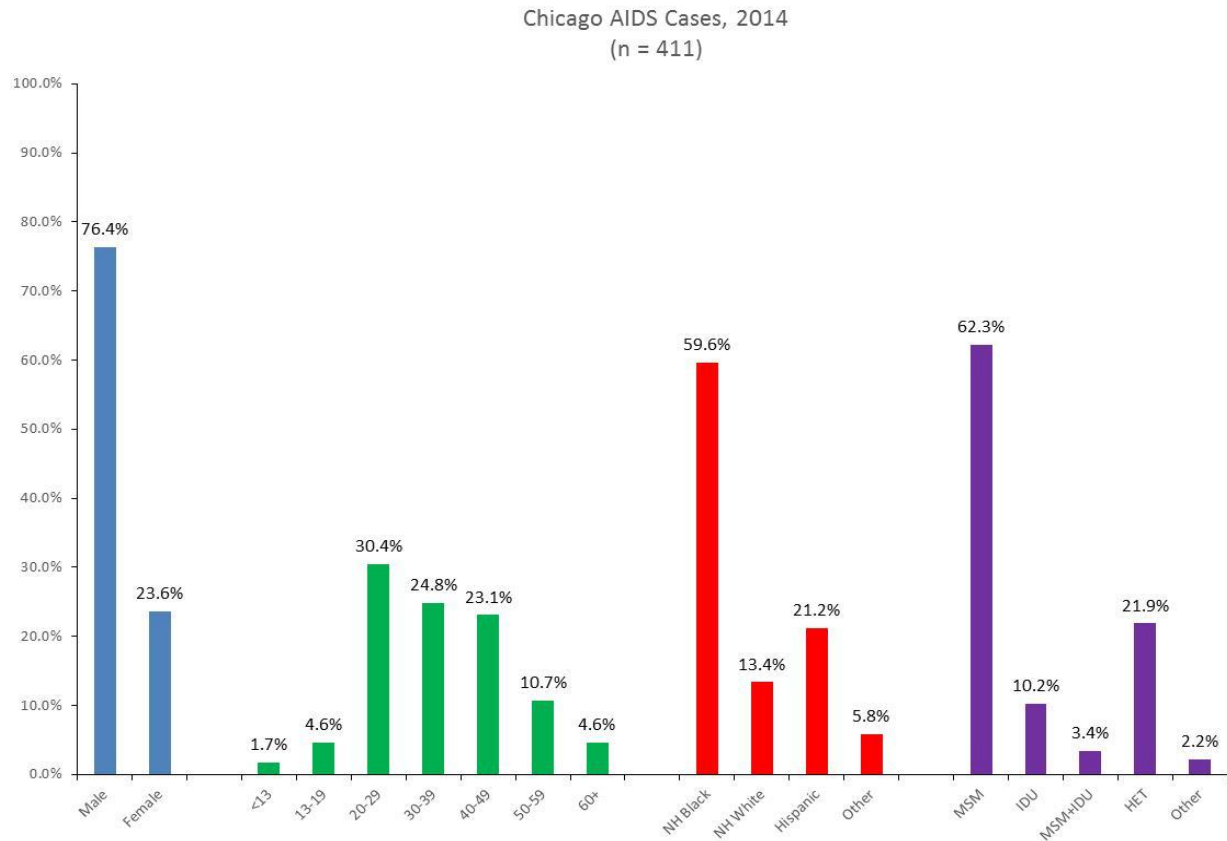
Chicago New HIV Infection Diagnoses 2014
(n = 970)



People Living with HIV Infection (PLWH) in Chicago, 2013
(n = 22,890)

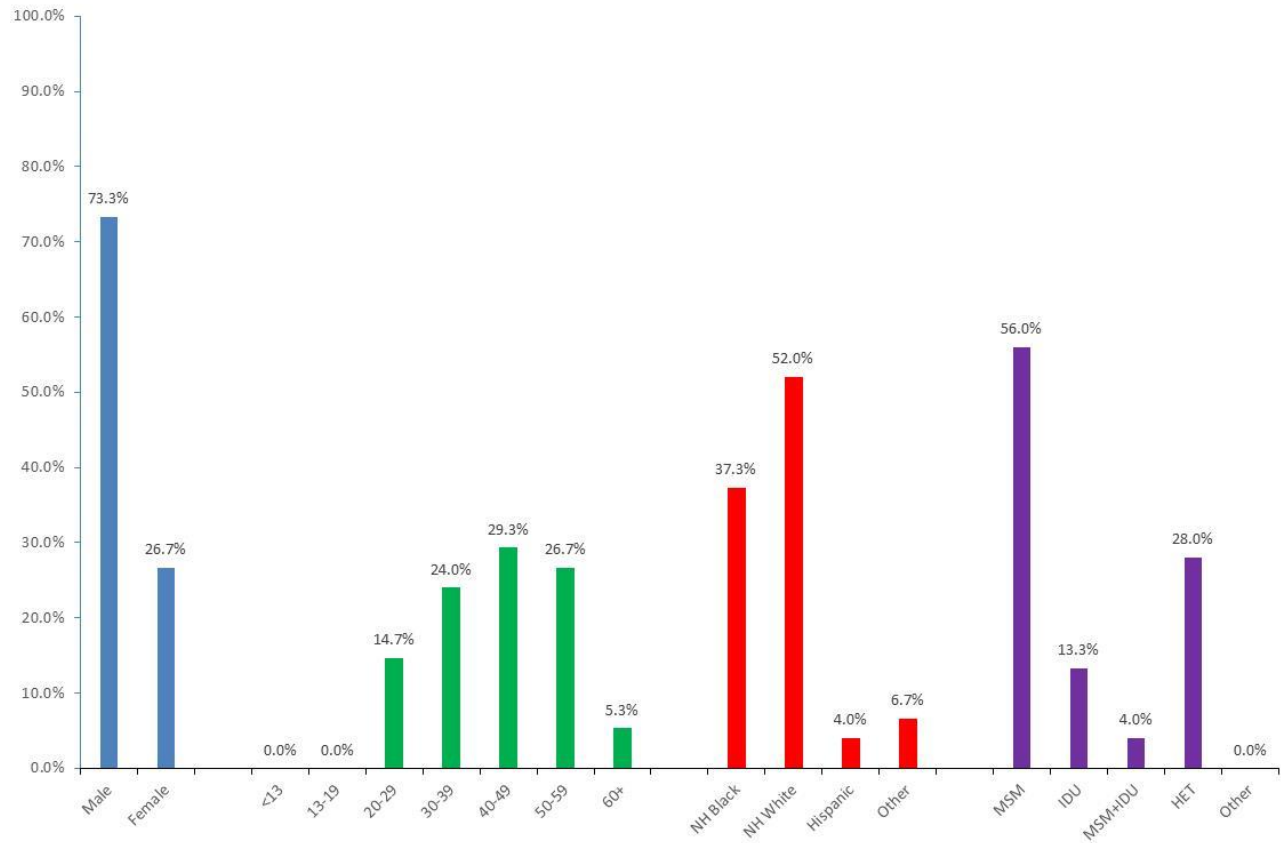


APPENDIX 1: Chicago EMA HIV/AIDS Profile



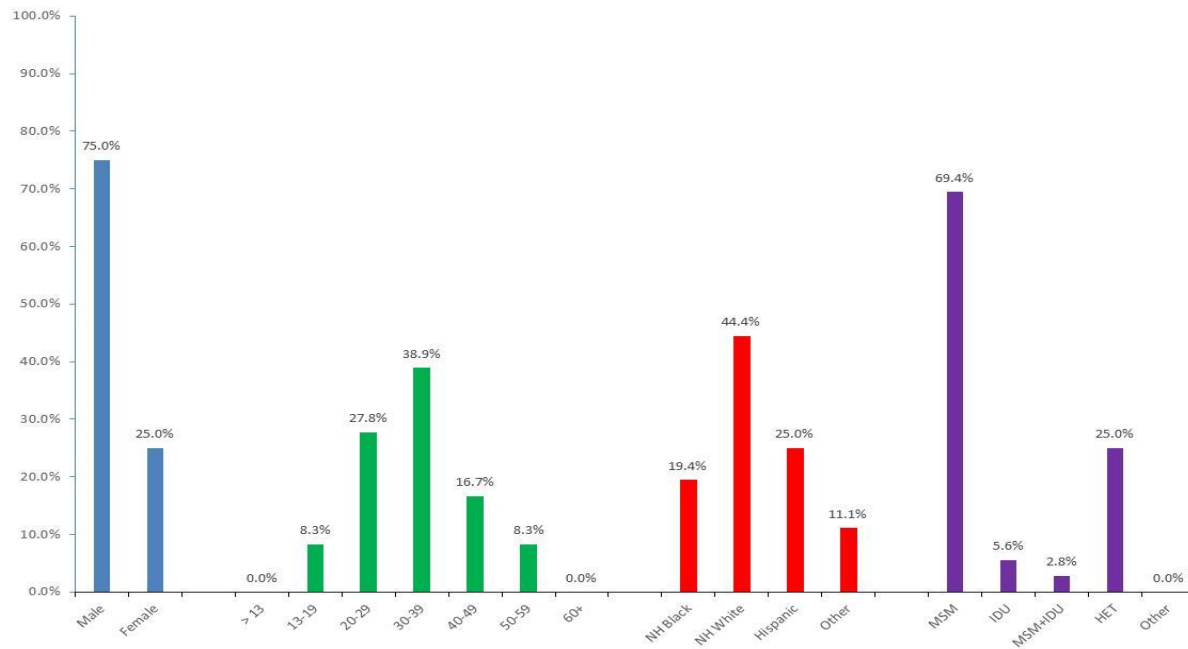
DeKalb County

People Living with HIV Infection (PLWH) in DeKalb County, 2013
(n = 75)

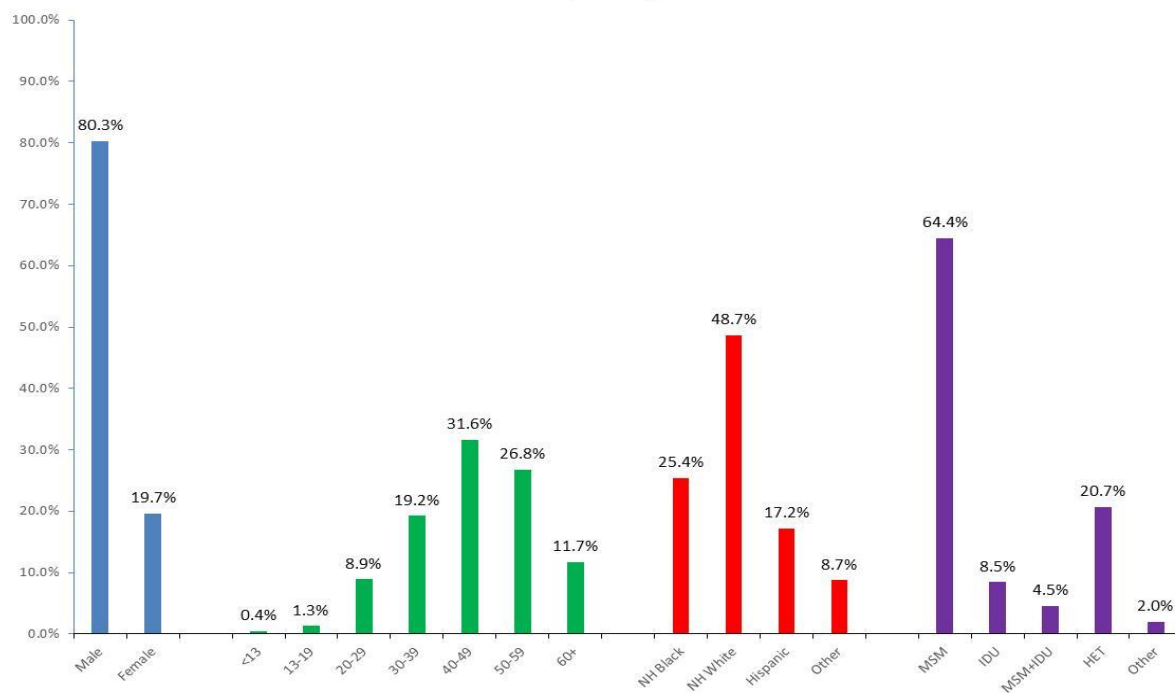


DuPage County

Dupage County New HIV Infection Diagnoses 2014
(n = 36)

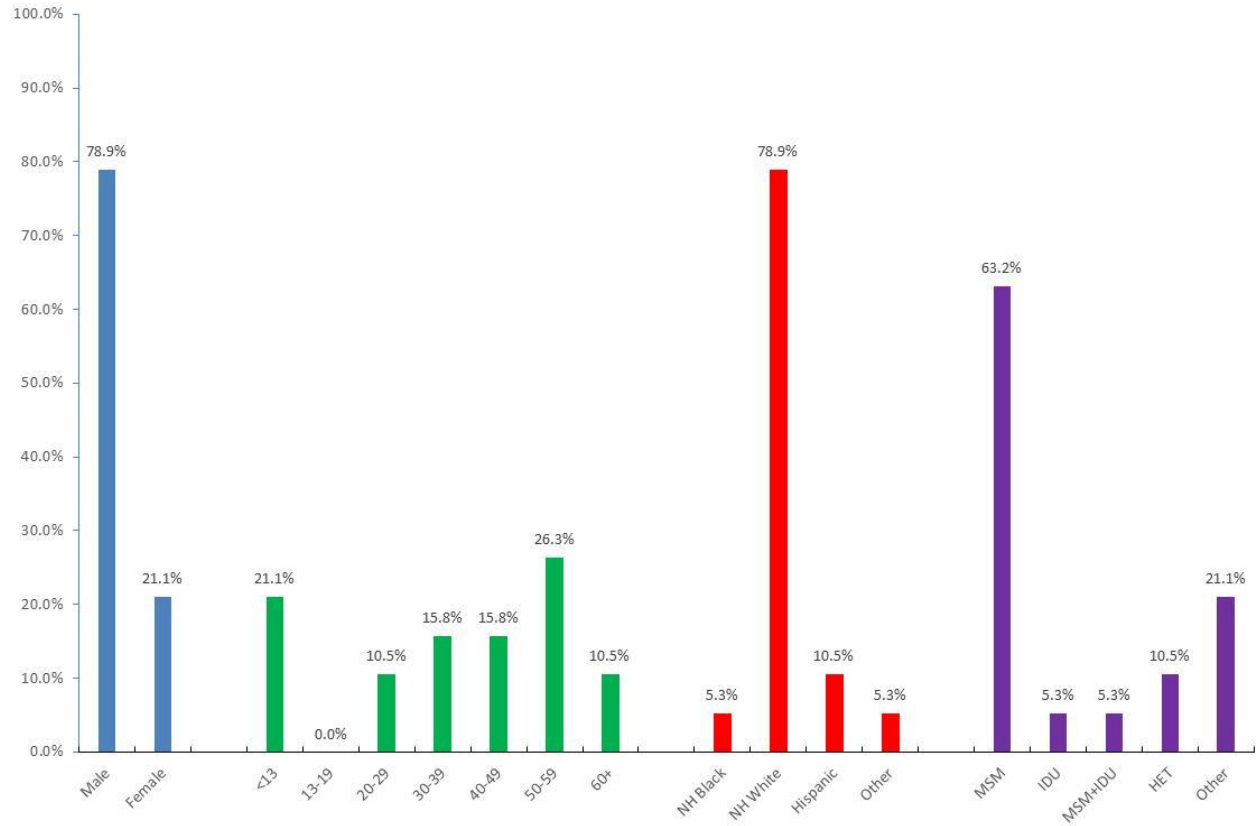


People Living with HIV Infection (PLWH) in DuPage County, 2013
(n = 686)



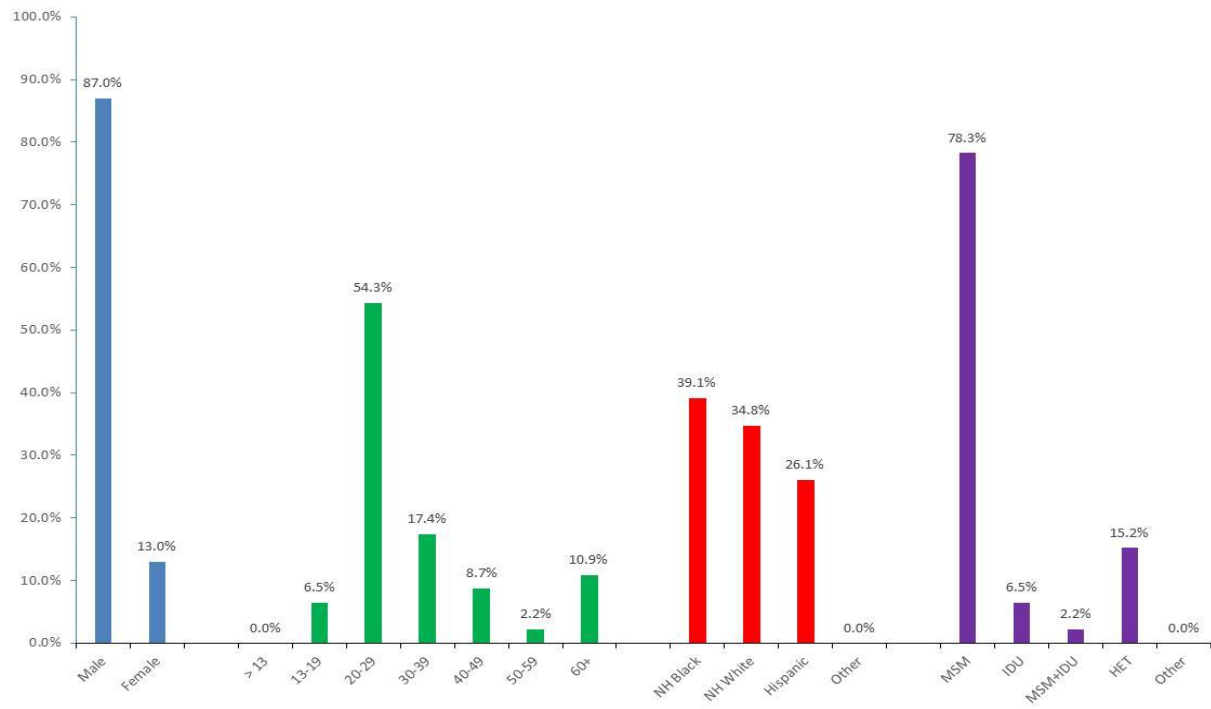
Grundy County

People Living with HIV Infection (PLWH) in Grundy County, 2013
(n = 19)

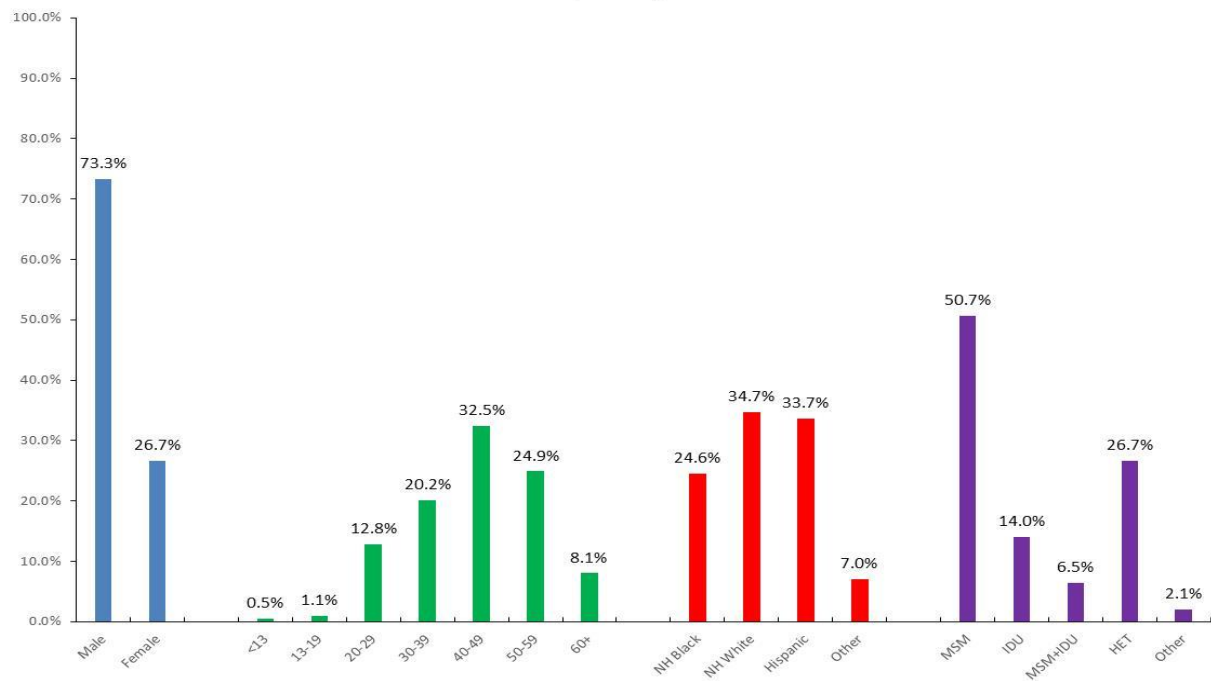


Kane County

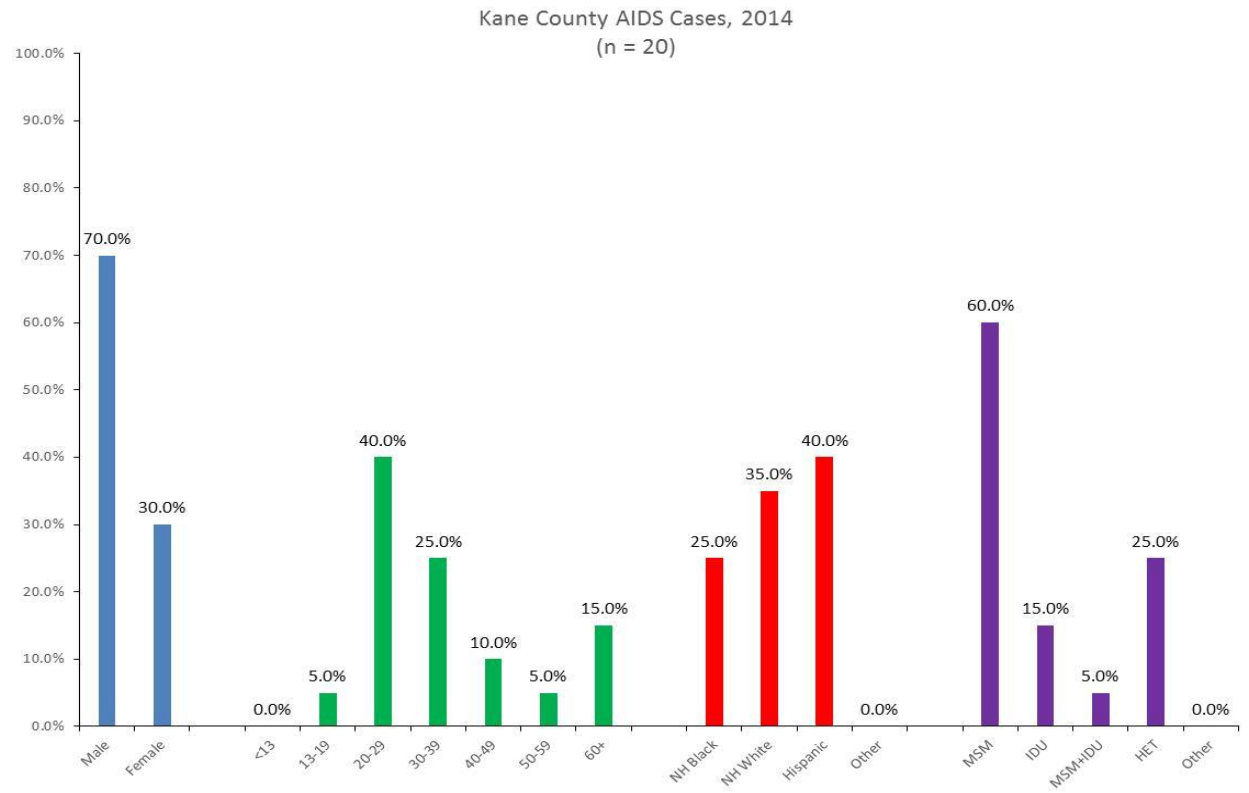
Kane County New HIV Infection Diagnoses 2014
(n = 46)



People Living with HIV Infection (PLWH) in Kane County, 2013
(n = 570)

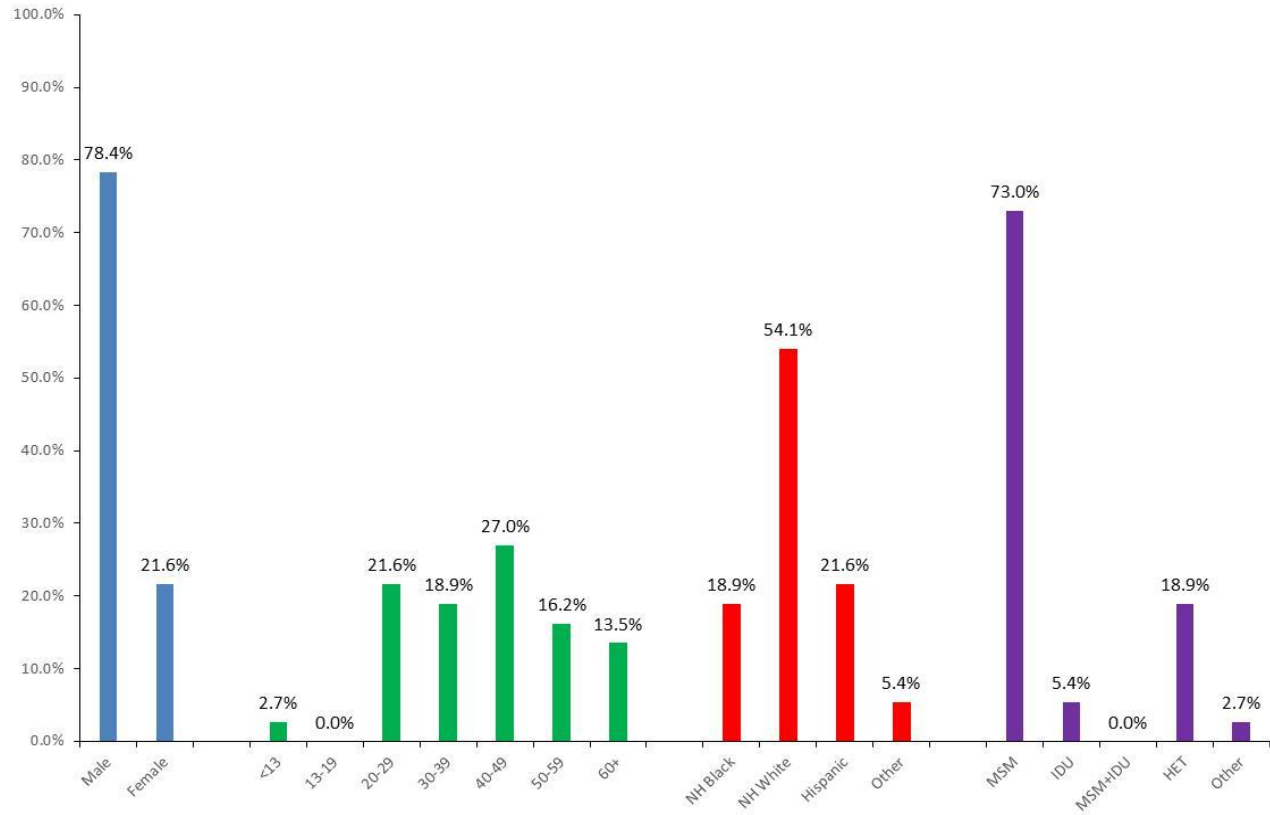


APPENDIX 1: Chicago EMA HIV/AIDS Profile



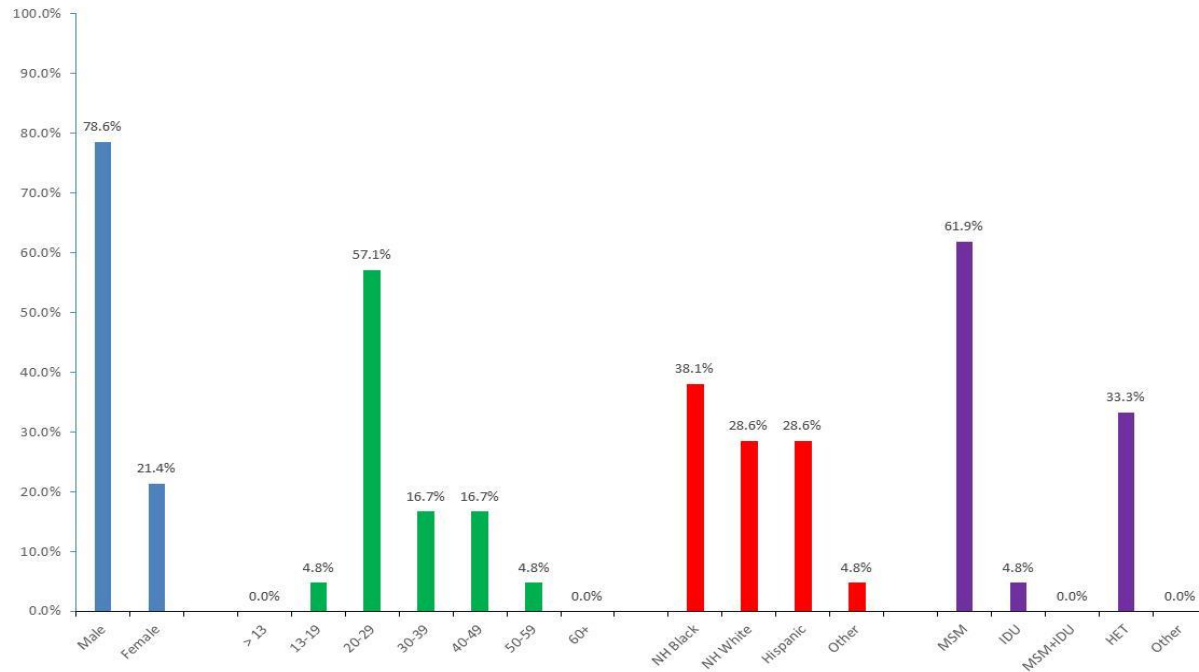
Kendall County

People Living with HIV Infection (PLWH) in Kendall County, 2013
(n = 37)

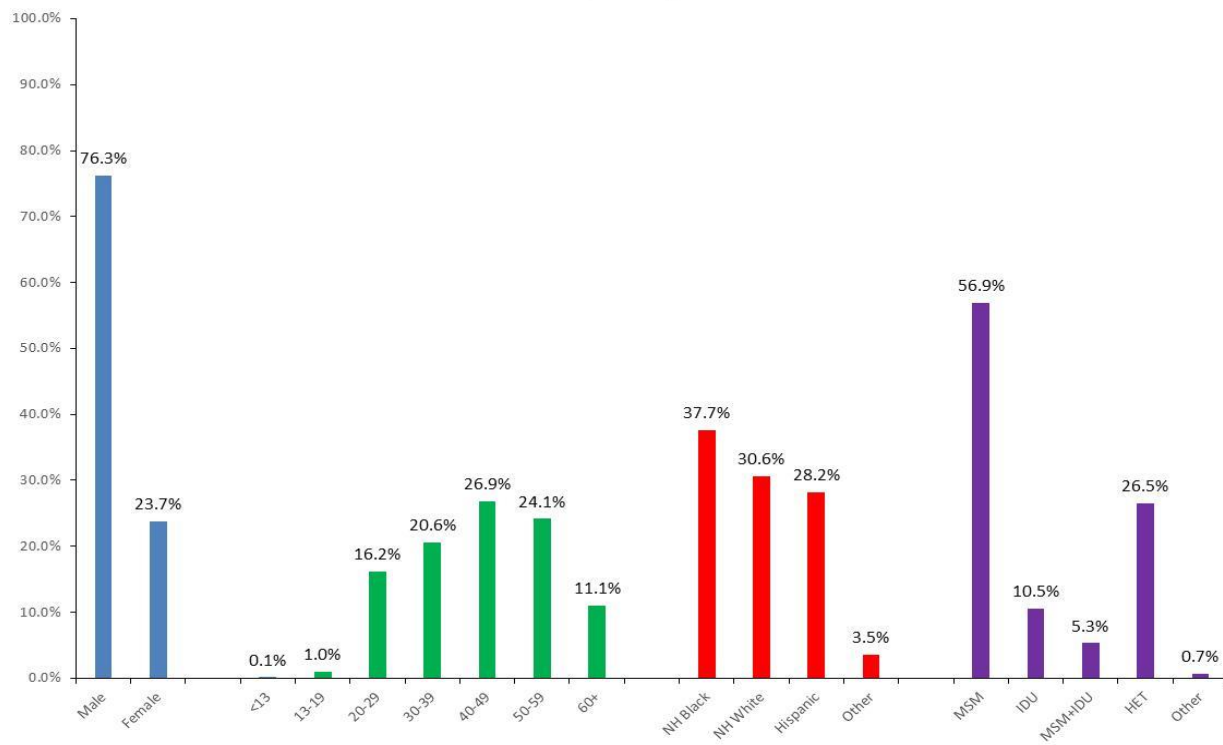


Lake County

Lake County New HIV Infection Diagnoses 2014
(n = 42)

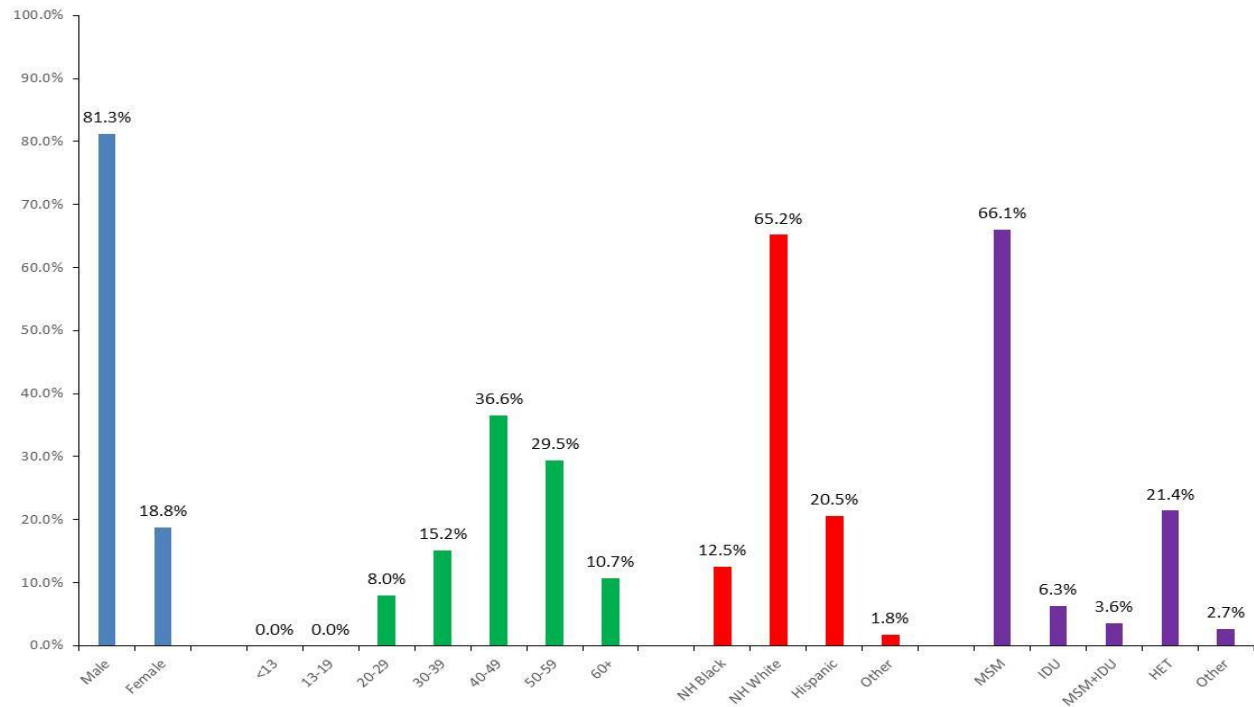


People Living with HIV Infection (PLWH) in Lake County, 2013
(n = 733)



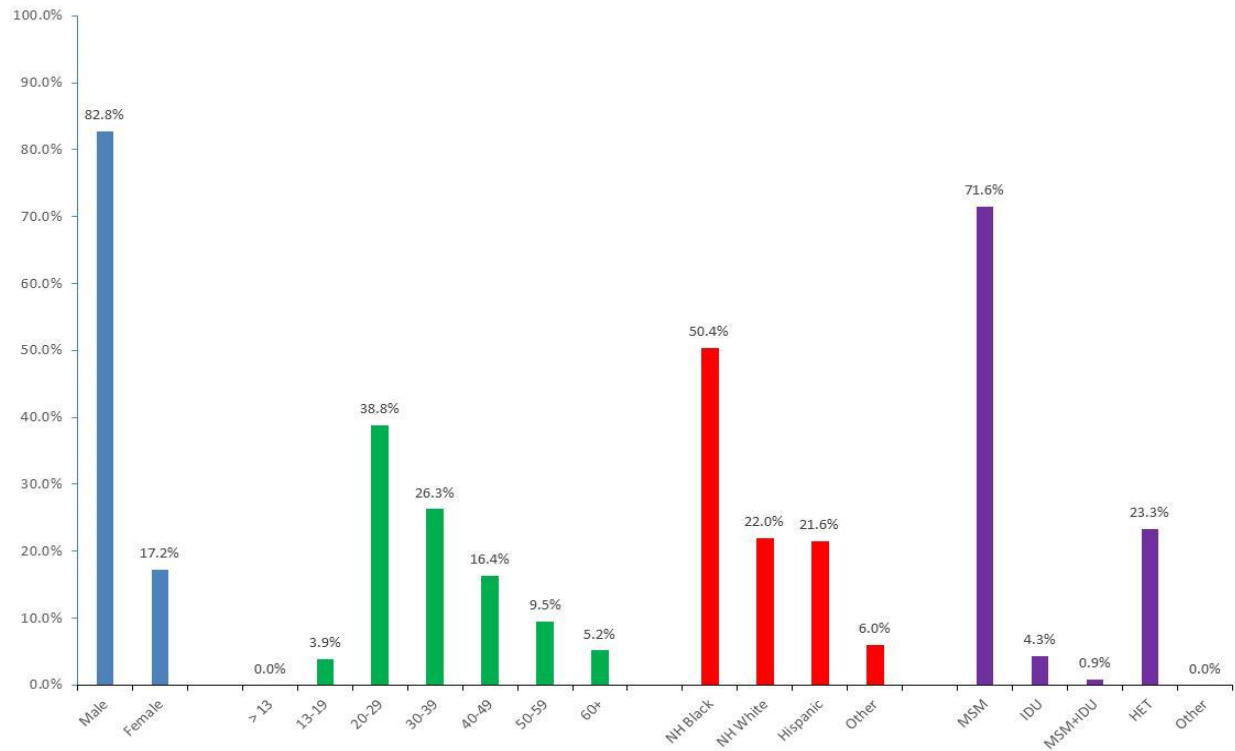
McHenry County

People Living with HIV Infection (PLWH) in McHenry County, 2013
(n = 112)

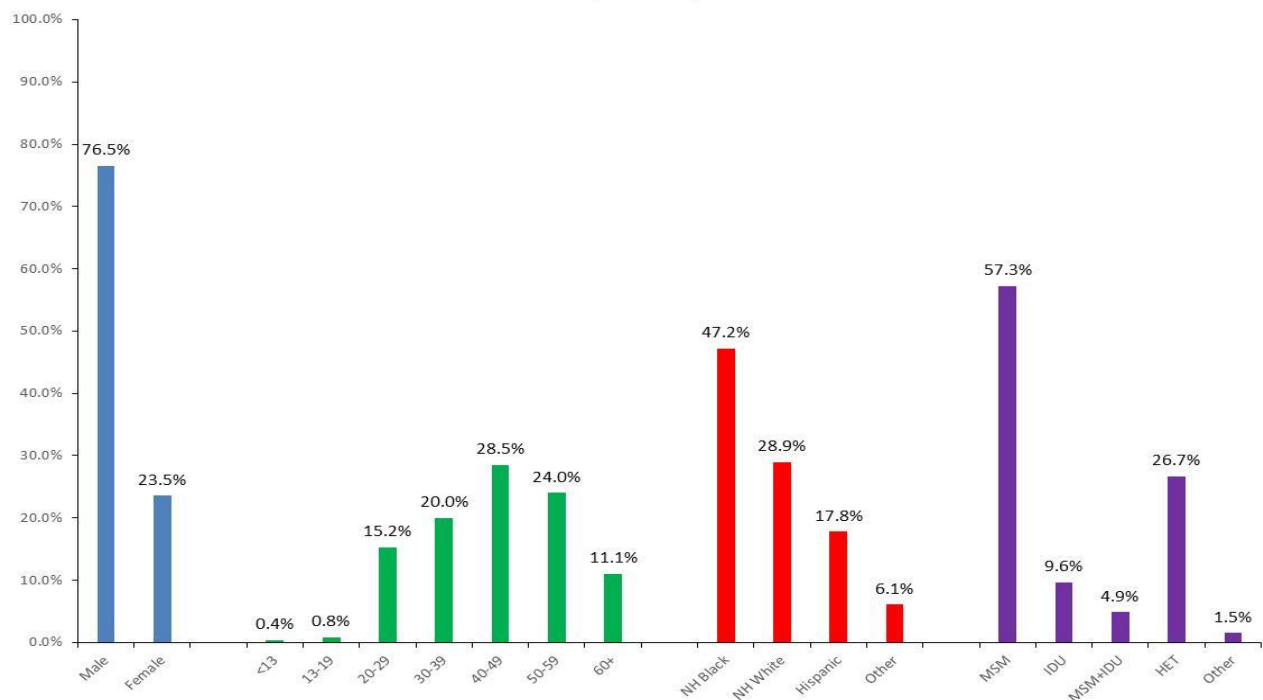


Suburban Cook County (excluding Chicago)

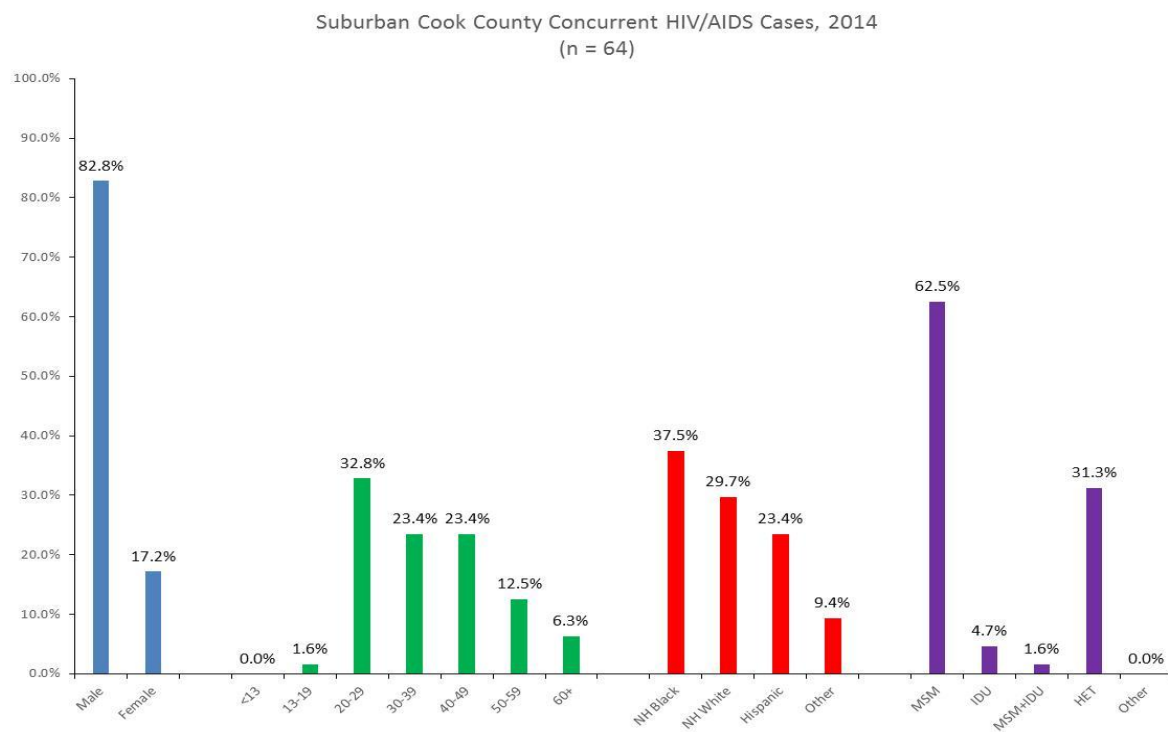
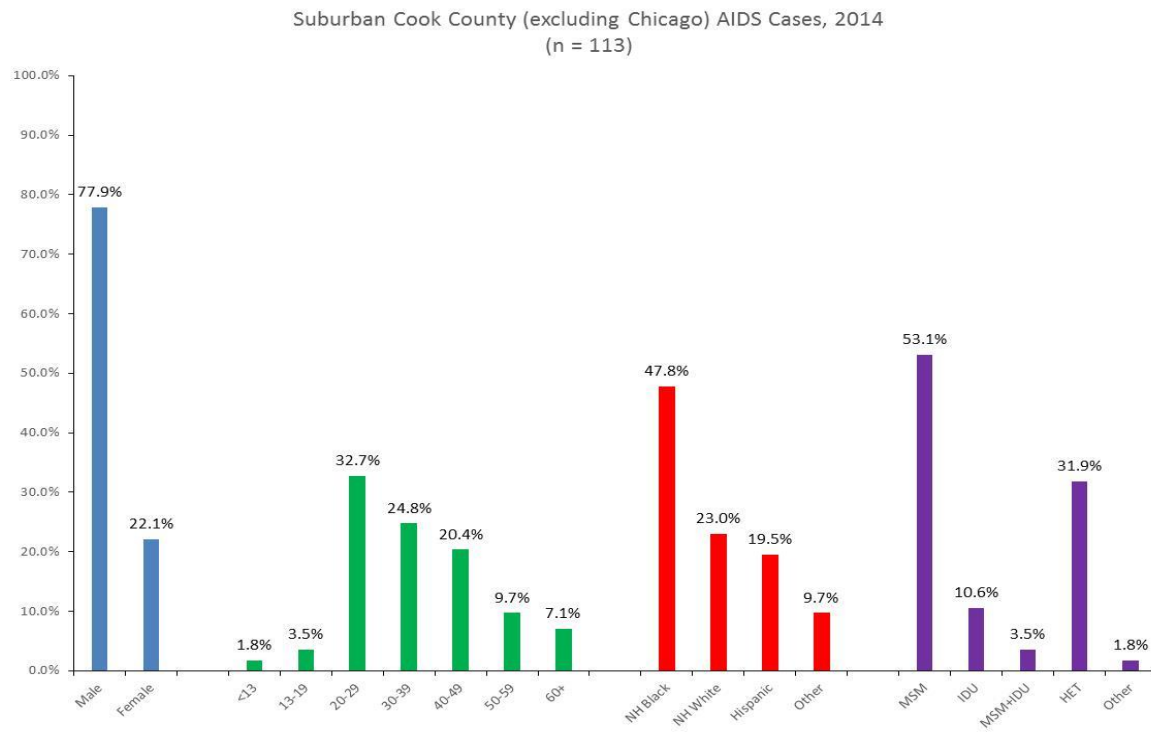
Suburban Cook County New HIV Infection Diagnoses 2014
(n = 232)



People Living with HIV Infection (PLWH) in Suburban Cook County (excluding Chicago), 2013
(n = 4197)

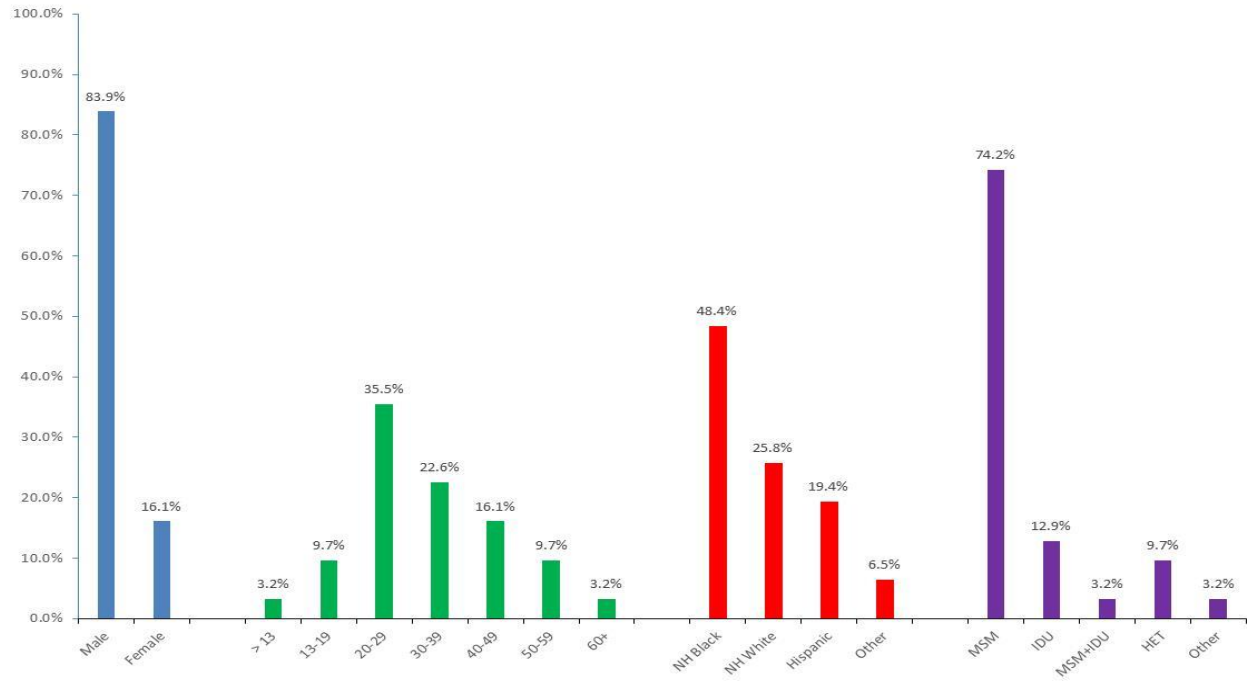


APPENDIX 1: Chicago EMA HIV/AIDS Profile

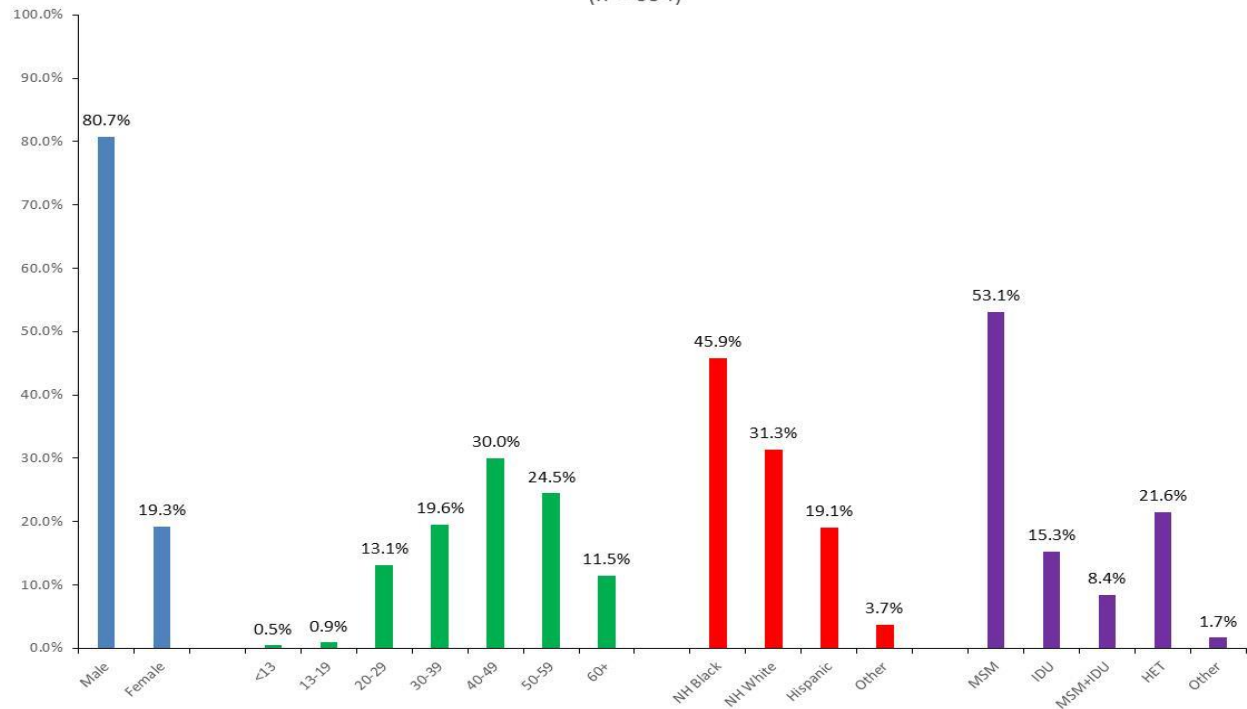


Will County

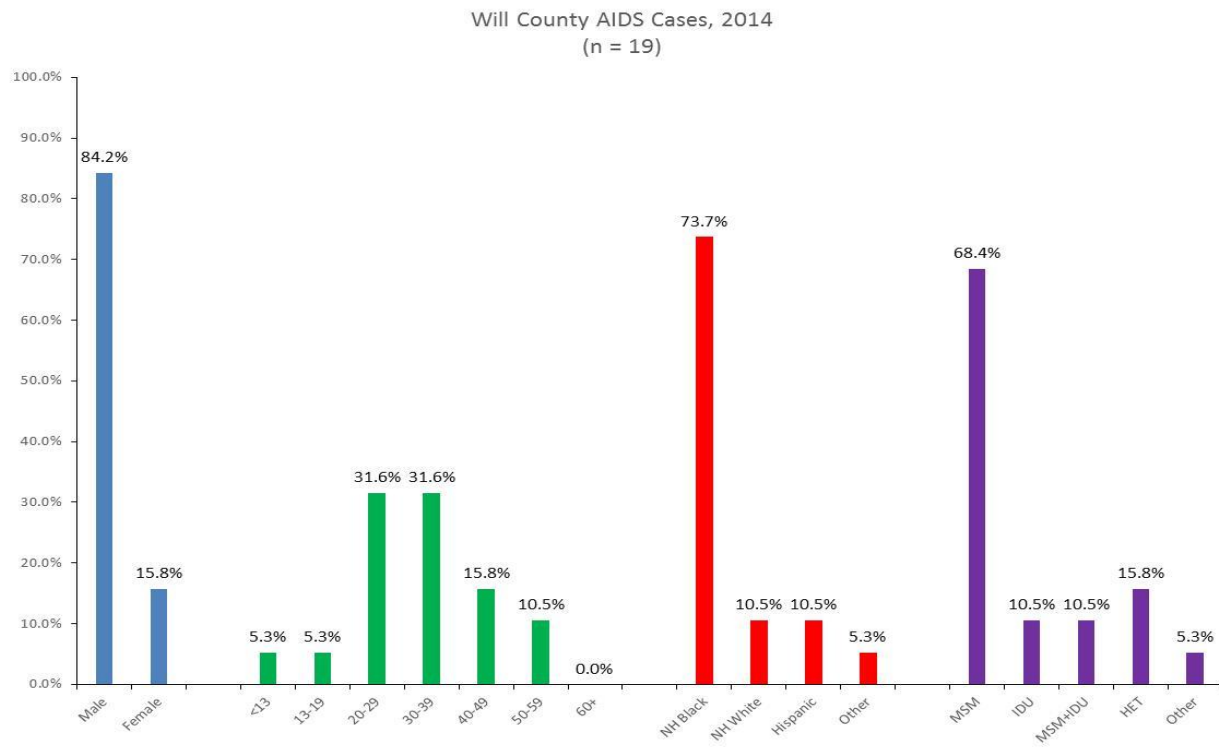
Will County New HIV Infection Diagnoses 2014
(n = 31)



People Living with HIV Infection (PLWH) in Will County, 2013
(n = 654)



APPENDIX 1: Chicago EMA HIV/AIDS Profile





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HIV / STI SURVEILLANCE REPORT

TABLE OF CONTENTS

Commissioner's Letter

1 Executive & Data Summary

5 Section One: HIV and STIs in Chicago, 2016

6 HIV

8 Chlamydia

9 Gonorrhea

10 Primary & Secondary Syphilis

12 Congenital Syphilis

13 Table 1.1: HIV, AIDS, and STI Case Rates and HIV Prevalence Rates by Race/Ethnicity and Birth Sex, Chicago and United States

14 Table 1.2: HIV and AIDS Infections and Late Diagnosis by Selected Demographic Characteristics, Chicago, 2016

15 Table 1.3: People Living with HIV Infection (PLWH) and AIDS (PLWA) in 2015, by Selected Demographic Characteristics, Chicago

16 Table 1.4: Reported Cases of Chlamydia, Gonorrhea, Primary and Secondary (P&S) Syphilis by Selected Demographic Characteristics, Chicago, 2016

17 Table 1.5: Co-Infection between HIV Infection Diagnoses & Reported Cases of Chlamydia, Gonorrhea, Primary & Secondary (P&S) Syphilis by Selected Demographic Characteristics, Chicago, 2016

18 Table 1.6: Congenital Syphilis Cases by Selected Demographic Characteristics, Chicago, 2012-2016

19 Figure 1.1: 2016 Chicago HIV Continuum of Care Among Cases 13 Years and Older, with 2020 National HIV/AIDS Strategy Indicators

20 Figure 1.2: 2016 Rate of HIV Infection Diagnoses in Chicago by Community Area

21 Figure 1.3: 2015 Rate of People Living with HIV/AIDS in Chicago by Community Area

22 Figure 1.4: Chlamydia Case Rates by Community Area, Chicago, 2016

23 Figure 1.5: Gonorrhea Case Rates by Community Area, Chicago, 2016

24 Figure 1.6: Primary and Secondary Syphilis Case Rates by Community Area, Chicago, 2016

25 Figure 1.7: Average Annual Congenital Syphilis Case Rates by Community Area, Chicago, 2012-2016



TABLE OF CONTENTS

26 SECTION TWO: Trends in HIV and STIs in Chicago, 2012-2016.

27 Trends

29 **Figure 2.1:** People Living with HIV Infection (PLWH), People Diagnosed with HIV Infection, People Diagnosed with AIDS, Concurrent HIV/AIDS Diagnoses, and Deaths Among PLWH, Chicago, 1990-2016

30 **Figure 2.2:** Number of Reported Sexually Transmitted Infections, Chicago, 1997-2016

31 **Table 2.1:** HIV/STI Cases by Year of Diagnosis and Sex, Chicago, 2012-2016

32 **Table 2.2:** HIV/STI Cases by Year of Diagnosis and Age Group, Chicago, 2012-2016

33 **Table 2.3:** HIV/STI Cases by Year of Diagnosis and Race/Ethnicity, Chicago, 2012-2016

34 SECTION THREE: Looking Forward – STIs are on the Rise

35 Discussion

37 **Figure 3.1:** Reported Gonorrhea Infections by Birth Sex, Age, and Year-end Treatment Status, Chicago, 2010-2016

38 **Figure 3.2:** Reported Chlamydia Infections among Women by Age, Race/Ethnicity, and Year-end Treatment Status, Chicago, 2010-2016

39 **Figure 3.3:** Reported Chlamydia Infections among Women under 25 by Race/Ethnicity and Year-end Treatment Status, Chicago, 2010-2016

40 **Figure 3.4:** Reported Primary & Secondary Syphilis Infections by Birth Sex, Age, and Year-end Treatment Status, Chicago, 2012-2016

41 SECTION FOUR: Spotlight - Spatial Patterns of Gonorrhea Screening, Chicago, 2014-2016

42 Discussion

43 **Figure 4.1:** Gonorrhea Infections in 2014 in Chicago Getis-ord Gi* Statistic (Optimized Hot Spot Analysis)

44 **Figure 4.2:** Gonorrhea Infections in 2015 in Chicago Getis-ord Gi* Statistic (Optimized Hot Spot Analysis)

45 **Figure 4.3:** Gonorrhea Infections in 2016 in Chicago Getis-ord Gi* Statistic (Optimized Hot Spot Analysis)



TABLE OF CONTENTS

Appendices

Appendix A: Technical Notes - General

Appendix B: Geocoding Methodology and Limitations

Appendix C: List of Acronyms

Appendix D: Supplemental Data Tables

Table D.1: 2016 HIV Infection Diagnosis Rates
by Community Area, Chicago

Table D.2: People Living with HIV Infection (PLWH) in 2015
by Community Area, Chicago

Table D.3: Chlamydia Case Rates
by Community Area, Chicago, 2016

Table D.4: Gonorrhea Case Rates
by Community Area, Chicago, 2016

Table D.5: Primary and Secondary Syphilis Case Rates
by Community Area, Chicago, 2016

Appendix E: Technical Notes – Hardship Index and Hotspot Analysis



COMMISSIONER'S LETTER

Dear Friends,

Chicago is making real progress in our fight against HIV and AIDS. As this report shows, in 2016, Chicago recorded 839 new HIV cases, the fewest number of new HIV diagnoses in more than fifteen years and a 55 percent decline from 2001. We attribute this monumental decline to three key efforts:

1. The increased use of medications to treat HIV. Persons living with HIV who are on anti-retroviral treatment can achieve viral suppression, which means they are healthier and unable to transmit the virus to sexual partners.
2. The increased use of medications to prevent HIV. Persons more vulnerable to HIV who use anti-retroviral medications for pre-exposure prophylaxis (PrEP) are protected from HIV.
3. Ongoing efforts to reach and educate individuals who are either HIV positive or at greater risk to contract the disease, so we can ensure they receive the medication and supportive services they require to stay healthy.



Though this progress is historic, it is not enough. This is why, earlier this year, Mayor Rahm Emanuel and CDPH launched **Getting to Zero** together with our partners across the city and state. Getting to Zero is an ambitious plan to end the HIV epidemic within the next 10 years by prioritizing HIV treatment and the use of PrEP. First, we will increase the number of people living with HIV who are virally suppressed. Currently, just under half of Chicagoans living with HIV have achieved viral suppression. Second, we will increase the number of HIV-vulnerable people who successfully use PrEP. Currently, approximately only 10 percent of people who can benefit from PrEP are using it. By increasing both viral suppression and PrEP use by 20 percent in the next 10 years, we will end the HIV epidemic within our lifetime.

Despite our success in reducing HIV infections, this report makes clear that certain communities continue to face an unacceptable burden of HIV. Gay, bisexual and other men who have sex with men, particularly Black and Latinx men, bear a disproportionate burden of HIV. Among women, Black women represented nearly 81 percent of new HIV diagnoses in 2016.

While Chicago has seen dramatic declines in new HIV diagnoses over the years, we have seen rising numbers of newly diagnosed sexually transmitted infections (STI), similar to trends observed nationwide. In 2016, new cases of chlamydia, gonorrhea and primary and secondary syphilis continued to climb. While some of the increases may be attributed to improved access to STI screening for more residents, we must redouble efforts to ensure people diagnosed with STIs and their partners receive appropriate treatment.

As this report also shows, there are health disparities when it comes to STI infections. Specifically, infections are concentrated in high hardship, low childhood opportunity community areas and among specific populations. Black women accounted for nearly 27 percent of all chlamydia cases in 2016, and Black men nearly 22 percent of all gonorrhea cases in 2016, while they only account for 17 and 14 percent of Chicago's adult population respectively. Nearly 75 percent of primary and secondary syphilis cases occurred in gay, bisexual and other men who have sex with men.

We are proud of the progress we have made, but recognize that there is more work to be done. This report will be used by CDPH and our partners to help inform HIV and STI programming and planning, allowing us to allocate resources to the most vulnerable communities and populations; and ultimately ensure that all Chicagoans are able to lead healthier lives.

Working together, we can eliminate new HIV infections and reduce the number of STIs in every community across Chicago.

Julie Morita, M.D.
Commissioner, Chicago Department of Public Health



EXECUTIVE & DATA SUMMARY

EXECUTIVE SUMMARY

The Chicago Department of Public Health (CDPH) believes that all Chicagoans should have the opportunity to be sexually healthy. However, CDPH recognizes that specific population groups, such as residents of certain community areas or individuals of a specific race/ethnicity, do not have an equitable chance at achieving sexual health. Through vital partnerships with communities, researchers, and public and private organizations, CDPH continues its commitment to have a city where every person can attain full sexual health.

The annual CDPH HIV/STI Surveillance Report presents cases of HIV, AIDS, chlamydia, gonorrhea, syphilis, and congenital syphilis. Similar to other large urban areas, Chicago has higher disease morbidity than suburban and rural areas. This report provides HIV and STI data useful for service providers, community organizations, program planners, policy makers, and the general public.

DATA SUMMARY

HIV CARE CONTINUUM

- In 2016, 80% of those newly diagnosed with HIV were linked to HIV medical care within 1 month of HIV diagnosis, and by 12 months post-diagnosis 92% of individuals newly diagnosed had been linked to medical care.
- Among all people living with HIV (PLWH) in Chicago, 60% had accessed care in 2016 and 40% were retained in medical care.
- Forty-eight percent of PLWH in Chicago were virally suppressed.

HIV

- There were a total of 839 new HIV diagnoses among Chicago residents in 2016 (lowest since 1990), corresponding to a rate of 31.1 per 100,000 population. There was a total of 23,824 individuals who had been diagnosed through 2015 and were living with HIV in 2016, corresponding to a rate of 882.8 per 100,000 population.
- There were 4.8 times as many new HIV diagnoses in men than in women.
- In 2016, individuals aged 20-29 years old were the most frequently diagnosed population group, representing 40.3% of all new HIV diagnoses.
- Non-Hispanic (NH) Blacks were the most frequently diagnosed population, representing 58.5% of new diagnoses, 56.4% of AIDS diagnoses, and 55.2% of late diagnoses.
- Compared with other HIV transmission groups, there were 3.7 times more new HIV diagnoses among men who have sex with men (MSM) than those reporting heterosexual (HET) contact transmission and 13.7 times more new HIV diagnoses than those reporting injection drug use (IDU).
- In 2016, the highest rates of new HIV infection diagnoses were seen in individuals residing in Douglas, Edgewater, Grand Boulevard, Kenwood, North Lawndale, Rogers Park, Washington Park, West Garfield Park, and Uptown. The highest rates of PLWH were observed in Edgewater, Rogers Park, and Uptown.

CHLAMYDIA, GONORRHEA, PRIMARY & SECONDARY (P&S) SYPHILIS, AND CONGENITAL SYPHILIS

- There were a total of 29,776 chlamydia cases, 10,836 gonorrhea cases, and 813 syphilis cases reported to CDPH in 2016. The the number of chlamydia and P&S syphilis cases are the highest ever since 1997.
- There were 1.6 times as many reported chlamydia cases in women than men, 1.8 times as many reported gonorrhea cases in men than women, and 15.6 times as many reported syphilis cases in men than women. The largest proportion of P&S syphilis cases (74.9%) were among MSM.
- In 2016, individuals aged 20-29 years old were the most frequently diagnosed age group for chlamydia, gonorrhea, and P&S syphilis.
- NH Blacks were the most frequently diagnosed population among all three reportable STIs, representing 40.3% of reported chlamydia cases, 44.3% of reported gonorrhea cases, and 36.2% of reported P&S Syphilis cases. However, NH Blacks were the only population to a decrease in the number of cases for all three reportable STIs from 2015 to 2016.
- In 2016, community areas with the highest rates of chlamydia and gonorrhea included areas considered to have a high economic hardship.

This year's report highlights the continued a decrease in new HIV diagnoses, reinforces the need to address sexual health disparities experienced by certain populations and in certain community areas in our city, and acts as a call to action for health partners to address the rising STI rates within Chicago.

**Chicago Department of Public Health. HIV/STI Surveillance Report 2017.
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SECTION ONE HIV & STIs IN CHICAGO 2016

HIV

HIV CONTINUUM OF CARE, CHICAGO 2016

The HIV continuum of care is an important tool for monitoring progress and identifying opportunities for HIV prevention and treatment interventions. Since ensuring HIV-positive individuals are engaged in care is critical to both individual and population level health, the continuum was developed to depict two paths: (1) the percentages of newly diagnosed individuals linked to HIV medical care over the course of one year; and (2) the percentages of people living with HIV at specific levels of care engagement and viral suppression.

In 2016, 80% of those diagnosed with HIV were linked to HIV medical care within one month of HIV diagnosis. By 12 months post-diagnosis, 92% of the newly diagnosed had been linked to medical care. For individuals diagnosed with HIV through 2015 and living with HIV in 2016, 60% had accessed medical care (having at least one medical visit in 2016), 40% were considered to be retained in care (having at least 2 medical visits in 2016), and 56% had a viral load test in the past 12 months. Reaching viral suppression for individuals that are HIV positive is essential to living a healthy life and to reducing the likelihood HIV will be transmitted to others. For individuals diagnosed with HIV through 2015 and living with HIV in 2016, only 48% were considered to be virally suppressed (< 200 copies/mL), indicating an opportunity to strengthen HIV prevention and treatment interventions. The data represented in the continuum highlight the need for increased attention on services that assist individuals living with HIV to obtain viral suppression (Figure 1.1).

HIV IN CHICAGO

In 2016, a total of 839 individuals were newly diagnosed with HIV in the city of Chicago, and 367 individuals were newly diagnosed with AIDS (Stage 3 HIV infection) (Table 1.1). These case counts correspond to rates of 31.1 per 100,000 population and 13.6 per 100,000 population, respectively (Table 1.1). Of those newly diagnosed in 2016, a total of 192 individuals were considered to have a late/concurrent diagnosis, indicating that those individuals were diagnosed with HIV and subsequently AIDS within a 12-month period (Table 1.2).

There was a total of 23,824 individuals who had been diagnosed with HIV through 2015 and living with HIV in 2016 (Table 1.3). This case count corresponds to a rate of 882.8 per 100,000 population (Table 1.1). Of those living with HIV in 2015, a total of 12,444 individuals were living with AIDS (Table 1.3).

HIV BY CHICAGO COMMUNITY AREA

In 2016, the rates of reported cases of HIV ranged from 0 to 72.9 per 100,000 population throughout the city of Chicago (Figure 1.2). The five community areas with the highest average HIV infection diagnosis rates from 2015 to 2016 were Kenwood (72.9 per 100,000), Washington Park (68.3 per 100,000), West Garfield Park (66.7 per 100,000), Rogers Park (63.6 per 100,000), and Uptown (62.1 per 100,000) (Figure 1.2; Appendix Table D.1). Of these community areas listed, Washington Park and West Garfield Park were also considered to be areas of high economic hardship (Figure 1.2).

HIV BY CHICAGO COMMUNITY AREA (cont.)

In 2015, the rates of people living with HIV/AIDS ranged from 36.7 to 2,262.2 per 100,000 population throughout the city of Chicago (Figure 1.3). The three community areas with the highest prevalence rates were Uptown (2,262.2 per 100,000), Edgewater (2,078.9 per 100,000), and Rogers Park (1,640.3 per 100,000) (Figure 1.3; Appendix Table D.2).

HIV BY GENDER

In 2016, there were 4.8 times as many new HIV diagnoses in men than women, with 683 cases reported among males and 141 cases reported among females (Table 1.2). The largest number of late diagnoses occurred among males when compared to females (Table 1.2). New diagnoses among transgender individuals accounted for < 2.0% of the total 2016 new diagnoses (Table 1.2).

In 2015, there were 4.1 times as many men living with HIV than women (18,994 males and 4,592 females) (Table 1.3). HIV prevalence among transgender individuals accounted for < 1% of the total Chicago prevalence (Table 1.3).

HIV BY AGE

In 2016, individuals aged 20-29 years old were the most frequently diagnosed age group, representing 40.3% of all new HIV diagnoses and were the age group with the largest percentage of late diagnosed individuals (Table 1.2). If this group were combined with those aged 30-39 years old, then those individuals (aged 20-39) would represent almost two-thirds (64.3%) of new HIV diagnoses in 2016 (Table 1.2).

In 2015, individuals aged 40-59 years old accounted for over half (55.3%) of those individuals living with HIV in the city of Chicago (Table 1.3). Individuals aged 20-29 years old (who accounted for the largest number of new diagnoses) only represented 11.9% of those living with HIV (Table 1.3).

HIV BY RACE/ETHNICITY

In 2016, Non-Hispanic (NH) Blacks were the most frequently diagnosed population, representing 58.5% of new HIV diagnoses, 56.4% of AIDS diagnoses, and 55.2% of late diagnoses (Table 1.2). When compared to the next two populations with the largest number of individuals newly diagnosed, there were 2.7 times as many new HIV diagnoses in NH Blacks than Hispanics and 4.0 times as many than NH White new HIV diagnoses (Table 1.2).

In 2015, NH Blacks accounted for just over half (50.2%) of those individuals living with HIV in the city of Chicago (Table 1.3). When compared with the next two populations with the largest number of people living with HIV, there were 2.6 times more NH Blacks living with HIV than Hispanics living with HIV and 2.1 times more than NH Whites living with HIV (Table 1.3).

HIV BY TRANSMISSION GROUP

In 2016, men who have sex with men (MSM) accounted for the majority (71.8%) of new HIV diagnoses in the city of Chicago (Table 1.2). Compared with other HIV transmission groups, there were 3.7 times more new HIV diagnoses among MSM than those reporting heterosexual contact transmission (HET) and 13.7 times more new HIV diagnoses than those reporting injection drug use (IDU) transmission (Table 1.2).

In 2015, MSM represented 62.4% of individuals living with HIV in the city of Chicago (Table 1.3). In comparison to other HIV transmission groups, there were 3.5 times as many MSM living with HIV than HET and 4.9 times as many MSM living with HIV than IDU (Table 1.3).

CHLAMYDIA

CHLAMYDIA IN CHICAGO

Chlamydia, a sexually transmitted bacterial infection caused by *Chlamydia trachomatis*, is the most common notifiable disease in the United States. According to the CDC 2016 STD Surveillance Report, chlamydia is one the most prevalent STIs and has comprised the largest proportion of all STIs reported to CDC since 1994. In 2016, a total of 29,776 chlamydia cases were reported in the city of Chicago (Table 1.4). This case count corresponds to a rate of 1,103.3 per 100,000 population (Table 1.1).

CHLAMYDIA BY CHICAGO COMMUNITY AREA

In 2016, the rates of reported cases of chlamydia ranged from 116.2 to 2,915.8 per 100,000 population throughout the city of Chicago (Figure 1.4). The three community areas with the highest average chlamydia case rates from 2015 to 2016 were Riverdale (2,915.8 per 100,000), North Lawndale (2,870.9 per 100,000), and Washington Park (2,654.3 per 100,000) (Figure 1.4; Appendix Table D.3). All three of these community areas were also considered to be areas of high economic hardship (Figure 1.4).

CHLAMYDIA BY BIRTH SEX

In 2016, there were 1.6 times as many reported chlamydia cases in women than men, with 18,464 cases reported among females and 11,279 cases reported among males (Table 1.4). This disparity between the sexes is consistent with previous years and likely reflects a larger number of females screened for this infection. It is also likely that many of the sex partners of women with chlamydia did not receive a diagnosis nor were they reported as having chlamydia infections.

CHLAMYDIA BY AGE

In 2016, individuals aged 20-29 years old were the most frequently diagnosed age group, representing 54.2% of all reported chlamydia cases (Table 1.4). If this group were combined with those aged 13 to 19 years old, then all those individuals (13 to 29 years) would represent 80.6% of all reported chlamydia cases in 2016 (Table 1.4).

CHLAMYDIA BY RACE/ETHNICITY

In 2016, NH Blacks were the most frequently diagnosed population, representing 40.3% of reported chlamydia cases in Chicago (Table 1.4). When compared to the next two populations with the largest number of reported cases, there were 3 times as many chlamydia cases in NH Blacks than Hispanics and 5.1 times as many than in NH Whites (Table 1.4).

CHLAMYDIA + HIV CO-INFECTION

In 2016, a total of 994 reported chlamydia cases were also co-infected with HIV (Table 1.5). The majority of co-infected individuals were male (92.0%), NH Black (31.1%), aged 20-29 years (38.6%), and were MSM (69.6%) (Table 1.5).

GONORRHEA

GONORRHEA IN CHICAGO

Gonorrhea is a sexually transmitted bacterial infection caused by *Neisseria gonorrhoeae* and is the second most commonly reported notifiable disease in the United States. According to the CDC 2016 STD Surveillance Report, gonorrhea infections are a major cause of pelvic inflammatory disease (PID) in the United States and certain strains of the bacteria have developed resistance to many of the antimicrobials used for treatment. In 2016, a total of 10,836 gonorrhea cases were reported in the city of Chicago (Table 1.4). This case count corresponds to a rate of 401.5 per 100,000 population (Table 1.1).

GONORRHEA BY CHICAGO COMMUNITY AREA

In 2016, the rates of reported cases of gonorrhea ranged from 36.7 to 1,037.9 per 100,000 population throughout the city of Chicago (Figure 1.5). The three community areas with the highest average gonorrhea case rates from 2015 to 2016 were Uptown (1,037.9 per 100,000), Washington Park (1,032.7 per 100,000), and North Lawndale (1,027.5 per 100,000) (Figure 1.5; Appendix Table D.4). Of these listed community areas, Washington Park and North Lawndale were considered areas of high economic hardship (Figure 1.5).

GONORRHEA BY BIRTH SEX

In 2016, there were 1.8 times as many reported gonorrhea cases in men than women, with 6,900 cases reported among males and 3,920 cases reported among females (Table 1.4). This disparity between the sexes may be reflective of either increased transmission or increased case ascertainment (e.g., through increased extra-genital screening) among men.

GONORRHEA BY AGE

Similar to reported cases of chlamydia, gonorrhea cases in Chicago are concentrated among adolescents and young adults. In 2016, individuals aged 20-29 years old were the most frequently diagnosed age group, representing 50.6% of all reported gonorrhea cases (Table 1.4). If this group were combined with those aged 13 to 19 years old, then all those individuals (13 to 29 years) would represent 72.0% of all reported gonorrhea cases in 2016 (Table 1.4).

GONORRHEA BY RACE/ETHNICITY

In 2016, NH Blacks were the most frequently diagnosed population, representing 44.3% of reported gonorrhea cases in Chicago (Table 1.4). When compared to the next two populations with the largest number of reported cases, there were 5.2 times as many gonorrhea cases in NH Blacks than Hispanics and 3.7 times as many than in NH Whites (Table 1.4).

GONORRHEA + HIV CO-INFECTION

In 2016, a total of 1,078 reported gonorrhea cases were also co-infected with HIV (Table 1.5). The majority of co-infected individuals were male (96.3%), NH Black (32.2%), aged 20-29 years (41.0%), and were MSM (69.2%) (Table 1.5).

PRIMARY & SECONDARY (P&S) SYPHILIS

P&S SYPHILIS IN CHICAGO

Syphilis is a sexually transmitted bacterial infection caused by *Treponema pallidum* and results in a genital ulcerative disease that if left untreated can result in significant medical complications and facilitate the transmission and acquisition of HIV infection (CDC STD Surveillance Report, 2016). Primary and secondary syphilis are the earliest stages of the infection that reflect symptomatic disease and are used as indicators of new infection. In 2016, a total of 813 P&S syphilis cases were reported in the city of Chicago (Table 1.4). This case count corresponds to a rate of 30.1 per 100,000 population (Table 1.1).

P&S SYPHILIS BY CHICAGO COMMUNITY AREA

In 2016, the rates of reported cases of syphilis ranged from 0 to 130.9 per 100,000 population throughout the city of Chicago (Figure 1.6). The three community areas with the highest average P&S syphilis case rates from 2015 to 2016 were Edgewater (130.9 per 100,000), Uptown (127.7 per 100,000), and Lake View (100.7 per 100,000) (Figure 1.6; Appendix Table D.5) .

P&S SYPHILIS BY BIRTH SEX

In 2016, there were 15.6 times as many reported syphilis cases in men than women, with 764 cases reported among males and 49 cases reported among females (Table 1.4). This disparity between the sexes may be reflective of either increased transmission or increased diagnostic screening among men, especially MSM.

P&S SYPHILIS BY AGE

In 2016, individuals aged 20-29 years old were the most frequently diagnosed age group, representing 35.8% of all reported syphilis cases (Table 1.4). However, unlike cases reported for chlamydia and gonorrhea, older age groups made up the majority of reported P&S syphilis cases. Thus, individuals aged 20 to 39 represented 68.1% of all reported P&S syphilis cases in 2016 (Table 1.4).

P&S SYPHILIS BY RACE/ETHNICITY

Like with other reportable STIs in 2016, NH Blacks were the most frequently diagnosed population, representing 36.2% of reported P&S syphilis cases in Chicago (Table 1.4). When compared to the next two populations with the largest number of reported cases, there were 1.7 times as many P&S syphilis cases in NH Blacks than Hispanics and 1.2 times as many than in NH Whites (Table 1.4).

P&S SYPHILIS BY TRANSMISSION GROUP

Since 2011, gender of sex partner was added to the Illinois National Electronic Disease Surveillance System (INEDSS), which allows providers to report this information to the health department to assess trends of syphilis cases among MSM. According to the 2016 CDC STD Surveillance Report, MSM accounted for the majority of reported P&S syphilis cases in 2016 in the United States. Similarly in Chicago, the largest proportions of P&S syphilis cases (74.9%) were among MSM, while men who have sex with females represent 8.7% of the cases (Table 1.4). Notably, 10.3% of male syphilis cases were reported as 'unknown' risk, which, if known, could potentially increase the number of MSM cases.

P&S SYPHILIS + CO-INFECTION

In 2016, a total of 310 reported P&S syphilis cases were also co-infected with HIV (Table 1.5). The majority of co-infected individuals were male (99.7%), NH Black (38.4%), aged 30-39 years (32.6%), and were MSM (80.9%) (Table 1.5).

CONGENITAL SYPHILIS

CONGENITAL SYPHILIS IN CHICAGO

If an early syphilis infection is left untreated in a pregnant woman, it can lead to congenital syphilis which can lead to infection of the fetus and increase the risk for stillbirth or death of the infant. According to the 2016 CDC STD Surveillance Report, after decreasing from 2008-2012, there has been a national increase in congenital syphilis cases from 2013-2016. However, in Chicago, there were 12 congenital syphilis cases reported in 2016, the lowest number of cases in the past 5 years (Table 1.6). In 2016, CDPH launched a campaign to bring awareness to this disease.

(https://www.cityofchicago.org/city/en/depts/cdph/supp_info/hiv/protect-your-baby-from-congenital-syphilis.html)

CONGENITAL SYPHILIS BY CHICAGO COMMUNITY AREA

From 2012-2016, the rates of reported cases of congenital syphilis ranged from 0 to 526.3 per 100,000 population throughout the city of Chicago (Figure 1.7). The Chicago community areas with the higher average congenital syphilis case rates from 2012 to 2016 were West Garfield Park, North Lawndale, Oakland, Fuller Park, Calumet Heights, Roseland, Riverdale, West Englewood, and Greater Grand Crossing (Figure 1.7). Of these nine listed community areas, seven were considered to be areas of high economic hardship (Figure 1.7).

CONGENITAL SYPHILIS BY MATERNAL AGE

In 2016, mothers aged 20-29 accounted for 67.0% of the congenital syphilis cases in the city of Chicago (Table 1.6). This age group has accounted for the majority of congenital syphilis cases for the past 5 years, with mothers aged 20-24 years consistently representing nearly half of those cases, except in 2016 where mothers aged 25-29 accounting for 42.0% of the cases (Table 1.6). The median maternal age for congenital syphilis cases in 2016 was 27 years old, an increase from the median age of 23 years in 2015 (Table 1.6).

CONGENITAL SYPHILIS BY RACE/ETHNICITY

NH Blacks accounted for the majority (75%) of reported congenital syphilis cases in 2016 and have consistently accounted for the majority of these cases for the past 5 years (Table 1.6). When compared to the next two populations with the largest number of reported cases, there were 9 times as many congenital syphilis cases in NH Blacks than Hispanics and NH Whites (Table 1.6).

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Table 1.1: HIV, AIDS, and STI Case Rates and HIV Prevalence Rates by Race/Ethnicity and Birth Sex, Chicago and United States

Demographic Characteristics	Diagnosed/Reported Cases, 2016 [¥]										HIV Prevalence, 2015 [†]			
	HIV Infection [§]		AIDS		Gonorrhea		Chlamydia		Syphilis [€]		HIV Prevalence, 2015 [†]		United States ^{**}	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Race/Ethnicity														
Black, non-Hispanic	491	54.8	207	23.1	4,798	535.9	12,003	1,340.7	294	32.8	11,971	1,337.1	405,321	1,069.5
White, non-Hispanic	124	14.5	54	6.3	1,283	150.3	2,346	274.7	253	29.6	5,784	677.4	300,156	152.4
Hispanic	181	23.7	78	10.2	921	120.6	3,970	519.7	173	22.6	4,609	603.3	198,456	391.1
Asian/Pi, non-Hispanic	24	16.1	7	4.7	85	57.2	295	198.4	29	19.5	261	175.6	13,189	87.7
AI/AN, non-Hispanic	< 5	100.7	< 5	33.6	14	470.1	34	1,141.7	< 5	67.2	24	805.9	2,908	140.2
Other, non-Hispanic	16	23.5	20	29.4	85	124.9	268	393.9	62	91.1	1,175	1,726.9	35,051	525.7
Unknown	0		0		3,650		10,860		0		0			
Sex[^]														
Male	694	53.1	296	22.7	6,900	528.3	11,279	863.6	764	58.5	19,150	1,466.3	722,244	474.9
Female	145	10.4	71	5.1	3,920	281.4	18,464	1,325.7	49	3.5	4,674	335.6	230,360	146.5
Unknown	0		0		16		33		0		0			
Chicago[§]	839	31.1	367	13.6	10,836	401.5	29,776	1,103.3	813	30.1	23,824	882.8	-	-
United States[†] **	39,782	12.3	18,274	5.9	468,514	145.8	1,598,354	497.3	27,814	8.7	-	-	973,846	303.5

¥ 2016 Diagnoses for HIV and AIDS; 2016 Reported Cases for STIs; 2015 HIV Prevalence. † Prevalence rate per 100,000 population. § HIV infection diagnosis and prevalence represents people with HIV at any stage of disease through 9/26/17. β Totals of newly diagnosed HIV and AIDS may be lower due to incomplete laboratory reporting. * Rate per 100,000 population using 2010 U.S. Census Bureau Population figures. € Primary and secondary syphilis (symptomatic and infectious stages) only. ** Centers for Disease Control and Prevention. HIV Surveillance Report, 2016; vol. 28. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published November 2017. ‡ Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2016. Atlanta: U.S. Department of Health and Human Services; 2017. ^ Counts based on birth sex.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Table 1.2: HIV and AIDS Infections and Late Diagnosis by Selected Demographic Characteristics, Chicago, 2016. (as of 09/26/2017)

Demographic Characteristics	HIV*		AIDS*		Late Diagnosis†	
	No.	%	No.	%	No.	%
Gender**						
Male	683	81.4%	292	79.6%	153	79.7%
Female	141	16.8%	70	19.1%	37	19.3%
Transgender: MtF	11	1.3%	< 5	1.1%	< 5	< 1%
Transgender: FtM	< 5	< 1%	< 5	< 1%	< 5	< 1%
Race/Ethnicity^						
Black, non-Hispanic	491	58.5%	207	56.4%	106	55.2%
White, non-Hispanic	124	14.8%	54	14.7%	24	12.5%
Hispanic	181	21.6%	78	21.3%	49	25.5%
Asian/PI, non-Hispanic	24	2.9%	7	1.9%	6	3.1%
AI/AN, non-Hispanic	< 5	< 1%	< 5	< 1%	< 5	< 1%
Multiple, non-Hispanic	16	1.9%	20	5.4%	6	3.1%
Unknown	0	0.0%	0	0.0%	0	0.0%
Transmission Group						
Male Sex w/Male	602	71.8%	231	62.9%	122	63.5%
Injection Drug Use	44	5.2%	35	9.5%	13	6.8%
MSM and IDU§	23	2.7%	13	3.5%	5	2.6%
Heterosexual	164	19.5%		22.3%	50	26.0%
Other¶	6	< 1%	6	1.6%	< 5	< 1%
Age Category†						
Less than 13	5	< 1%	< 5	< 1%	< 5	< 1%
13-19	64	7.6%	8	< 1%	6	1.2%
20-29	338	40.3%	100	27.2%	66	34.4%
20-24	140	16.7%	40	10.9%	28	14.6%
25-29	198	23.6%	60	16.3%	38	19.8%
30-39	201	24.0%	92	25.1%	45	23.4%
40-49	113	13.5%	67	18.3%	31	16.1%
50-59	86	10.3%	59	16.1%	33	17.2%
60+	32	3.8%	39	10.6%	10	5.2%
Total€	839		367		192	

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, at any stage of disease through 09/26/2017.

AIDS represents all newly diagnosed as stage 3 HIV (AIDS), through 09/26/2017.** Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender independently of values using birth sex, total diagnoses may differ slightly across tables.

^ Multiple, non-Hispanic indicates more than one race identified. § Men who have sex with men and inject drugs.

¶ Includes perinatal transmission, blood transfusion, hemophilia, and no indicated risk (NIR).

† Age at time of diagnosis. ‡ Late diagnosis represents those diagnosed with stage 3 HIV (AIDS) within 1 year of being diagnosed with HIV.

€Total case count may be lower due to incomplete laboratory reporting.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Table 1.3: People Living with HIV Infection (PLWH) and AIDS (PLWA) in 2015, by Selected Demographic Characteristics, Chicago. (as of 09/26/2017)

Demographic Characteristics	HIV*		AIDS†	
	No.	%	No.	%
Gender**				
Male	18,994	79.7%	9,977	80.2%
Female	4,592	19.3%	2,356	18.9%
Transgender: MtF	157	< 1%	70	< 1%
Transgender: FtM	79	< 1%	39	< 1%
Additional Gender	< 5	< 1%	0	0.0%
Race/Ethnicity^				
Black, non-Hispanic	11,971	50.2%	6,479	52.1%
White, non-Hispanic	5,784	24.3%	2,628	21.1%
Hispanic	4,609	19.3%	2,554	20.5%
Asian/PI, non-Hispanic	261	1.1%	124	1.0%
AI/AN, non-Hispanic	24	< 1%	9	< 1%
Multiple, non-Hispanic	1,175	4.9%	650	5.2%
Unknown	0	0.0%	0	0.0%
Transmission Group				
Male Sex w/Male	14,863	62.4%	7,180	57.7%
Injection Drug Use	3,043	12.8%	2,000	16.1%
MSM and IDUs	1,278	5.4%	858	6.9%
Heterosexual	4,247	17.8%	2,215	17.8%
Other¶	393	1.6%	191	1.5%
Age Category†				
Less than 13	69	< 1%	8	< 1%
13-19	184	< 1%	33	< 1%
20-29	2,829	11.9%	785	6.3%
20-24	993	4.2%	233	1.9%
25-29	1,836	7.7%	556	4.5%
30-39	4,174	17.5%	1,696	13.6%
40-49	6,210	26.1%	3,301	26.5%
50-59	6,949	29.2%	4,311	34.6%
60+	3,409	14.3%	2,306	18.5%
Total	23,824		12,444	

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 prevalence represents people diagnosed with HIV through 2015 and living with HIV in 2016. † AIDS represents people diagnosed with stage 3 HIV (AIDS) through 2015 and living with AIDS in 2016.

** Current gender identity or gender with which a person identifies. Because total diagnoses were calculated using current gender independently of values using birth sex, total diagnoses may differ slightly across tables.

^ Multiple, non-Hispanic indicates more than one race identified. § Men who have sex with men and inject drugs. ¶ Includes perinatal transmission, blood transfusion, hemophilia, and NIR. † Current age as of 2015.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Table 1.4: Reported Cases of Chlamydia, Gonorrhea, Primary and Secondary (P&S) Syphilis by Selected Demographic Characteristics, Chicago, 2016

Demographic Characteristics	Chlamydia		Gonorrhea		P&S Syphilis	
	No.	%	No.	%	No.	%
Birth Sex[¥]						
Male	11,279	37.9%	6,900	63.7%	764	94.0%
Female	18,464	62.0%	3,920	36.2%	49	6.0%
Race/Ethnicity[^]						
Black, non-Hispanic	12,003	40.3%	4,798	44.3%	294	36.2%
White, non-Hispanic	2,346	7.9%	1,283	11.8%	253	31.1%
Hispanic	3,970	13.3%	921	8.5%	173	21.3%
Asian/PI, non-Hispanic	295	1.0%	85	< 1%	29	3.6%
AI/AN, non-Hispanic	34	< 1%	14	< 1%	< 5	< 1%
Other, non-Hispanic	268	< 1%	85	< 1%	62	7.6%
Unknown	10,860	36.5%	3,650	33.7%	0	0.0%
Transmission Group[‡]						
Male sex w/Male	—	—	—	—	609	74.9%
Heterosexual Males	—	—	—	—	71	8.7%
Females	—	—	—	—	49	6.0%
Male unknown	—	—	—	—	84	10.3%
Age Category[†]						
Less than 13	37	< 1%	16	< 1%	0	0.0%
13-19	7,867	26.4%	2,315	21.4%	27	3.3%
20-29	16,137	54.2%	5,483	50.6%	291	35.8%
20-24	10,033	33.7%	3,117	28.8%	101	12.4%
25-29	6,104	20.5%	2,366	21.8%	190	23.4%
30-39	4,078	13.7%	1,952	18.0%	263	32.3%
40-49	1,135	3.8%	682	6.3%	141	17.3%
50-59	415	1.4%	304	2.8%	77	9.5%
60+	107	< 1%	84	< 1%	14	1.7%
Total**	29,776		10,836		813	

Note: Groups may not total 100% due to rounding.

Use caution when interpreting data based on less than 20 events; rate/percent is unreliable.

¥ Does not include unknown. ‡ Transmission Group represents the sex of sexual partner of syphilis cases.

Data are not collected for chlamydia and gonorrhea.

† Age a time of diagnosis. ^ AI/AN refers to American Indian/Alaska Native.

** Includes cases with unknown sex.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Table 1.5: Co-Infection between HIV Infection Diagnoses & Reported Cases of Chlamydia, Gonorrhea, Primary & Secondary (P&S) Syphilis by Selected Demographic Characteristics, Chicago, 2016[€]

Demographic Characteristics	HIV + Chlamydia		HIV + Gonorrhea		HIV + P&S Syphilis	
	No.	%	No.	%	No.	%
Gender**						
Male	914	92.0%	1038	96.3%	309	99.7%
Female	79	7.9%	37	3.4%	< 5	< 1%
Unknown	< 5	< 1%	< 5	< 1%	0	0.0%
Race/Ethnicity[^]						
Black, non-Hispanic	309	31.1%	347	32.2%	119	38.4%
White, non-Hispanic	205	20.6%	237	22.0%	91	29.4%
Hispanic	144	14.5%	149	13.8%	72	23.2%
Asian/PI, non-Hispanic	6	0.6%	16	1.5%	8	2.6%
AI/AN, non-Hispanic	< 5	< 1%	< 5	< 1%	< 5	< 1%
Multiple, non-Hispanic	5	< 1%	10	< 1%	5	1.6%
Unknown	324	32.6%	318	29.5%	14	4.5%
Transmission Group[¥]						
Male Sex w/Male	691	69.6%	746	69.2%	251	80.9%
Injection Drug Use	13	1.3%	10	< 1%	< 5	< 1%
MSM and IDU [§]	37	3.7%	63	5.8%	12	3.7%
Heterosexual	56	5.7%	31	2.9%	< 5	1.1%
Other [¶]	9	< 1%	10	< 1%	0	0.0%
Missing	187	18.8%	218	20.2%	42	13.5%
Age Category[†]						
13-19	32	3.2%	33	3.1%	8	2.6%
20-29	384	38.6%	442	41.0%	83	26.8%
20-24	156	15.7%	161	14.9%	25	8.1%
25-29	228	22.9%	281	26.1%	58	18.7%
30-39	290	29.2%	341	31.6%	101	32.6%
40-49	191	19.2%	172	16.0%	69	22.3%
50-59	84	8.5%	76	7.1%	43	13.9%
60+	13	1.3%	14	1.3%	6	1.9%
Total	994	100.0%	1,078	100.0%	310	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+Chlamydia, HIV+Gonorrhea and HIV+Syphilis diagnoses represents people living with HIV and also diagnosed with the respective STI during 2016.

€ Data Source: Illinois Department of Public Health (IDPH) as of 10/10/2017.

** Current gender identity or gender with which a person identifies.

Because total diagnoses were calculated using current gender, independently of values using birth sex, total diagnoses may differ slightly across tables.

[^] Multiple, non-Hispanic indicates more than one race identified.

AI/AN refers to American Indian/ Alaskan Native.

[¥] Transmission Group data based on HIV surveillance data as of 9/26/2017

[§] Men who have sex with men and inject drugs.

[¶] Includes perinatal transmission, blood transfusion, hemophilia, and NIT.

[†] Age at time of STI diagnosis.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Table 1.6: Congenital Syphilis Cases by Selected Demographic Characteristics, Chicago, 2012-2016

Demographic Characteristics	Year of Report									
	2012		2013		2014		2015		2016	
	No.	%	No.	%	No.	%	No.	%	No.	%
Case Classification										
Presumptive Cases	22	100.0%	13	87.0%	18	90.0%	24	100.0%	12*	100%
Stillborns	0	0.0%	< 5	13.0%	< 5	10.0%	0	0.0%	0	0.0%
Race/Ethnicity										
Black, non-Hispanic	17	77.3%	9	60.0%	13	65.0%	18	75.0%	9	75.0%
White, non-Hispanic	< 5	4.5%	< 5	13.3%	< 5	5.0%	< 5	4.2%	< 5	8.3%
Hispanic	< 5	9.1%	< 5	20.0%	< 5	5.0%	5	20.8%	< 5	8.3%
Asian/PI, non-Hispanic	< 5	9.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
AI/AN, non-Hispanic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other/Unknown	0	0.0%	< 5	6.7%	5	25.0%	0	0.0%	< 5	8.3%
Maternal Age Category†										
Less than 13	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
13-19	5	22.7%	< 5	20.0%	0	0.0%	< 5	8.3%	0	0.0%
20-29	15	68.2%	10	66.7%	15	75.0%	19	79.2%	8	67.0%
20-24	13	59.1%	7	46.7%	9	45.0%	12	50.0%	< 5	25.0%
25-29	< 5	9.1%	< 5	20.0%	6	30.0%	7	29.2%	5	42.0%
30-39	< 5	4.5%	< 5	13.3%	5	25.0%	< 5	8.3%	< 5	33.0%
40+	< 5	4.5%	0	0.0%	0	0.0%	< 5	4.2%	0	0.0%
Median Age	22		22		26		23		27	
Total	22		15		20		24		12*	

Note: Groups may not total 100% due to rounding.

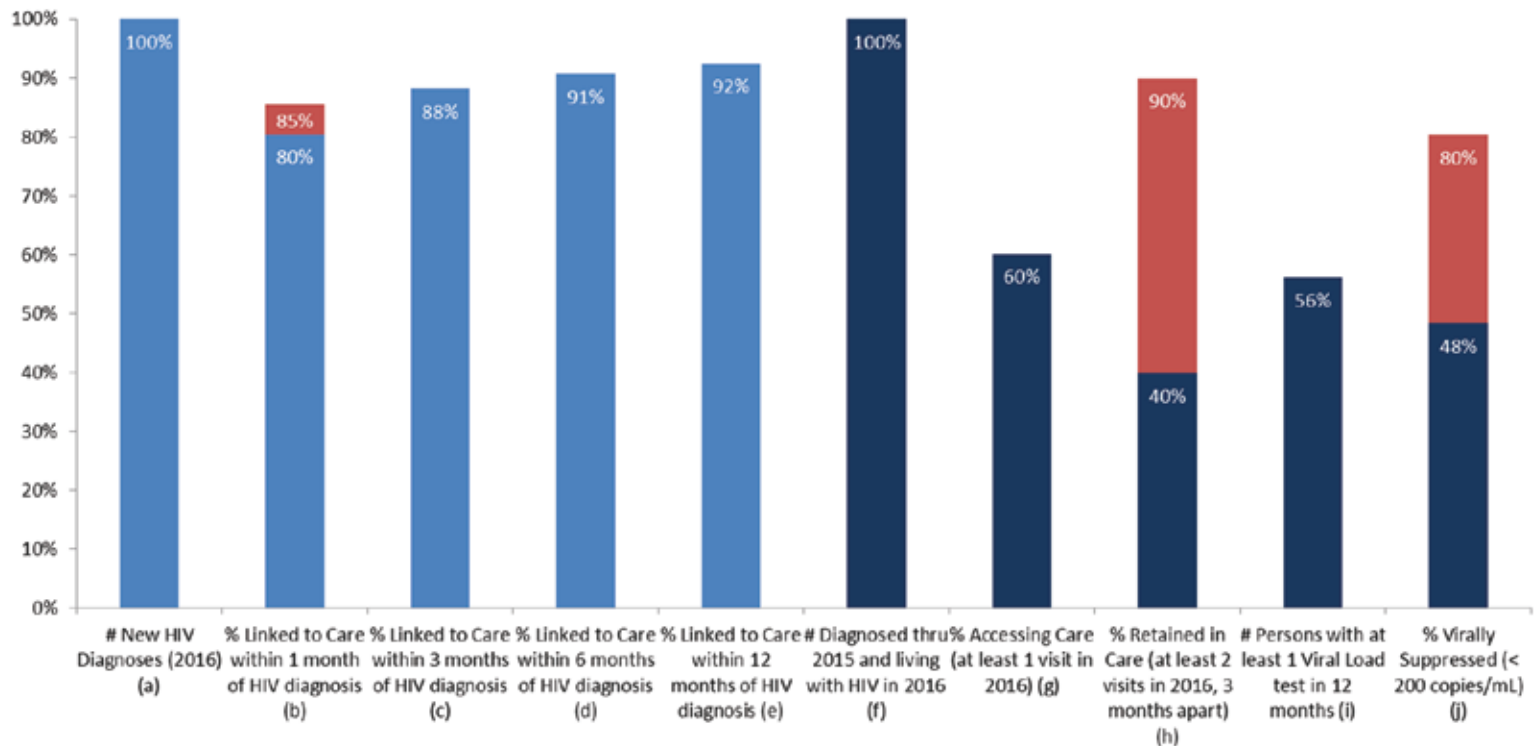
Use caution when interpreting data based on less than 20 events; rate/percent is unreliable.

† Age at time of diagnosis.

*Number of cases are based on the date of report to the Health Department

SECTION ONE: HIV & STIS IN CHICAGO, 2016

Figure 1.1: HIV Continuum of Care Among Cases 13 Years and Older, Chicago, 2016 (as of 9/26/2017) with 2020 National HIV/AIDS Strategy Indicators #4-6(red)



(a) Number of persons ≥ 13 years of age at diagnosis with HIV infection between 1/1/2016 and 12/31/2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Link1 Table.

(b) Percent of persons ≥ 13 years of age linked to care (at least one CD4, Viral Load (VL), or HIV-1 genotype test) within 1 month of HIV diagnosis among those diagnosed with HIV infection between 1/1/2016 and 12/31/2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Link1 Table.

(c) Percent of persons ≥ 13 years of age linked to care (at least one CD4, VL, or HIV-1 genotype test) within 3 months of HIV diagnosis among those diagnosed with HIV infection between 1/1/2016 and 12/31/2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Link1 Table.

(d) Percent of persons ≥ 13 years of age linked to care (at least one CD4, VL, or HIV-1 genotype test) within 6 months of HIV diagnosis among those diagnosed with HIV infection between 1/1/2016 and 12/31/2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Link1 Table.

(e) Percent of persons ≥ 13 years of age linked to care (at least one CD4, VL, or HIV-1 genotype test) within 12 months of HIV diagnosis among those diagnosed with HIV infection between 1/1/2016 and 12/31/2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Link1 Table.

(f) Number of persons ≥ 13 years of age on 12/31/2015 diagnosed with HIV through 12/31/2015 and living with HIV on 12/31/2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Care1 and VL1 Tables.

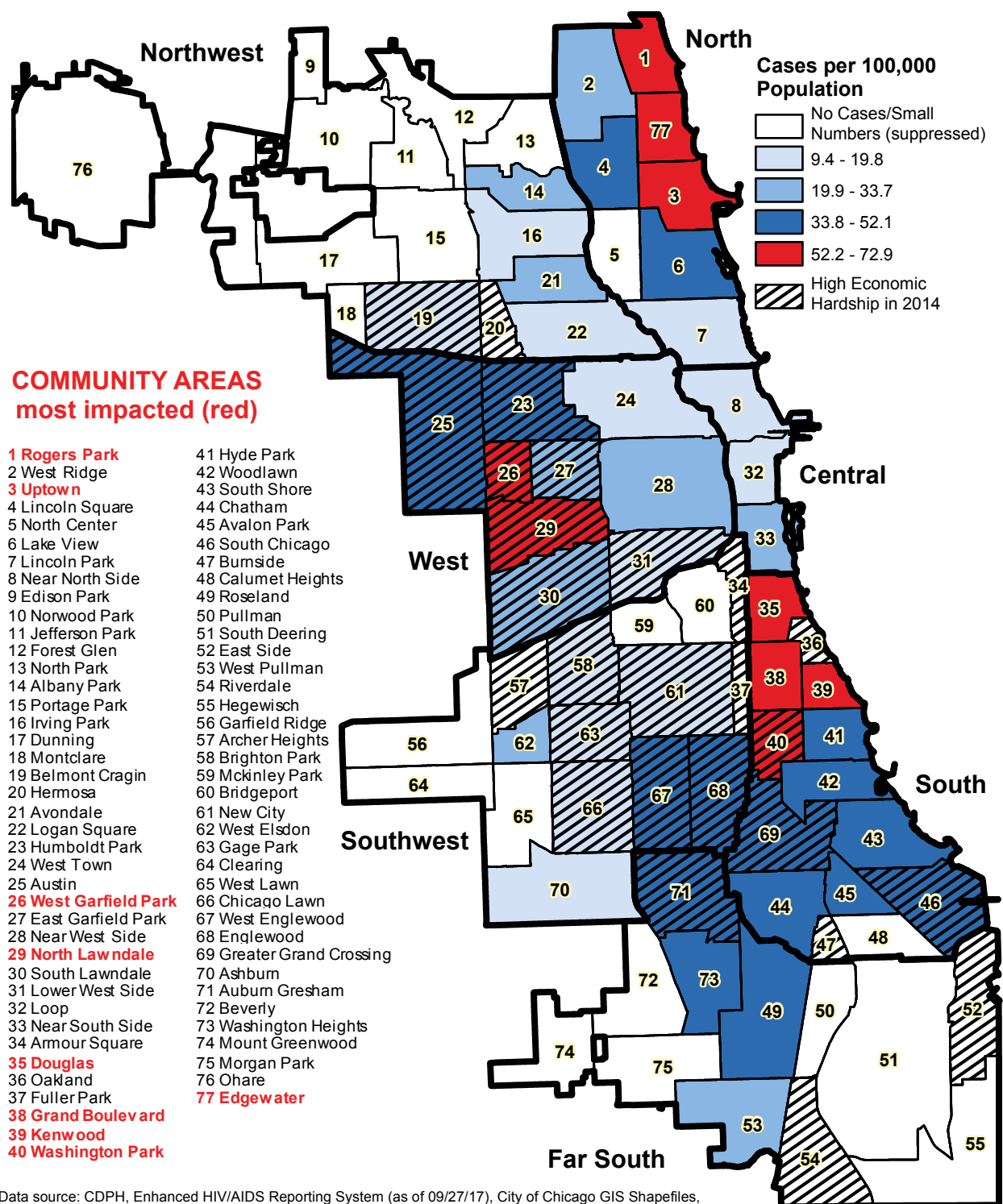
(h) Number of persons ≥ 13 years of age on 12/31/2015 diagnosed with HIV through 12/31/2015 and living with HIV on 12/31/2016 who received at least two medical care visits (at least one CD4 or VL at each), 3 months apart, between January 2016 and December 2016. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, Care1 Table.

(i) Number of persons ≥ 13 years of age on 12/31/2015 diagnosed with HIV through 12/31/2015 and living with HIV on 12/31/2016 who received at least one VL test in the past 12 months. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, VL1 Table.

(j) Percent of persons ≥ 13 years of age on 12/31/2015 diagnosed with HIV through 12/31/2015 and living with HIV on 12/31/2016 whose most recent VL test result was < 200 copies /mL. Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (as of 9/26/2017). NHAS output, VL1 Table.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

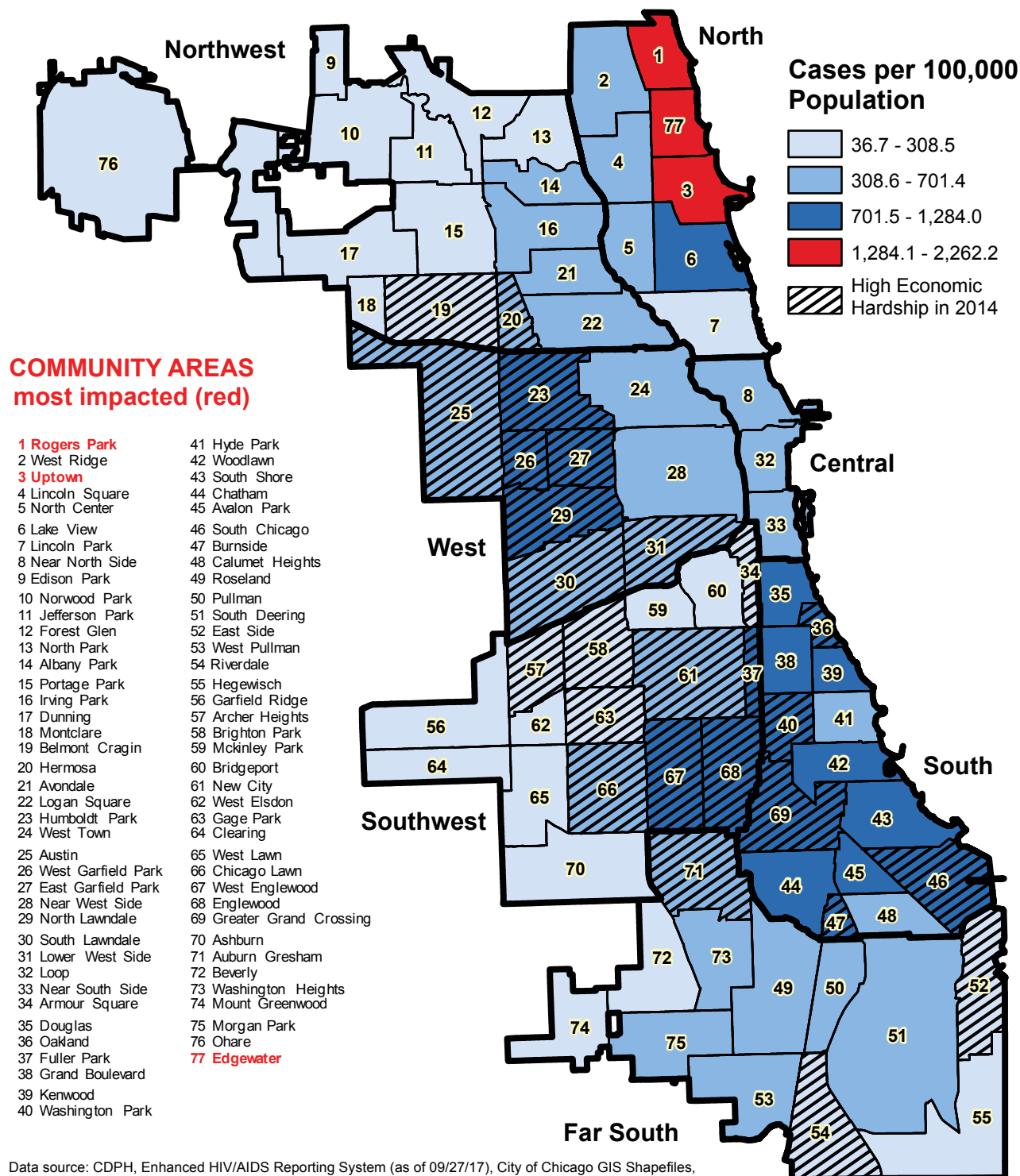
Figure 1.2: 2016 Rate of HIV Infection Diagnoses in Chicago by Community Area



Data source: CDPH, Enhanced HIV/AIDS Reporting System (as of 09/27/17), City of Chicago GIS Shapefiles, and U.S. Census. This map represents 88% (738/839) of total new HIV infection diagnoses. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

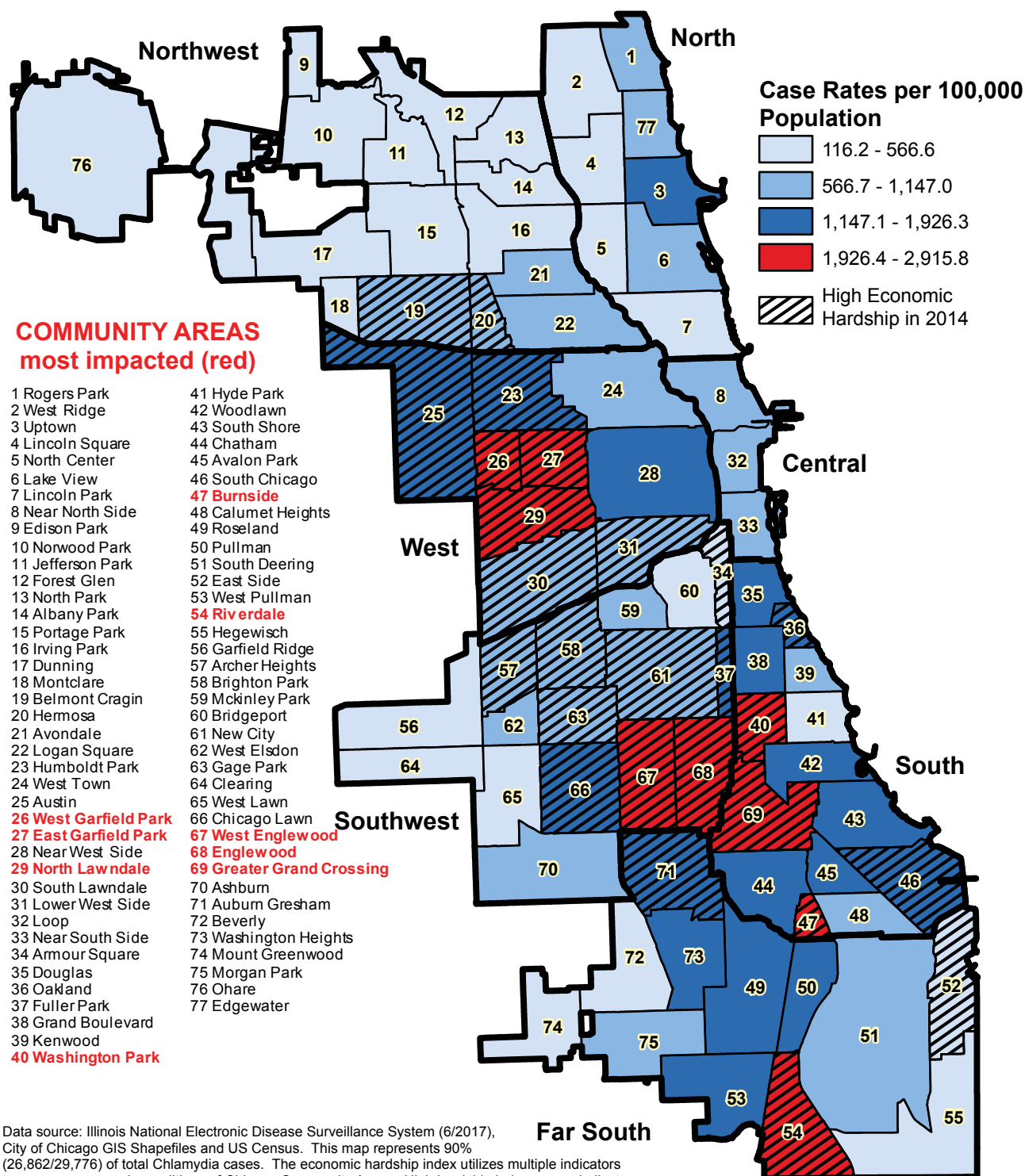
Figure 1.3: 2015 Rate of People Living with HIV/AIDS in Chicago by Community Area



Data source: CDPH, Enhanced HIV/AIDS Reporting System (as of 09/27/17), City of Chicago GIS Shapefiles, and U.S. Census. This map represents 68% (16,226/23,824) of people living with HIV/AIDS. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.

SECTION ONE: HIV & STIs IN CHICAGO, 2016

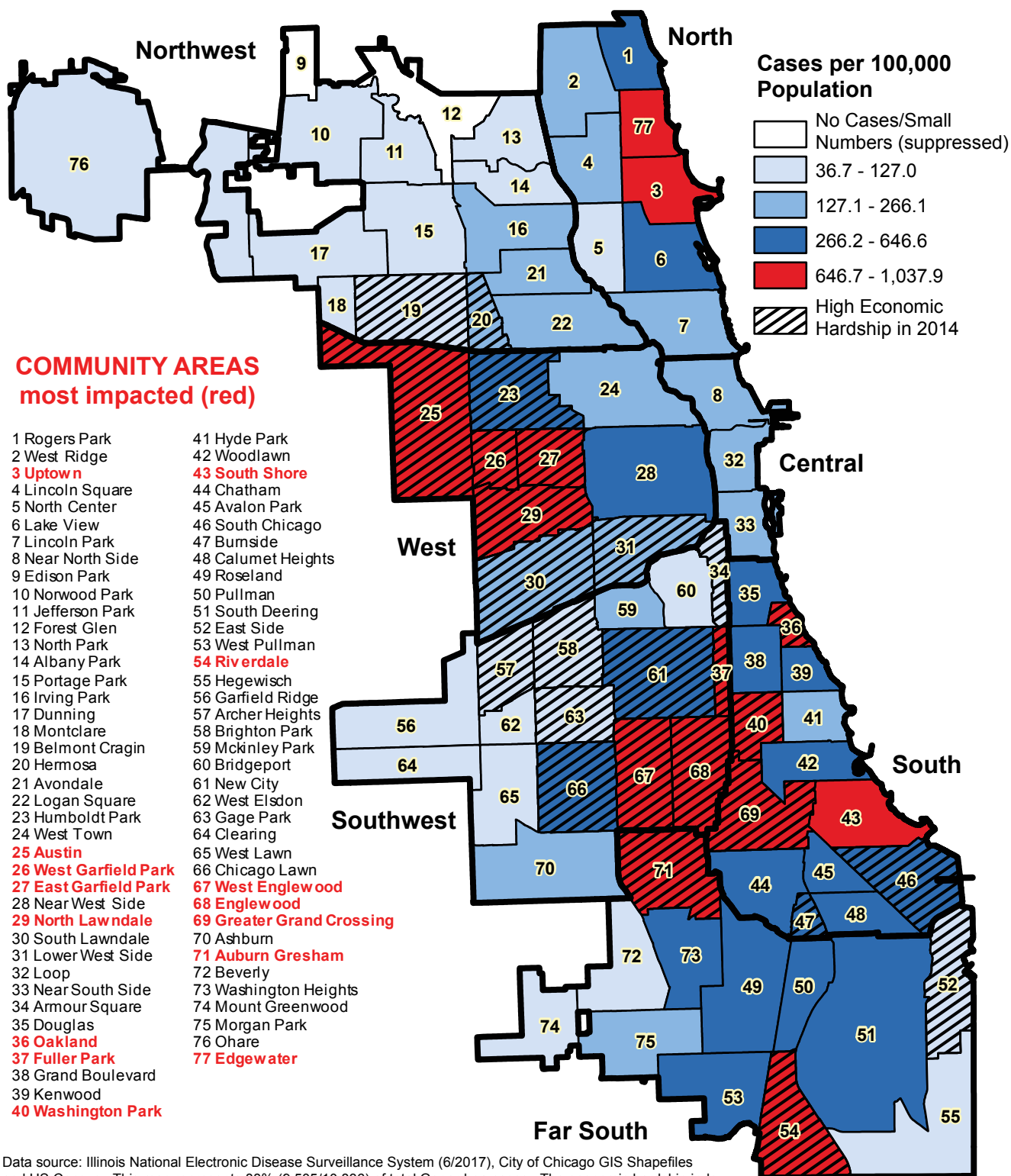
Figure 1.4: Chlamydia Case Rates by Community Area, Chicago, 2016



Data source: Illinois National Electronic Disease Surveillance System (6/2017), City of Chicago GIS Shapefiles and US Census. This map represents 90% (26,862/29,776) of total Chlamydia cases. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.

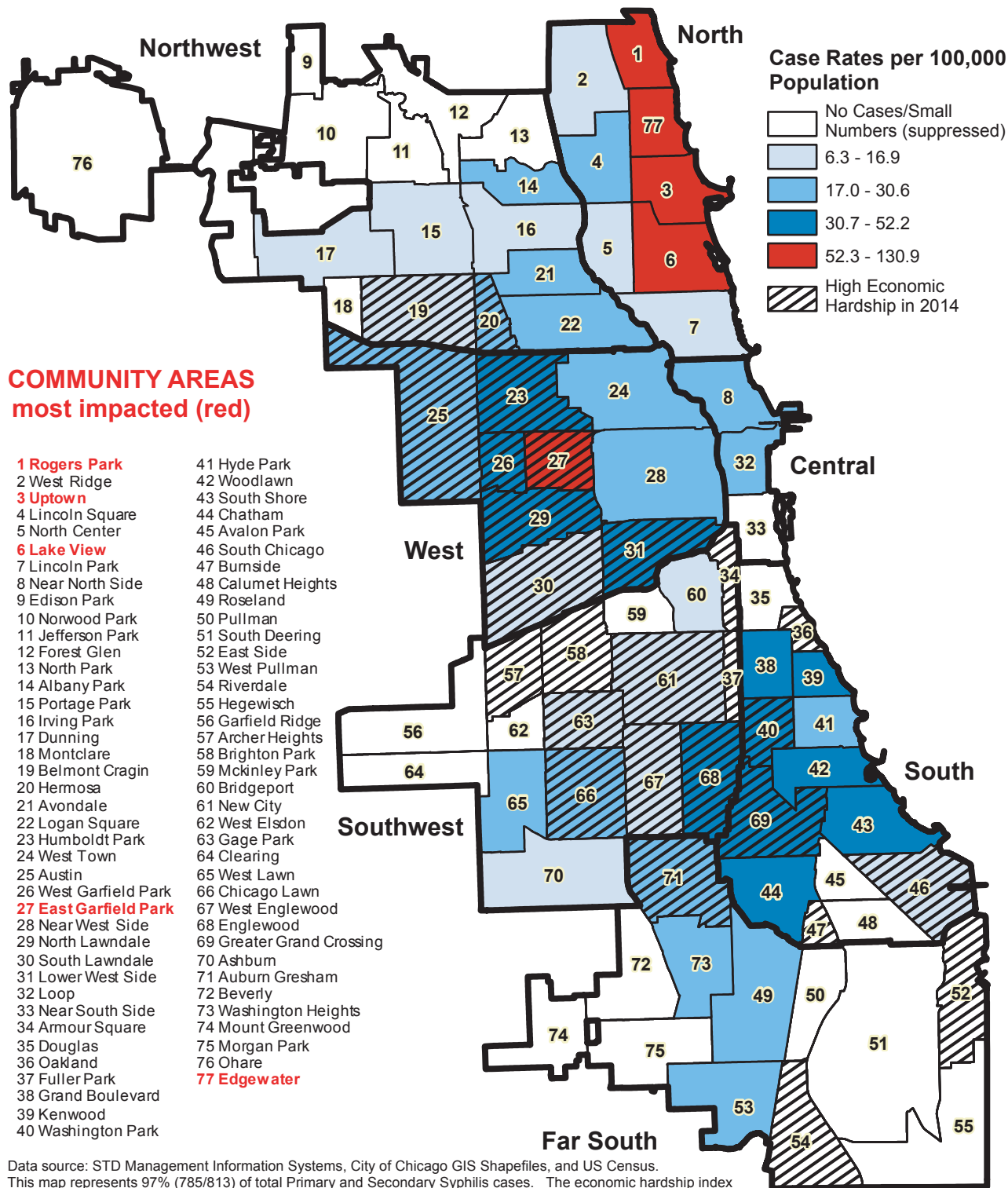
SECTION ONE: HIV & STIs IN CHICAGO, 2016

Figure 1.5: Gonorrhea Case Rates by Community Area, Chicago, 2016



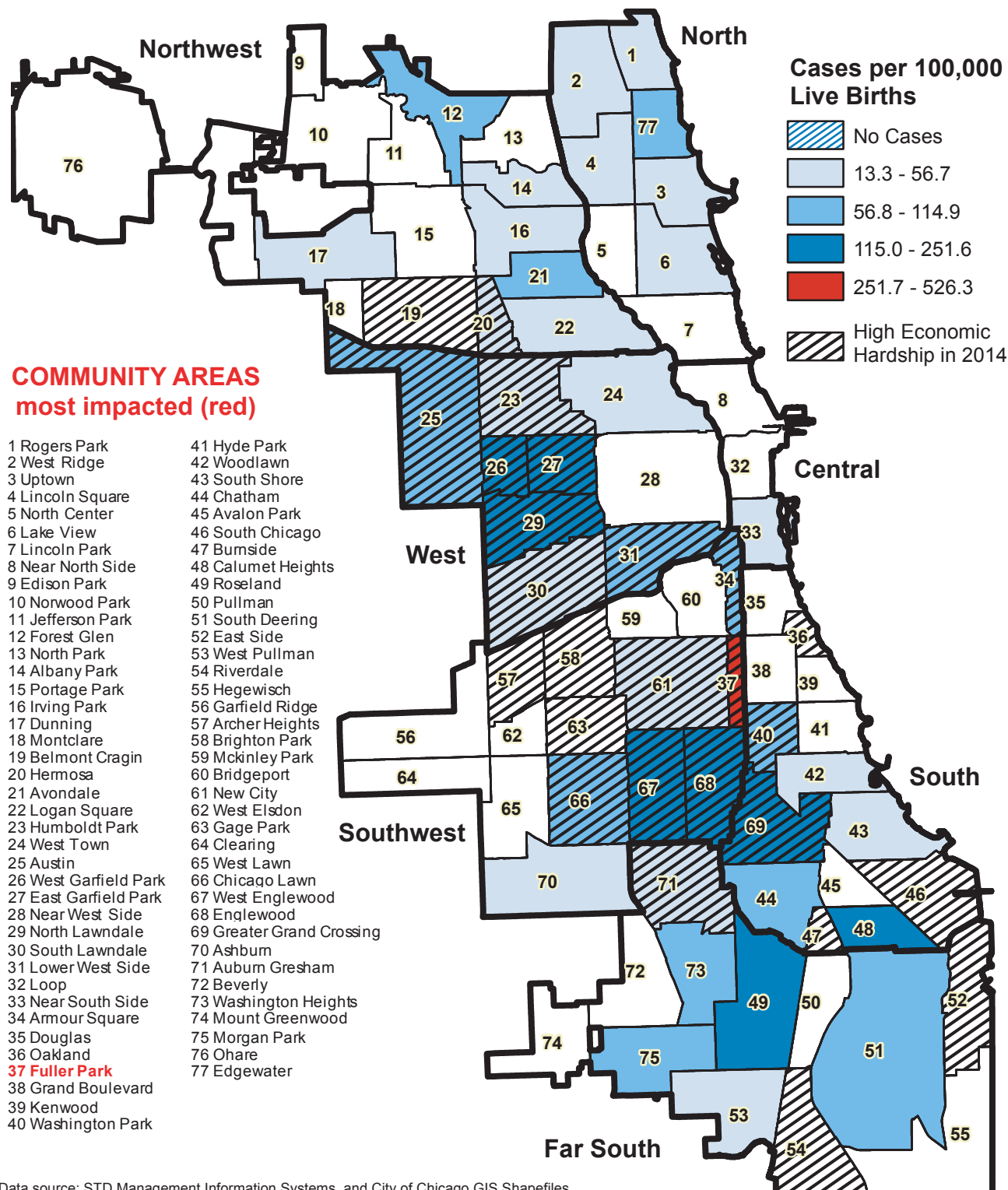
Data source: Illinois National Electronic Disease Surveillance System (6/2017), City of Chicago GIS Shapefiles and US Census. This map represents 88% (9,505/10,836) of total Gonorrhea cases. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.

SECTION ONE: HIV & STIS IN CHICAGO, 2016

Figure 1.6: Primary and Secondary Syphilis Case Rates by Community Area, Chicago, 2016

SECTION ONE: HIV & STIs IN CHICAGO, 2016

Figure 1.7: Average Annual Congenital Syphilis Case Rates by Community Area, Chicago, 2012-2016



Data source: STD Management Information Systems, and City of Chicago GIS Shapefiles

Note: Rates per 100,000 were calculated using 2014 live births as the denominator. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.



SECTION THREE LOOKING FORWARD: STIs ARE ON THE RISE

DISCUSSION

SEXUALLY TRANSMITTED INFECTIONS ARE ON THE RISE

Sexually transmitted infections (STIs) have re-entered the national spotlight following the release of the CDC's 2016 Sexually Transmitted Disease Surveillance Report. In a press release for the report CDC noted that for the third year in a row reportable STIs reached an all-time high in 2016, and emphasized the need for expanded efforts in STI prevention, especially for those at greatest risk.¹ Though the distribution of cases varies by disease, nationally the majority of STI diagnoses occur among young men and women, non-Hispanic Blacks, and youth aged 15-24. As with HIV, men who have sex with men (MSM) are also a priority population.²

In order to combat this growing trend, CDC has called on local health departments, providers, and members of the public to renew efforts towards STI detection, treatment, and prevention. In Chicago, CDPH has utilized STI Specialty clinics as well as established partnerships with health care providers and delegate agencies to focus on priority populations and strengthen responses to the increasing trends of STIs. However, there is need to continue to promote STI screening with a specific focus on testing extra-genital sites. A recent study of extra-genital gonorrhea and chlamydia testing among individuals identified as MSM found that in Chicago between 2010 and 2012 9.3% of MSM screened tested positive for pharyngeal gonorrhea, 11.8% tested positive for rectal gonorrhea, 3.7% tested positive for pharyngeal chlamydia and 11.4% tested positive for rectal chlamydia, underscoring the importance of extra-genital testing within this population.³

It is vital to increase awareness and promote regular testing and the use of risk reduction strategies. Though the burden of STIs is high, these strategies are the key to addressing the growing number of STI infections and promoting sexual and reproductive health among Chicagoans.

STI PRIORITY POULATIONS

Gonorrhea (Figure 3.1)

The number of reported gonorrhea has increased by 37% between 2010 and 2016. During the same time the proportion of cases with confirmed treatment increased from 51% to 60%. In previous years, gonorrhea infections occurred fairly evenly between males and females. However, starting in 2015, trends shifted and the majority of reported gonorrhea cases were among men (64%). An increase in the number of reported gonorrhea cases among males could be partially attributed to the expanding extra-genital screening among MSM. Figure 3.1 highlights population shifts that occurred between 2010 and 2016, specifically among men over 25 years old and women under 25 years old. Among men over the age of 25 this trend is reversed. In 2010 the proportion of gonorrhea cases reported among men over 25 was 22% while in 2016 men in the same age group accounted for 41% of gonorrhea cases.

Between 2010 and 2016, overall number of reported cases among females decreased by 21% (from 4,948 to 3,920 in 2016). During the same time period the proportion of gonorrhea cases among women under 25 years old decreased from 41% to 25%.

In 2016, the median age of all gonorrhea cases was 25, however when examining age by sex the median age among women was lower than that of men (22 versus 27) in 2016. By race, the median age of NH Blacks (23) is lower than that of Hispanics (27) and NH Whites (31).

CHLAMYDIA (Figures 3.2 and 3.3)

Chlamydia is the most commonly diagnosed sexually transmitted infection in the United States. Between 2010 and 2016, the number of Chlamydia cases reported to CDPH increased by 18%. The vast majority of chlamydia cases reported between 2010 and 2016 were among women (67%), primarily women under the age of 25 years old (47%) (median age=22 years old in 2016). In comparison, 32% of cases were reported among men and men under 25 years old comprised only 17% of all reported cases during this time period. In 2016, 58% of females and 55% of males were treated for *Chlamydia trachomatis* infections, though it is worth noting that treatment data are incomplete due to underreporting or incomplete reporting.

Among women, the distribution of chlamydia infection varies by race/ethnicity: NH Black women have consistently comprised the majority (39%) of reported cases in women between 2010 and 2016; however, the proportion of cases reported among this group have decreased by 16% (from 58% in 2010 to 50% in 2016). The vast majority of cases (73%) among NH Black women were under the age of 25 years old (median age =22 in 2016). During the same time period, cases among Hispanic women have increased by 19% (from 10% in 2010 to 14% in 2016). Similarly to NH Black women, the majority of cases (61%) among Hispanic women were under the age of 25 years old (median age=22 years old in 2016). The proportion of chlamydia cases among NH White women is low, but has increased slightly from less than 3% in 2010 to 4% in 2016. Contrary to the trends in age seen among NH Black and Hispanic women, the median age among NH White women in 2016 was slightly older at 26, and cases were evenly divided by age with 49% of 2016 cases falling within the under 25 group.

Primary and Secondary Syphilis (Figure 3.4)

During 2016, a total of 813 cases of P&S syphilis were reported to CDPH; 764 (94%) were in males and 49 (6%) were among women. Cases among men who have sex with men (MSM) comprise the majority (75%) of P&S syphilis cases in the city. The median age among all reported P&S syphilis cases in 2016 was 33 years old, but was higher among men (33) than women (29) and higher among NH Whites (37) and Hispanics (33) than among NH Blacks (30). Between 2012 and 2016 the proportion of cases among men over the age of 25 increased, comprising 70% of new diagnoses in 2012 and 81% of cases in 2016. During this same time period the number of cases among men under 25, and women of both age groups decreased. Cases among men under 25 decreased from 20% in 2012 to 13% in 2016. Similarly to males under 25, the proportion of cases among women under 25 years old decreased from 4% of cases in 2012 to 2% in 2016, while cases among women 25 and older decreased from 6% in 2012 to 4% in 2016. Although women accounted for only 6% of P&S syphilis cases in 2016, addressing syphilis among women remains an essential part of preventing congenital syphilis (CS). CS is a serious but preventable outcome of syphilis infection during pregnancy. Screening and treatment of syphilis infection in women, especially pregnant women, are required to prevent any increase in CS infections.

References

1. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. (2017, September 26). STDs at record high, indicating urgent need for prevention [Press release]. Retrieved November 3, 2017, from <https://www.cdc.gov/media/releases/2017/p0926-std-prevention.html>.
2. Centers for Disease Control and Prevention. (2017). Sexually Transmitted Disease Surveillance 2016. Atlanta, GA: U.S. Department of Health and Human Services. Retrieved November 3, 2017, from https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.
3. Patton, M. E. (2014). Extragenital Gonorrhea and Chlamydia Testing and Infection Among Men Who Have Sex With Men—STD Surveillance Network, United States, 2010–2012. *Clinical Infectious Diseases*, 58(11), 1564–1570. Retrieved November 3, 2017, from <https://academic.oup.com/cid/article/58/11/1564/2895546>.

Figure 3.1: Reported Gonorrhea Infections by Birth Sex, Age, and Year-end Treatment Status, Chicago, 2010-2016

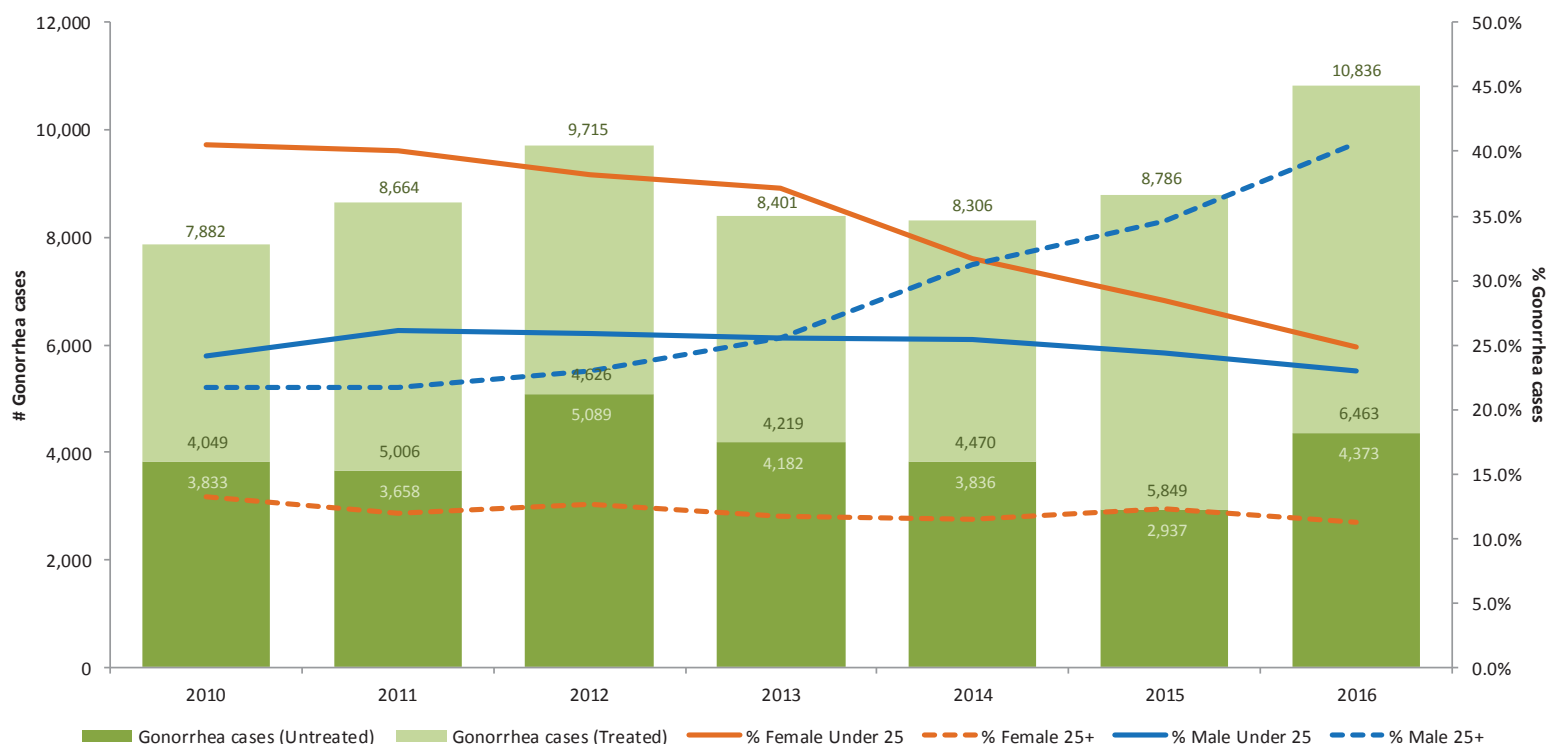


Figure 3.2: Reported Chlamydia Infections among Women by Age, Race/Ethnicity, and Year-end Treatment Status, Chicago, 2010-2016

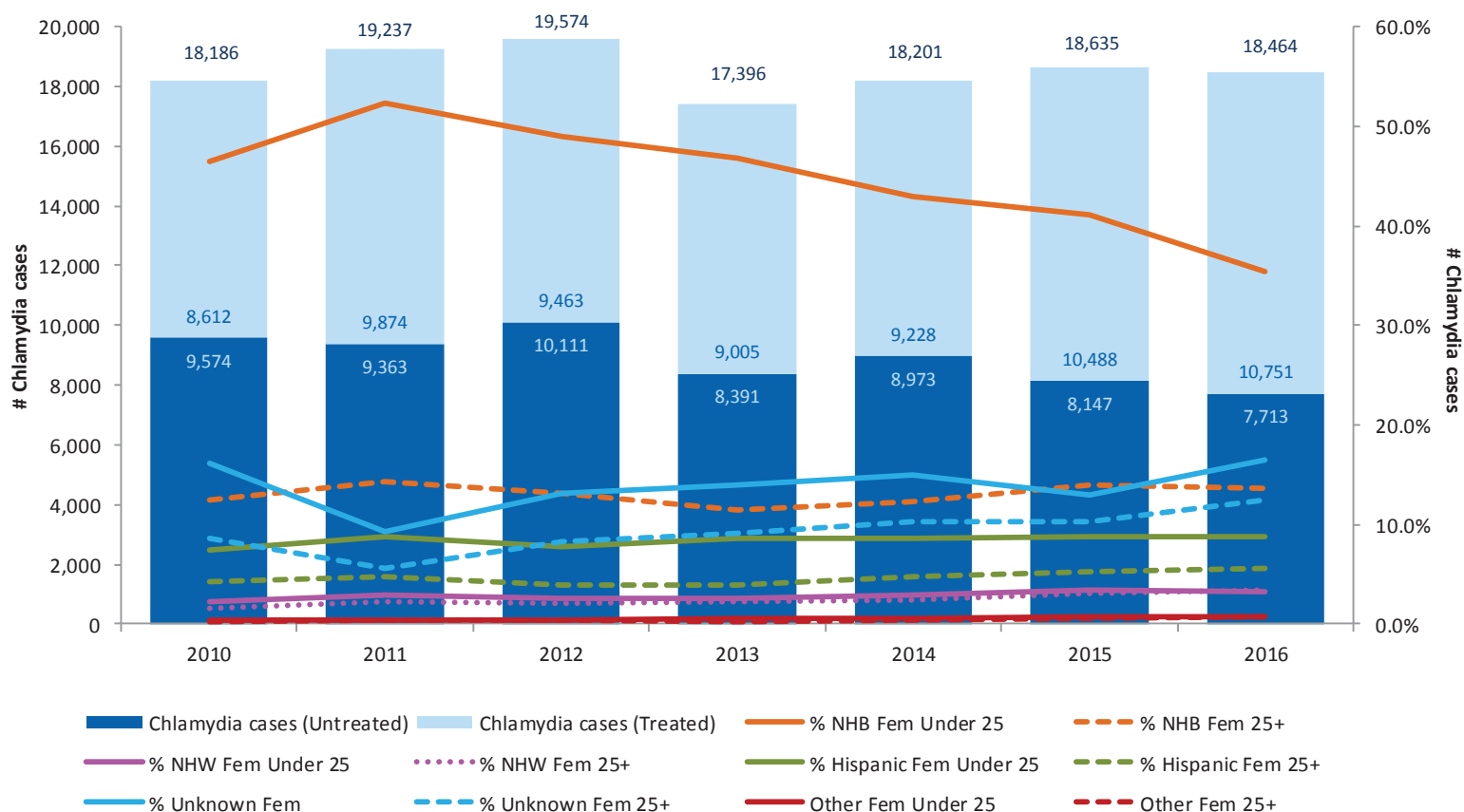


Figure 3.3: Reported Chlamydia Infections among Women under 25 by Race/Ethnicity and Year-end Treatment Status, Chicago, 2010-2016

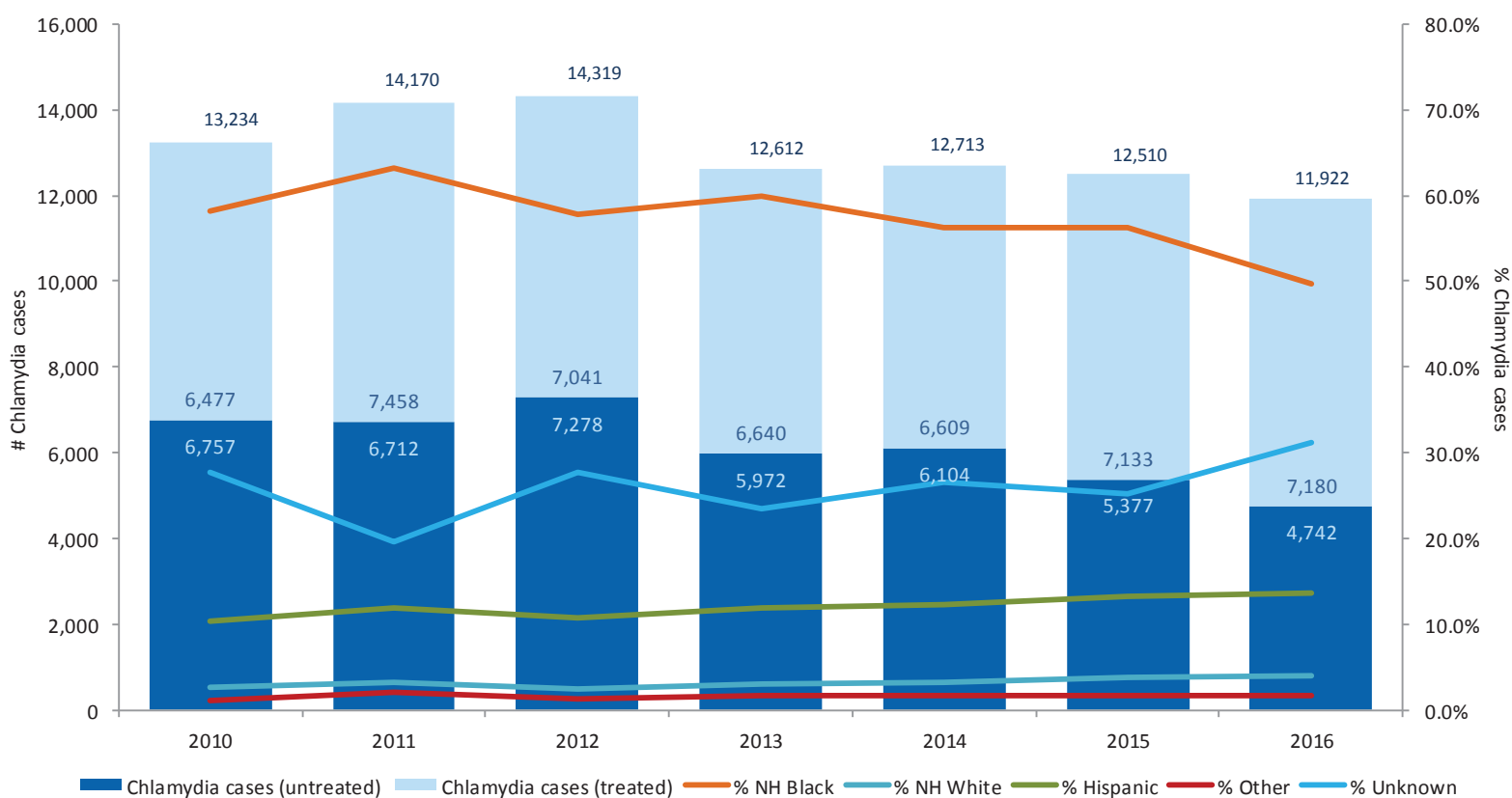
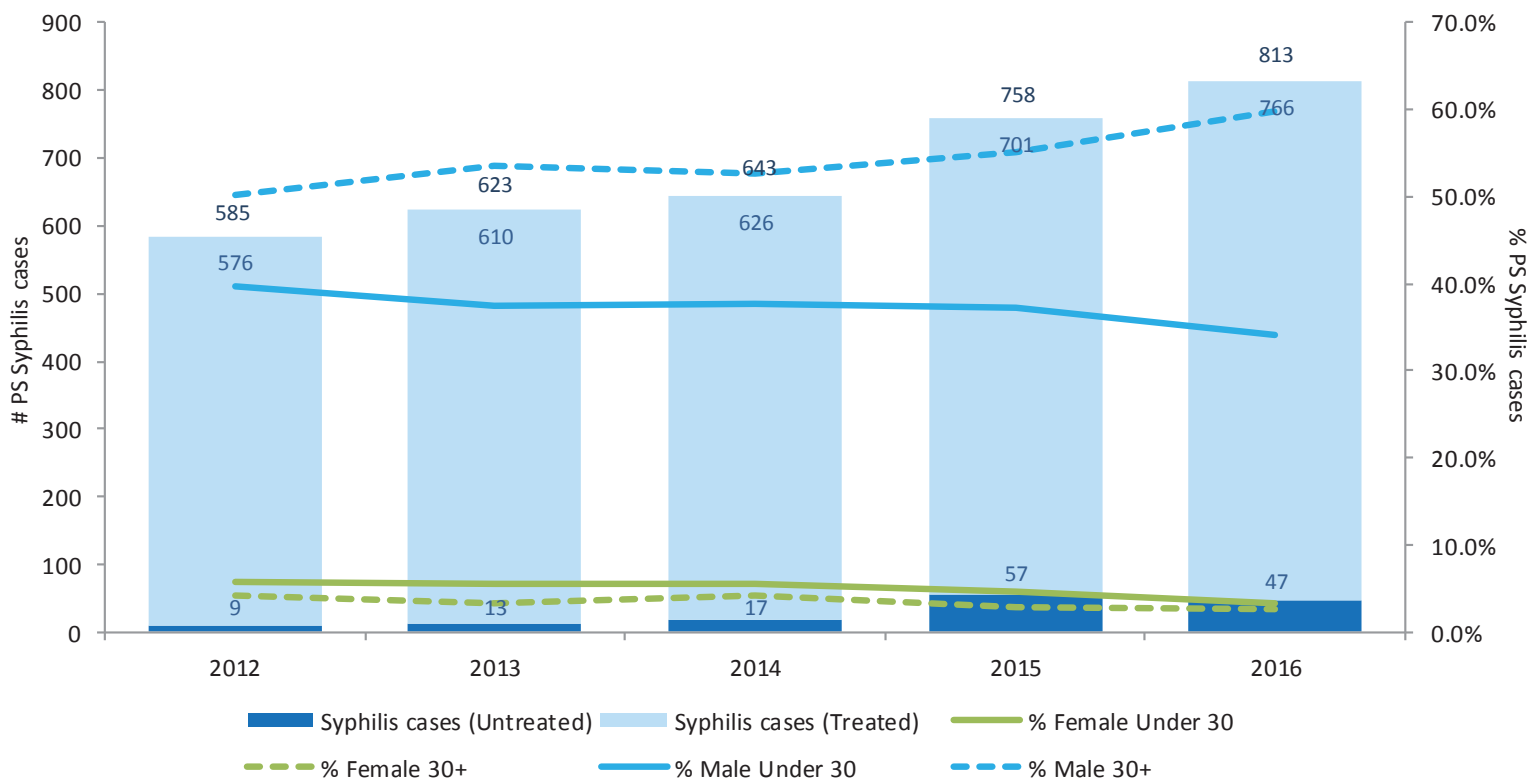


Figure 3.4: Reported Primary & Secondary Syphilis Infections by Birth Sex, Age, and Year-end Treatment Status, Chicago, 2012-2016





SECTION FOUR SPATIAL PATTERNS OF GONORRHEA SCREENING CHICAGO, 2014-2016

DISCUSSION

SPOTLIGHT: SPATIAL PATTERNS OF GONORRHEA SCREENING CHICAGO, 2014-2016

Chicago, like most other large urban areas, has higher rates of Sexually Transmitted Infections (STIs) (e.g. syphilis, gonorrhea and chlamydia) than the country overall. In 2016, a total of 10,836 gonorrhea (GC) cases were reported to the Chicago Department of Public Health (CDPH) and represents an increase by 30% in comparison to 2014. Increase in the number of GC during 2014–2016 was observed among both males and females; however, the increase was larger among males (Table 2.1). Similarly to previous years, in 2016, adolescents, racial and ethnic minorities and men who have sex with men (MSM) are disproportionately affected with STIs (Table 1.4).

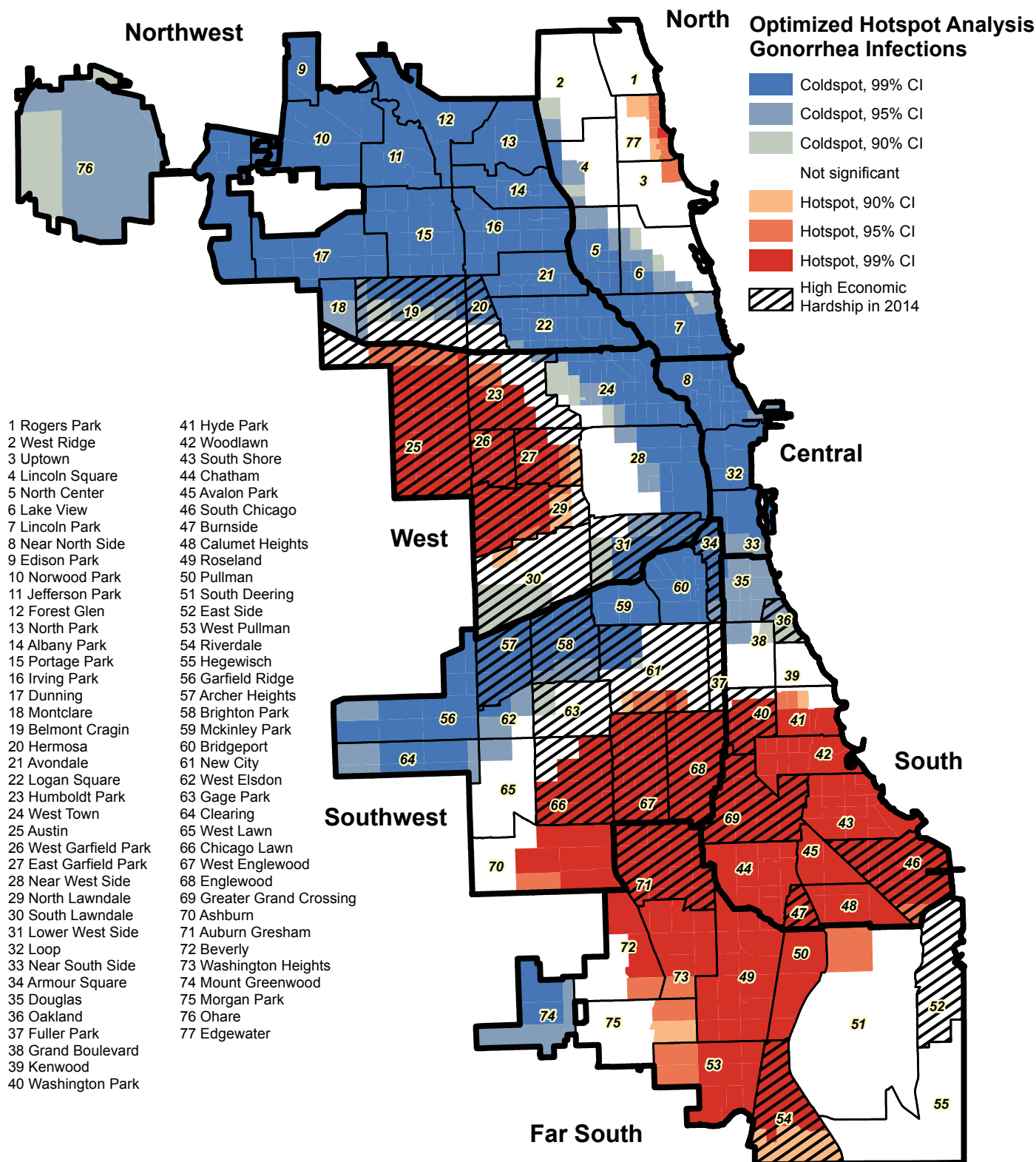
In order to combat these trends, in 2015, CDPH awarded two agencies to promote and expand STI screening and treatment among STI high-risk populations. Delegate agencies were selected through competitive Request for Proposal (RFP) process. Agencies (Howard Brown Health and Core Foundation at Cook County) were funded to provide safety net STI services for MSM and adolescent females. Specifically, Howard Brown Health (HBH) was awarded to expand syphilis and extra-genital gonorrhea (GC) screening in MSM. Between 2015 and 2016, rectal GC screening at HBH increased by 66% (from 7,446 to 12,377 in 2016), with an increase by 59% (from 1,020 to 1,620 in 2016) in Black MSM and 74% (from 1,517 to 2,635 in 2016) in Hispanic MSM.

In addition to the descriptive analysis, clustering of GC infections was assessed using Optimized Hot Spot within ArcGIS 10.2.2. The Optimized Hot Spot analysis uses the Getis-Ord G_i^* statistic to identify hot and cold spots of GC infections at the Chicago census tract level.

From 2014 through 2016, clustering of GC infections on the West and South side of the city remained unchanged. Over the same time period, clustering increased on the North side of the city. In 2014, significant clustering of GC infections occurred in nine census tracts, involving Edgewater and Uptown community areas ($P \leq 0.05$) (Figure 4.1). In comparison, in 2016, the number of census tracts with significant clustering of GC infections ($P \leq 0.05$) increased five-fold from nine in 2014 to 60 in 2016, involving seven community areas (Rogers Park, West Ridge, Uptown, Lincoln Square, North Center Lake View and Edgewater) outside of the hardship areas (Figure 4.3).

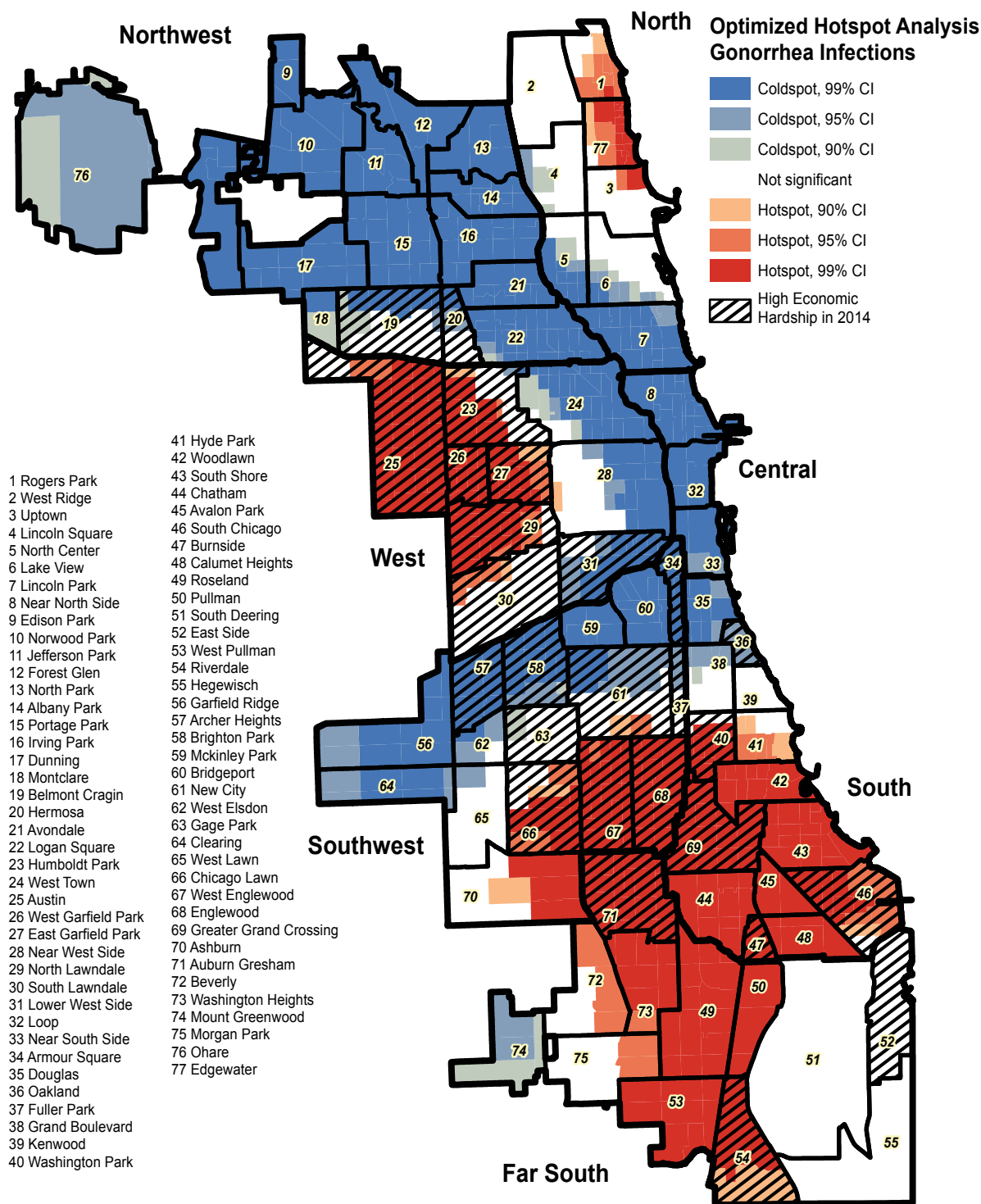
In summary, changes in the burden of GC cases in Chicago can be explained by changes in screening (e.g., increased screening at extra-genital anatomic sites) and/or changes in reporting practices. The magnitude of the increase of the Hot Spots on the North side of the city suggests increased case ascertainment through increased extra-genital screening. Ongoing assessment of screening practices for extra-genital infections is necessary for interrupting transmission among persons with exposures at these sites, and has shown to detect substantial numbers of cases that would be missed by urogenital screening alone.

Figure 4.1: Gonorrhea Infections in 2014 in Chicago
Getis-ord Gi* Statistic (Optimized Hot Spot Analysis)



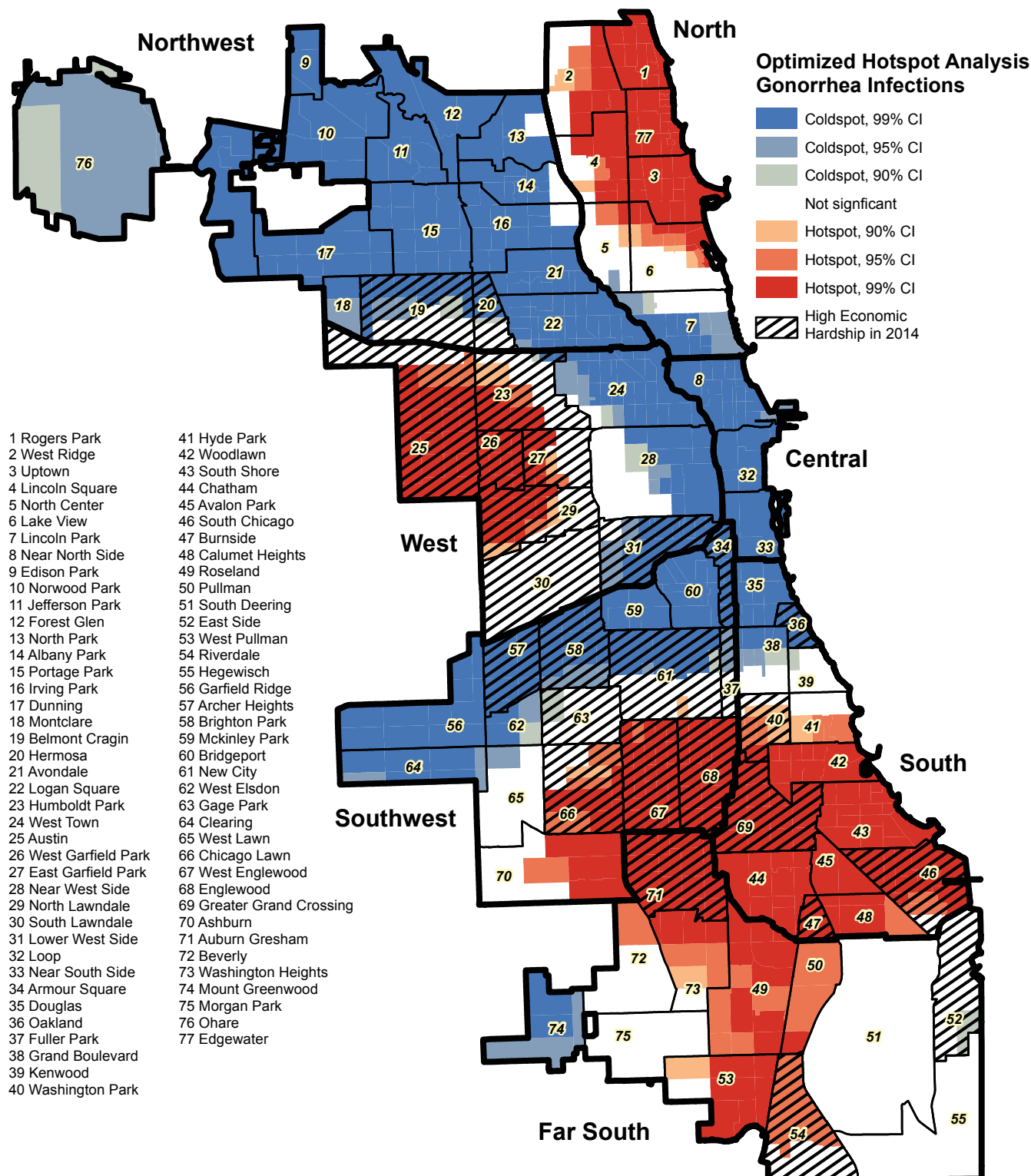
Data source: Illinois National Electronic Disease Surveillance System (6/2014), City of Chicago GIS Shapefiles and US Census. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.

Figure 4.2: Gonorrhea Infections in 2015 in Chicago
Getis-ord G_i^* Statistic (Optimized Hot Spot Analysis)



Data source: Illinois National Electronic Disease Surveillance System (6/2015), City of Chicago GIS Shapefiles and US Census. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.

Figure 4.3: Gonorrhea Infections in 2016 in Chicago
Getis-ord Gi* Statistic (Optimized Hot Spot Analysis)



Data source: Illinois National Electronic Disease Surveillance System (6/2017), City of Chicago GIS Shapefiles and US Census. The economic hardship index utilizes multiple indicators to measure economic conditions of Chicago Community Areas. High hardship index scores indicate worse economic conditions.



APPENDIX

As the HIV epidemic and HIV reporting systems change, new opportunities arise to better describe the epidemic. Thus, in keeping with these changes we have made a number of modifications to STI/HIV Chicago. A description of the changes and other technical notes follow.

Diagnoses data are presented through 2016. While STI data are final, AIDS and HIV data for 2016 are still provisional.

HIV/AIDS

When interpreting data in this report, keep in mind that the eHARS database is updated continuously to reflect the most current and complete information on people infected and newly diagnosed with HIV or AIDS; data in this report were up-to-date as of 9/26/2017. Reporting delays are important when interpreting trends in case numbers and rates over time and especially, the most recent year of diagnosis. Report delay is defined as the interval between the date an HIV or AIDS case is diagnosed and the date the case is reported to the health department. Within 3 years, the total number of HIV diagnoses reported are relatively stable (fluctuating < 10 cases) and the data are no longer considered provisional. In order to provide the most complete data as possible, we will be presenting trend data through 2016. Additional cases continue to be reported in subsequent years and new cases are identified through laboratory reporting and registry matches. Thus, the numbers of cases diagnosed for each year are subject to change as new information is received from any of the reporting sources.

The “HIV Infection Diagnosis” data presented in this issue include 3 categories of diagnoses: (1) a diagnosis of HIV infection, (2) a diagnosis of HIV infection with a later diagnosis of AIDS, and (3) concurrent diagnoses of HIV infection and AIDS [defined as receiving an AIDS diagnosis within 12 months of an HIV diagnosis]. Data from the HIV reporting system should be interpreted with caution. HIV surveillance reports may not be representative of all persons infected with HIV because not all infected persons have been tested. The guidelines for cell suppression used in this report try to balance data accessibility with confidentiality and confidence in the stability of the estimates published. Rates and percentages based on twenty or fewer cases can vary widely just by random chance even when there is no meaningful statistical difference between measurements. Thus, the number and rate for categories with less than 5 are suppressed.

For surveillance purposes, HIV and AIDS cases are counted only once in a hierarchy of modes of transmission. Persons with more than one reported mode of transmission are classified in the transmission mode first in the hierarchy. The exception is men who have sex with men and also inject drugs, which has its own category. Persons whose transmission mode is classified as male-to-male sexual contact (MSM) include men who report sexual contact with other men and men who report sexual contact with both men and women. Persons whose mode of transmission is classified as heterosexual contact are persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injection drug user).

Because many cases of HIV infection and AIDS are initially reported without a defined mode of transmission, we use multiple imputation to assign a mode of transmission for these cases. Multiple imputation is a statistical approach in which each missing mode of transmission is replaced with a set of plausible values that represent the uncertainty about the true, but missing, value. The plausible values are analyzed by using standard procedures, and the results from these analyses are then combined to produce the final results. Multiple imputation is used by the Centers for Disease Control and Prevention (CDC) in their national HIV Surveillance Report.



Gonorrhea

Gonorrhea is one of three sexually transmitted infections (STI) that local providers are required to report to CDPH per 77 Illinois Administrative Code 693 (Control of sexually transmissible infections code). Gonorrhea is a bacterial STI caused by *Neisseria gonorrhoeae*; infection varies in course, severity, and symptoms among males and females (Heymann, 2004). Co-infection with chlamydia can occur. Left untreated, disease sequelae can include pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. *Neisseria gonorrhoeae* has progressively developed resistance to each of the antibiotics used for treatment of gonorrhea. Most recently, declining susceptibility to cefixime resulted in a change in the CDC treatment guidelines, so that dual therapy with ceftriaxone and either azithromycin or doxycycline is now a CDC recommended treatment regimen for gonorrhea.

Chlamydia

Chlamydia trachomatis infection is the most commonly reported notifiable disease and is one of three sexually transmitted infections (STI) that local providers are required to report to CDPH per 77 Illinois Administrative Code 693 (Control of sexually transmissible infections code). Chlamydial infections in women are usually asymptomatic. However, these can result in pelvic inflammatory disease (PID), which is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. In addition, pregnant women infected with chlamydia can pass the infection to their infants during delivery, potentially resulting in neonatal ophthalmia and pneumonia. Because of the large burden of disease and risks associated with infection, CDC recommends that all sexually active women younger than age 26 years receive annual chlamydia screening.

Syphilis

Syphilis is one of three sexually transmitted infections that local providers are required to report to CDPH per 77 Illinois Administrative Code 693 (Control of sexually transmissible infections code). Syphilis is caused by a bacterial STI called *Treponema pallidum*. Syphilis, a genital ulcerative disease, causes significant complications if untreated and facilitates the transmission of HIV infection. Syphilis is characterized by stages: primary (can have a lesion known as a chancre, usually occurring 3 weeks post exposure), secondary (symptoms include rash and fatigue), early latent (less than 1 year post exposure), and late latent (greater than 1 year post exposure). Primary and secondary syphilis are the most infectious and symptomatic stages. Periods of latency vary and may lead to increased morbidity and, potentially, mortality.

A probable case of congenital syphilis is defined as: “A condition affecting an infant whose mother had untreated or inadequately treated syphilis at delivery, regardless of signs in the infant, or an infant or child who has a reactive treponemal test for syphilis and any one of the following:

- Any evidence of congenital syphilis on physical examination
- Any evidence of congenital syphilis on radiographs of long bones
- A reactive cerebrospinal fluid (CSF) venereal disease research laboratory (VDRL)
- An elevated CSF cell count or protein (without other cause)
- A reactive fluorescent treponemal antibody absorbed - 19S-IgM antibody test or IgM enzyme-linked immunosorbent assay” (CDC 1997)

A syphilitic stillbirth is defined as: “A fetal death that occurs after a 20-week gestation or in which the fetus weighs >500g and the mother had untreated or inadequately treated syphilis at delivery” (CDC 1997)

References:

1. Centers for Disease Control and Prevention (2013). Sexually Transmitted Disease Surveillance. Retrieved from <http://www.cdc.gov/std/default.htm>.
2. Centers for Disease Control and Prevention (1997). Case Definition for Infectious Conditions Under Public Health Surveillance. MMWR; 46(No. RR-10).
3. Heymann, D (Ed) (2004). Control of Communicable Diseases Manual (18th Ed). American Public Health Association: Washington, DC.
4. Illinois Department of Public Health (2013). Control of Sexually Transmissible Infections Code. Retrieved from http://www.idph.state.il.us/2013_Rules/Adopted/77_IAC_693_6-13.pdf
5. Zenilman, J. (2007). Sexually Transmitted Diseases. In K. Nelson & C Masters Williams (Eds.), Infectious Disease Epidemiology: Theory and Practice, 2nd edition. Sudbury, MA: Jones and Bartlett Publishers.

INEDSS - Address Validation

On March 24, 2012, INEDSS Release 10.2 was deployed. This release included address validation within INEDSS and geocoded data. Before case information is submitted to the Illinois Department of Public Health (IDPH) for counting, addresses are verified to ensure the accuracy and standardization of the data. Addresses that are verified in INEDSS will be assigned latitude and longitude coordinates. For addresses not validated, INEDSS geocodes the data using the zip code centroid, followed by the city and then the country.

Twice a month, IDPH submits an updated morbidity file to the Chicago Department of Public Health (CDPH) via MOVEit File Transfer, a secured application for exchanging confidential files and data between servers and organizations. This file does not include the geocoded address field. Once CDPH receives the electronic file, it is prepared for submission to the City of Chicago GIS FTP server for validation and geocoding.

Geocoding INEDSS Morbidity File

Before the INEDSS data file is submitted to the City of Chicago GIS FTP site, the street address is rounded (e.g. 8634 to 8600) in order to preserve confidentiality. A new data file is created containing only the rounded street address and a record identifier (state case number). This file is converted from Microsoft Excel to a common delimited (.csv) file, and submitted to the City of Chicago GIS FTP server for processing.

The files submitted are assigned a name that does not associate it with a person, case, health condition, or CDPH. Once the geographic identifiers (e.g., community area number, zipcode, ward, and 2010 census tract) are selected, the file is submitted. After the geocoder has received the request, an email is sent notifying the user that the geocoding process has commenced. When the geocoding job is completed, the results (output) file is downloaded to a secure server that meets HIPPA security requirements. Lastly, the original (input) file that was submitted and the results (output) file are both deleted from the FTP folders.

Addresses that are not geocoded in the output file are cleaned using the Geocoder website by identifying the correct street components. All apartment components (e.g., FL, BSMT, Apt #1) are also removed from the address field. The file is resubmitted to the GIS FTP server for validation and geocoding. To increase the number of geocoded addresses, the match standard code can be changed from medium (default) to low to obtain nearest matches.

Reasons why addresses fail to match

- A. Addresses may be missing street segments or in the wrong format (AVE, ST., King Dr. instead of Dr. Martin Luther King Drive).
- B. Address may incorporate typographical errors that result in erroneous street names or local street names that are different than those officially recorded by the government.
- C. Addresses may end at jurisdictional boundaries.

Limitations in Determining Geographic Patterns in Rates of Health-Related Events

- Unable to determine if the geographical variation in the incidence rates across years is due to a true change in the progression of the disease or an artifact of the address validation process in INEDSS.
- Inflation of the rates due to increase in the proportion of exact or nearest matched addresses



APPENDIX C. LIST OF ACRONYMS

AI/AN	= American Indian/Alaskan Native
AIDS	= Acquired Immunodeficiency Syndrome
ART	= Anti-Retroviral therapy
CDC	= Centers for Disease Control and Prevention
CDPH	= Chicago Department of Public Health
EAPC	= Estimate Annual Percent Change
eHARS	= Enhanced HIV/AIDS Reporting System
FtM	= Female to Male Transgender
HAART	= Highly Active Anti-Retroviral Therapy
HIV	= Human Immunodeficiency Virus
IDPH	= Illinois Department of Public Health
IDU	= Injection Drug Use/Injection Drug User
MtF	= Male to Female Transgender
MSM	= Men who have sex with men
MSM/IDU	= Men with a history of injection drug use who have sex with men
NIR	= No identified risk
NH	= Non-Hispanic
PI	= Pacific Islander
PLWHA	= People Living with HIV/AIDS
P&S	= Primary and Secondary Syphilis
STI	= Sexually Transmitted Infection
SSun	= STD Surveillance Network



APPENDIX D. SUPPLEMENTAL DATA TABLES

Table D.1: 2016 HIV Infection* Diagnosis Rates by Community Area, Chicago (as of 09/27/17)

Community Area	Average HIV Infections†	Average HIV Infection Rate§	Community Area	Average HIV Infections†	Average HIV Infection Rate§
1 Rogers Park	35	63.6	40 Washington Park	8	68.3
2 West Ridge	17	23.6	41 Hyde Park	11	42.8
3 Uptown	35	62.1	42 Woodlawn	13	50.0
4 Lincoln Square	15	38.0	43 South Shore	20	40.2
5 North Center	<5	12.6	44 Chatham	12	38.7
6 Lake View	35	37.1	45 Avalon Park	5	49.1
7 Lincoln Park	6	9.4	46 South Chicago	12	38.5
8 Near North Side	14	17.4	47 Burnside	<5	102.9
9 Edison Park	0	0.0	48 Calumet Heights	<5	29.0
10 Norwood Park	<5	2.7	49 Roseland	20	44.8
11 Jefferson Park	<5	3.9	50 Pullman	<5	27.3
12 Forest Glen	0	0.0	51 South Deering	<5	6.6
13 North Park	0	0.0	52 East Side	<5	13.0
14 Albany Park	12	23.3	53 West Pullman	10	33.7
15 Portage Park	<5	6.2	54 Riverdale	<5	15.4
16 Irving Park	8	15.0	55 Hegewisch	<5	10.6
17 Dunning	<5	2.4	56 Garfield Ridge	<5	2.9
18 Montclare	0	0.0	57 Archer Heights	0	0.0
19 Belmont Cragin	13	16.5	58 Brighton Park	9	19.8
20 Hermosa	<5	16.0	59 McKinley Park	<5	19.2
21 Avondale	12	30.6	60 Bridgeport	<5	6.3
22 Logan Square	10	13.6	61 New City	7	15.8
23 Humboldt Park	29	51.5	62 West Elsdon	5	27.6
24 West Town	12	14.7	63 Gage Park	5	12.5
25 Austin	44	44.7	64 Clearing	<5	17.3
26 West Garfield Park	12	66.7	65 West Lawn	<5	3.0
27 East Garfield Park	5	24.3	66 Chicago Lawn	10	18.0
28 Near West Side	17	31.0	67 West Englewood	13	36.6
29 North Lawndale	20	55.7	68 Englewood	14	45.7
30 South Lawndale	18	22.7	69 Gr. Grand Crossing	17	52.1
31 Lower West Side	5	14.0	70 Ashburn	7	17.0
32 Loop	5	17.1	71 Auburn Gresham	23	47.2
33 Near South Side	6	28.1	72 Beverly	<5	5.0
34 Armour Square	<5	14.9	73 Washington Heights	11	41.5
35 Douglas	10	54.8	74 Mount Greenwood	<5	5.2
36 Oakland	<5	50.7	75 Morgan Park	<5	17.7
37 Fuller Park	<5	34.8	76 O'Hare	0	0.0
38 Grand Boulevard	12	54.7	77 Edgewater	33	58.4
39 Kenwood	13	72.9	Unknown CA	101	--
			Chicago Total¶	839	31.1

Note: Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. §Rate per 100,000 population using 2010 U.S. Census Bureau population figures. ¶Includes all persons with unknown/undetermined community area. *HIV infection diagnoses represents newly diagnosed with HIV in a given year, at any stage of the disease.

APPENDIX D. SUPPLEMENTAL DATA TABLES

Table D.2: People Living with HIV Infection (PLWH) in 2015 by Community Area, Chicago (as of 09/27/2017)

Community Area	Prevalent Cases	Prevalence Rate	Community Area	Prevalent Cases	Prevalence Rate
1 Rogers Park	902	1,640.3	40 Washington Park	122	1,041.2
2 West Ridge	295	410.1	41 Hyde Park	129	502.3
3 Uptown	1,275	2,262.2	42 Woodlawn	254	977.6
4 Lincoln Square	189	478.6	43 South Shore	639	1,284.0
5 North Center	111	348.3	44 Chatham	311	1,002.3
6 Lake View	937	992.9	45 Avalon Park	82	805.1
7 Lincoln Park	170	265.1	46 South Chicago	280	897.5
8 Near North Side	298	370.3	47 Burnside	24	823.0
9 Edison Park	10	89.4	48 Calumet Heights	77	557.5
10 Norwood Park	31	83.7	49 Roseland	261	585.0
11 Jefferson Park	33	129.7	50 Pullman	48	655.3
12 Forest Glen	26	140.5	51 South Deering	85	562.6
13 North Park	46	256.5	52 East Side	28	121.5
14 Albany Park	215	417.1	53 West Pullman	183	617.2
15 Portage Park	139	216.8	54 Riverdale	20	308.5
16 Irving Park	194	363.6	55 Hegewisch	9	95.5
17 Dunning	53	126.4	56 Garfield Ridge	44	127.5
18 Montclare	38	283.0	57 Archer Heights	20	149.3
19 Belmont Cragin	235	298.4	58 Brighton Park	124	273.3
20 Hermosa	99	395.8	59 McKinley Park	39	249.8
21 Avondale	163	415.2	60 Bridgeport	68	212.7
22 Logan Square	332	451.1	61 New City	185	416.9
23 Humboldt Park	437	775.9	62 West Elsdon	23	127.0
24 West Town	364	447.0	63 Gage Park	97	243.1
25 Austin	691	701.4	64 Clearing	30	129.7
26 West Garfield Park	161	894.4	65 West Lawn	55	164.9
27 East Garfield Park	217	1,055.1	66 Chicago Lawn	269	483.6
28 Near West Side	343	625.0	67 West Englewood	272	766.1
29 North Lawndale	337	938.4	68 Englewood	267	871.0
30 South Lawndale	510	643.2	69 Gr. Grand Crossing	344	1,055.1
31 Lower West Side	137	383.0	70 Ashburn	97	236.1
32 Loop	116	396.1	71 Auburn Gresham	341	699.6
33 Near South Side	105	490.9	72 Beverly	42	209.6
34 Armour Square	33	246.4	73 Washington Heights	140	528.4
35 Douglas	170	932.1	74 Mount Greenwood	7	36.7
36 Oakland	51	861.8	75 Morgan Park	105	465.8
37 Fuller Park	26	904.0	76 O'Hare	15	117.6
38 Grand Boulevard	281	1,281.4	77 Edgewater	1,175	2,078.9
39 Kenwood	145	812.7	Unknown CA	7,598	--
			Chicago Total[¶]	23,824	883.8

Note: Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. [†]All persons diagnosed with HIV, from the beginning of the epidemic through 12/31/2015 and living through 12/31/2016 as of 09/27/2017. [§]Rate per 100,000 population using 2010 U.S. Census Bureau population figures.

[¶]Includes all persons with unknown/undetermined community area.

APPENDIX D. SUPPLEMENTAL DATA TABLES

Table D.3: Chlamydia Case Rates by Community Area, Chicago, 2016

Community Area	Chlamydia Cases	Rate	Community Area	Chlamydia Cases	Rate
1 Rogers Park	540	982.0	40 Washington Park	311	2,654.3
2 West Ridge	314	436.5	41 Hyde Park	138	537.4
3 Uptown	694	1,231.3	42 Woodlawn	443	1,705.0
4 Lincoln Square	134	339.3	43 South Shore	839	1,685.9
5 North Center	86	269.9	44 Chatham	507	1,634.0
6 Lake View	889	942.1	45 Avalon Park	133	1,305.8
7 Lincoln Park	338	527.2	46 South Chicago	469	1,503.3
8 Near North Side	535	664.7	47 Burnside	60	2,057.6
9 Edison Park	13	116.2	48 Calumet Heights	158	1,143.9
10 Norwood Park	61	164.8	49 Roseland	682	1,528.5
11 Jefferson Park	65	255.4	50 Pullman	110	1,501.7
12 Forest Glen	36	194.5	51 South Deering	171	1,131.8
13 North Park	63	351.3	52 East Side	103	447.0
14 Albany Park	269	521.9	53 West Pullman	428	1,443.5
15 Portage Park	270	421.1	54 Riverdale	189	2,915.8
16 Irving Park	282	528.5	55 Hegewisch	45	477.4
17 Dunning	116	276.6	56 Garfield Ridge	143	414.3
18 Montclare	53	394.8	57 Archer Heights	83	619.7
19 Belmont Cragin	550	698.5	58 Brighton Park	327	720.8
20 Hermosa	210	839.7	59 McKinley Park	119	762.2
21 Avondale	242	616.4	60 Bridgeport	130	406.5
22 Logan Square	484	657.7	61 New City	509	1,147.0
23 Humboldt Park	904	1,605.0	62 West Elsdon	125	690.3
24 West Town	610	749.1	63 Gage Park	334	837.2
25 Austin	1,839	1,866.7	64 Clearing	117	505.6
26 West Garfield Park	470	2,611.0	65 West Lawn	189	566.6
27 East Garfield Park	498	2,421.4	66 Chicago Lawn	759	1,364.4
28 Near West Side	684	1,246.3	67 West Englewood	774	2,180.0
29 North Lawndale	1,031	2,870.9	68 Englewood	650	2,120.4
30 South Lawndale	675	851.3	69 Gr. Grand Crossing	711	2,180.8
31 Lower West Side	279	780.0	70 Ashburn	329	800.9
32 Loop	218	744.5	71 Auburn Gresham	856	1,756.1
33 Near South Side	138	645.2	72 Beverly	85	424.3
34 Armour Square	64	477.9	73 Washington Heights	418	1,577.8
35 Douglas	231	1,266.6	74 Mount Greenwood	46	240.9
36 Oakland	114	1,926.3	75 Morgan Park	190	842.8
37 Fuller Park	43	1,495.1	76 O'Hare	29	227.3
38 Grand Boulevard	363	1,655.3	77 Edgewater	549	971.3
39 Kenwood	199	1,115.4	Unknown CA	2,914	0
			Chicago Total [¶]	29,776	1,104.6

Note: Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. \$Rate per 100,000 population using 2010 U.S. Census Bureau population figures. ¶Includes all persons with unknown/undetermined community area.

APPENDIX D. SUPPLEMENTAL DATA TABLES

Table D.2: People Living with HIV Infection[†] (PLWH) in 2015 by Community Area, Chicago (as of 09/27/2017)

Community Area	Prevalent Cases	Prevalence Rate	Community Area	Prevalent Cases	Prevalence Rate
1 Rogers Park	902	1,640.3	40 Washington Park	122	1,041.2
2 West Ridge	295	410.1	41 Hyde Park	129	502.3
3 Uptown	1,275	2,262.2	42 Woodlawn	254	977.6
4 Lincoln Square	189	478.6	43 South Shore	639	1,284.0
5 North Center	111	348.3	44 Chatham	311	1,002.3
6 Lake View	937	992.9	45 Avalon Park	82	805.1
7 Lincoln Park	170	265.1	46 South Chicago	280	897.5
8 Near North Side	298	370.3	47 Burnside	24	823.0
9 Edison Park	10	89.4	48 Calumet Heights	77	557.5
10 Norwood Park	31	83.7	49 Roseland	261	585.0
11 Jefferson Park	33	129.7	50 Pullman	48	655.3
12 Forest Glen	26	140.5	51 South Deering	85	562.6
13 North Park	46	256.5	52 East Side	28	121.5
14 Albany Park	215	417.1	53 West Pullman	183	617.2
15 Portage Park	139	216.8	54 Riverdale	20	308.5
16 Irving Park	194	363.6	55 Hegewisch	9	95.5
17 Dunning	53	126.4	56 Garfield Ridge	44	127.5
18 Montclare	38	283.0	57 Archer Heights	20	149.3
19 Belmont Cragin	235	298.4	58 Brighton Park	124	273.3
20 Hermosa	99	395.8	59 McKinley Park	39	249.8
21 Avondale	163	415.2	60 Bridgeport	68	212.7
22 Logan Square	332	451.1	61 New City	185	416.9
23 Humboldt Park	437	775.9	62 West Elsdon	23	127.0
24 West Town	364	447.0	63 Gage Park	97	243.1
25 Austin	691	701.4	64 Clearing	30	129.7
26 West Garfield Park	161	894.4	65 West Lawn	55	164.9
27 East Garfield Park	217	1,055.1	66 Chicago Lawn	269	483.6
28 Near West Side	343	625.0	67 West Englewood	272	766.1
29 North Lawndale	337	938.4	68 Englewood	267	871.0
30 South Lawndale	510	643.2	69 Gr. Grand Crossing	344	1,055.1
31 Lower West Side	137	383.0	70 Ashburn	97	236.1
32 Loop	116	396.1	71 Auburn Gresham	341	699.6
33 Near South Side	105	490.9	72 Beverly	42	209.6
34 Armour Square	33	246.4	73 Washington Heights	140	528.4
35 Douglas	170	932.1	74 Mount Greenwood	7	36.7
36 Oakland	51	861.8	75 Morgan Park	105	465.8
37 Fuller Park	26	904.0	76 O'Hare	15	117.6
38 Grand Boulevard	281	1,281.4	77 Edgewater	1,175	2,078.9
39 Kenwood	145	812.7	Unknown CA	7,598	--
			Chicago Total[¶]	23,824	883.8

Note: Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. [†]All persons diagnosed with HIV, from the beginning of the epidemic through 12/31/2015 and living through 12/31/2016 as of 09/27/2017. [§]Rate per 100,000 population using 2010 U.S. Census Bureau population figures.

[¶]Includes all persons with unknown/undetermined community area.

APPENDIX D. SUPPLEMENTAL DATA TABLES

Table D.5: Primary and Secondary Syphilis Case Rates by Community Area, Chicago, 2016

Community Area	P&S Syphilis Cases	Rate	Community Area	P&S Syphilis Cases	Rate
1 Rogers Park	45	81.8	40 Washington Park	5	42.7
2 West Ridge	10	13.9	41 Hyde Park	5	19.5
3 Uptown	72	127.7	42 Woodlawn	9	34.6
4 Lincoln Square	9	22.8	43 South Shore	18	36.2
5 North Center	5	15.7	44 Chatham	10	32.2
6 Lake View	95	100.7	45 Avalon Park	<5	19.6
7 Lincoln Park	10	15.6	46 South Chicago	5	16
8 Near North Side	18	22.4	47 Burnside	<5	34.3
9 Edison Park	0	0	48 Calumet Heights	2	14.5
10 Norwood Park	<5	2.7	49 Roseland	9	20.2
11 Jefferson Park	<5	7.9	50 Pullman	0	0
12 Forest Glen	<5	10.8	51 South Deering	<5	6.6
13 North Park	<5	5.6	52 East Side	<5	13
14 Albany Park	10	19.4	53 West Pullman	8	27
15 Portage Park	8	12.5	54 Riverdale	0	0
16 Irving Park	9	16.9	55 Hegewisch	<5	10.6
17 Dunning	7	16.7	56 Garfield Ridge	<5	5.8
18 Montclare	<5	7.4	57 Archer Heights	0	0
19 Belmont Cragin	12	15.2	58 Brighton Park	<5	6.6
20 Hermosa	5	20	59 McKinley Park	<5	12.8
21 Avondale	12	30.6	60 Bridgeport	5	15.6
22 Logan Square	16	21.7	61 New City	6	13.5
23 Humboldt Park	22	39.1	62 West Elsdon	<5	5.5
24 West Town	18	22.1	63 Gage Park	6	15
25 Austin	26	26.4	64 Clearing	<5	4.3
26 West Garfield Park	9	50	65 West Lawn	8	24
27 East Garfield Park	16	77.8	66 Chicago Lawn	11	19.8
28 Near West Side	12	21.9	67 West Englewood	6	16.9
29 North Lawndale	15	41.8	68 Englewood	16	52.2
30 South Lawndale	5	6.3	69 Gr. Grand Crossing	13	39.9
31 Lower West Side	13	36.3	70 Ashburn	6	14.6
32 Loop	7	23.9	71 Auburn Gresham	13	26.7
33 Near South Side	<5	14.0	72 Beverly	0	0
34 Armour Square	<5	14.9	73 Washington Heights	8	30.2
35 Douglas	<5	21.9	74 Mount Greenwood	0	0
36 Oakland	<5	50.7	75 Morgan Park	<5	17.7
37 Fuller Park	<5	34.8	76 O'Hare	<5	7.8
38 Grand Boulevard	7	31.9	77 Edgewater	74	130.9
39 Kenwood	7	39.2	Unknown CA	28	
			Chicago Total [¶]	813	30.2

Note: Use caution when interpreting data based on less than 20 events; rate/percent is unreliable. \$Rate per 100,000 population using 2010 U.S. Census Bureau population figures. [¶]Includes all persons with unknown/undetermined community area.

APPENDIX E: TECHNICAL NOTES

HARDSHIP INDEX AND HOTSPOT ANALYSIS

Chicago Community Area Economic Hardship Index

- The economic hardship index (EHI), developed by Richard P. Nathan and Charles F. Adams Jr in 1975, is used to provide a complete, multidimensional measure of neighborhood socioeconomic conditions of inequality across the City of Chicago.
- The EHI is a composite of six indicators:
 - Crowded housing (percentage occupied by housing units with more than 1 person per room)
 - Poverty (percentage of persons living below the federal poverty level)
 - Unemployment (percentage of persons over the age of 16 years who are unemployed)
 - Education (percentage of persons over the age of 25 years without a high school education)
 - Dependency (percentage of the population under 18 or over 64 years of age)
 - Per capita income level
- The EHI score is a median of the six indicators that are standardized on a scale of 0 to 100, with a higher score representing a greater level of economic hardship or burden.
- The U.S. Census Bureau's American Community Survey estimates are used to calculate index values at the census tract levels. To calculate index values at the Chicago Community Area boundaries, the census tract data are aggregated using the Geographic Information Systems (GIS) software.

References:

1. UIC Great Cities Institute (2016). Fact Sheet #2: Chicago Community Area Economic Hardship Index. Retrieved from: <https://greatcities.uic.edu/wp-content/uploads/2016/07/GCI-Hardship-Index-Fact-SheetV2.pdf>
2. Shih, M., Dumke, K.A., Goran, M.I., and Simon, P.A. (2012). The association between community-level economic hardship and childhood obesity prevalence in Los Angeles. *Pediatric Obesity*, Volume 8(6): 411-417. Retrieved from: <http://corc.usc.edu/pdf/The%20association%20between%20commmunity-level%20economic%20hardship%20and%20childhood%20obesity%20prevalence%20in%20Los%20Angeles.pdf>

Optimized Hot Spot Analysis (ArcGIS 10.2.2 Spatial Statistics)

- Hotspot analysis is a spatial analysis and mapping technique used to identify clustering of spatial phenomena (i.e., new gonorrhea infections).
- A hotspot is defined as an area that has higher concentration of events (i.e., gonorrhea infections) compared to the expected number given a random distribution of events.
- The Optimized Hot Spot Analysis, a statistical method available in ArcGIS Version 10.2, used in the spotlight section of the 2017 HIV/STI Surveillance report identifies significant spatial clustering of high values (hot spots) and low values (cold spots) of gonorrhea infections across the city of Chicago.
- This method uses the Getis-Ord Gi* statistic to generate Z scores (standard deviation) and P values (statistical probabilities) to identify the location and degree of spatial clustering of gonorrhea infections at the census tract level.
- A Z score above 1.96 or below -1.96 means that there is a statistically significant hot spot or a statistically significant cold spot of gonorrhea infections at a significance level of $P < 0.05$. The larger a Z-score, the more intense the clustering of values (hot spot). A Z-score near zero, means no spatial clustering.

References:

1. Columbia University Mailman School of Public Health. Population Health Methods: Hot Spot Detection. Retrieved from: <https://www.mailman.columbia.edu/research/population-health-methods/hot-spot-detection>
2. Izumi, K., et. al. (2015). Detection of Tuberculosis Infection Hotspots Using Activity Spaces Based Spatial Approach in an Urban Tokyo, from 2003 to 2011. *PLoS*, 10(9): 1-16. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4575109/pdf/pone.0138831.pdf>
3. Children's Environmental Health Initiative. Introduction to Hotspot Analysis – GIS III: GIS Analysis. Retrieve from: https://www.cdc.gov/dhdsp/maps/GISX/training/module3/files/3_hotspot_analysis_module.PDF



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APPENDIX 3: Integrated Plan Work Plan

Goal #1: Reduce New HIV Infections

Objective 1.1: Systematically collect, analyze, interpret, and disseminate HIV and STI data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response.

Strategy 1.1.1: Maintain collection and use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan for an implement services.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
Ongoing	CDPH HIV Surveillance Team	Activity 1.1.1.1: Maintain the enhanced HIV/AIDS Reporting System (eHARS) in order to monitor trends in HIV infection and describe demographic and geographic distribution of HIV in Chicago.	All	Data submitted to CDC	N/A
Ongoing	CDPH HIV Surveillance Team	Activity 1.1.1.2: Maintain collection of MMP, NHBS, and STI surveillance in order to understand correlates of HIV risk and HIV health outcomes (ongoing).	All	Data submitted to CDC	N/A

Objective 1.2: By December 2021, lower the annual number of new HIV infections in the Chicago EMA by 25 percent, from 1,312 to 984.

Strategy 1.2.1: Increase the number of persons living with HIV who are aware of their HIV status.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.1.1: By March 2019, establish 3-5 Targeted HIV	People living with HIV	# tests provided # new diagnoses (1.5%	6,000

		Screening and Linkage to Care programs to provide 6,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons to care within 30 days. Link 60% of previously diagnosed persons who are out of care back to care within 3 months.		seroprevalence) % linked to care within 30 days # out-of-care % re-engaged in care within 3 months	90 90% (81) 200 60% (120)
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.1.2: By March 2019, establish 3-5 Essential Supportive Services programs to provide 6,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons to care within 30 days. Link 60% of previously diagnosed persons who are out of care back to care within 3 months.	People living with HIV	# tests provided # new diagnoses (1.5% seroprevalence) % linked to care within 30 days # out-of-care % re-engaged in care within 3 months	6,000 90 90% (81) 200 60% (120)
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.1.3: By March 2019, establish 10-15 Population Centered Health Homes (PCHH) to provide 54,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons who are out	People living with HIV	# tests provided # new diagnoses (1.5% seroprevalence) % linked to care within 30 days # out-of-care	54,000 810 90% (729) 400

		of care back to care within 30 days. Link 60% of previously diagnosed persons to care within 3 months.		% re-engaged in care within 3 months	60% (240)
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.1.4: By March 2019, establish 1 HIV Screening in Healthcare Settings program to provide 84,000 HIV tests annually to identify people newly and previously diagnosed with HIV. Link 90% of newly diagnosed persons to care within 30 days. Link 60% of previously diagnosed persons who are out of care back to care within 3 months.	People living with HIV	# tests provided # new diagnoses (0.1% seroprevalence) % linked to care within 30 days # out-of-care % re-engaged in care within 3 months	84,000 84 90% (76) 400 60% (240)

Objective 1.2: By 2021, lower the annual number of new HIV infections in the Chicago EMA by 25 percent, from 1,312 to 984.

Strategy 1.2.2: By December 2021, increase by 20% the number of people vulnerable to HIV who use PrEP, from approximately 20% (6,000/30,000) to 40% (12,000/30,000).¹

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.2.1: By March 2019, establish 10-15 PCHH to provide comprehensive clinical and essential supportive services for	People vulnerable to HIV	# PrEP-eligible individuals % referred to PrEP prescriber	13,750 80% (11,000)

¹ Data estimates were defined using Project PrIDE preliminary evaluation outcomes. Data suggest 80% of individuals identified as PrEP candidates are referred to a prescriber, 60% are linked to a prescriber, and 50% are prescribed PrEP. Through our programs, we anticipate approximately 50% of those prescribed PrEP will initiate PrEP use. Therefore, across Strategies 1.3.1 - 1.3.4, approximately 5,800 individuals will initiate PrEP by 2021 (11,625 prescribed * 50% = 5,813 initiate PrEP).

		13,750 persons who can benefit from PrEP. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.		% linked to PrEP prescriber % prescribed PrEP	60% (8,250) 50% (6,875)
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.2.2: By March 2019, establish 3-5 HIV Primary Care programs to provide clinical services to 50 persons who can benefit from PrEP who do not need supportive services. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.	People vulnerable to HIV	# PrEP-eligible individuals % referred to PrEP prescriber % linked to PrEP prescriber % prescribed PrEP	50 80% (40) 60% (30) 50% (25)
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.2.3: By March 2019, establish 3-5 Essential Supportive Services programs to provide non-clinical supportive services to 2,500 persons not engaged in healthcare that can benefit from PrEP. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.	People vulnerable to HIV	# PrEP-eligible individuals % referred to PrEP prescriber % linked to PrEP prescriber % prescribed PrEP	2,500 80% (2000) 60% (1,500) 50% (1,250)
By March	CDPH HIV Healthcare	Activity 1.2.2.4: By March 2019,	People vulnerable to	# PrEP-eligible	2,500

2019	Access Team	establish 3-5 Targeted HIV Screening and Linkage to Care programs to provide linkage to PrEP to 2,500 persons who can benefit. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.	HIV	individuals % referred to PrEP prescriber % linked to PrEP prescriber % prescribed PrEP	80% (2,000) 60% (1,500) 50% (1,250)
By March 2019	CDPH HIV Healthcare Access Team	Activity 1.2.2.5: By March 2019, establish 1 HIV Screening in Healthcare Settings program to provide linkage to PrEP to 4,200 persons who can benefit. Refer 80% and link 60% of PrEP-eligible individuals to PrEP prescriber. Prescribe PrEP to 50% of PrEP-eligible individuals.	People vulnerable to HIV	# PrEP-eligible individuals % referred to PrEP prescriber % linked to PrEP prescriber % prescribed PrEP	4,200 80% (3,360) 60% (2,520) 50% (2,100)

Goal #2: Increased Access to Care and Improved Health Outcomes for People living with HIV/AIDS and those vulnerable to infection.

Objective 2.1: By December 2021, increase by 20% the number of people living with HIV in the Chicago EMA who are virally suppressed, from approximately 50% (~15,134/30,165) to 70% (~21,115/30,165).

Strategy 2.1.1: Increase access to HIV care and treatment to promote viral suppression among persons living with HIV.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Healthcare Access Team	Activity 2.1.1.1: By March 2019, establish 10-15 PCHH to provide comprehensive clinical and	People living with HIV	# people living with HIV seeking care from CDPH-funded PCHH	18,000

		essential supportive services for 18,000 persons living with HIV. Achieve 81% viral suppression among patient population.		% people living with HIV seeking care from CDPH-funded PCHH who are virally suppressed	81% (14,580)
By March 2019	CDPH HIV Healthcare Access Team	Activity 2.1.1.2: By March 2019, establish 3-5 HIV Primary Care programs to provide clinical services to 2,000 persons living with HIV who do not need supportive services. Achieve 81% viral suppression among patient population.	People living with HIV	# people living with HIV seeking care from CDPH-funded HIV Primary Care programs % people living with HIV seeking care from CDPH-funded HIV Primary Care programs who are virally suppressed	2,000 81% (1,620)
By September 2019	CDPH HIV Healthcare Access Team	Activity 2.1.1.3: By September 2019, establish 1 Resource Hub to increase the number of people living with HIV who are provided information, real-time advice, and direct linkage to HIV clinical care services (including, but not limited to, services funded by CDPH).	People living with HIV	Contractor selected Resource hub launched # persons linked to Population Centered Health Homes and HIV Primary Care programs	N/A N/A Contingent on execution of new contracts for Resource Hub beginning March 1, 2019
By December 2019	CDPH HIV Healthcare Access Team	Activity 2.1.1.4: By December 2019, develop and deploy cohesive and consistent HIV/STI health marketing campaigns.	People living with and vulnerable to HIV	Contractor selected Campaigns launched	N/A 2 campaigns launched, at least one of which promotes ARV

					use for HIV treatment or PrEP
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Goal #3: Reduce HIV-Related Disparities and Health Inequities

Objective 3.1: By December 2021, increase viral suppression among Black gay, bisexual, and other MSM from 50% to 55%.

Strategy 3.1.1: Examine and address root causes of disparities among Black gay, bisexual, and other MSM.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Community Development Team	Activity 3.1.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of ARVs for HIV treatment and PrEP among Black gay, bisexual, and other MSM.	Black gay, bisexual, and other MSM	# Community Development initiatives established Additional indicators contingent on execution of new contracts for Community Development initiatives beginning March 1, 2019	1
By March 2019	CDPH HIV Housing Team	Activity 3.1.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including Black gay, bisexual, and other MSM, to support ARV use for HIV treatment. ²	Black gay, bisexual, and other MSM	# Housing programs established Additional indicators contingent on execution of new contracts for Housing programs beginning March 1, 2019	20

² Housing programs for persons living with HIV will be funded through Department of Housing and Urban Development Housing Opportunities for Persons with AIDS funding. CDPH will fund a total of 20 Housing programs. We reference the same 20 programs multiple times, under Strategies 3.1.2, 3.2.2, 3.3.2, and 3.4.2, as many of these programs will serve members of the referenced priority populations.

By March 2019	CDPH HIV Housing Team	Activity 3.1.1.3: By March 2019, establish 1 Housing program to provide housing opportunities for persons vulnerable to HIV, with an emphasis on Black gay, bisexual, and other MSM, to support ARV use for PrEP.	Black gay, bisexual, and other MSM	# Housing programs established Additional indicators contingent on execution of new contracts for Housing programs beginning March 1, 2019	1
By July 2019	CDPH HIV Healthcare Access Team	Activity 3.1.1.4: By July 2019, establish 2-3 PCHH for persons living with HIV who have complex medical and/or behavioral challenges (PCHH-Complex), including Black gay, bisexual, and other MSM, to support ARV use for HIV treatment. ³	Black gay, bisexual, and other MSM	# PCHH-Complex established Additional indicators contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019	2-3

Objective 3.2: Objective 3.1: By December 2021, increase viral suppression among cisgender Black heterosexual women from 47% to 52%.

Strategy 3.2.1: Examine and address root causes of disparities among cisgender Black heterosexual women.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Community Development Team	Activity 3.2.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of	Cisgender Black heterosexual women	# Community Development initiatives established Additional indicators contingent on execution of new contracts for Community Development	1

³ PCHH-Complex will be funded through Department of Health and Human Services Ryan White Minority AIDS Initiative funding. CDPH will fund a total of 2-3 PCHH-Complex. We reference the same 2-3 programs multiple times, under Strategies 3.1.4, 3.2.3, 3.3.3, and 3.4.3, as many of these programs will serve members of the referenced priority populations.

		health in order to increase use of ARVs for HIV treatment and PrEP among cisgender Black heterosexual women.		initiatives beginning March 1, 2019	
By March 2019	CDPH HIV Housing Team	Activity 3.2.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including cisgender Black heterosexual women, to support ARV use for HIV treatment.	Cisgender Black heterosexual women	# Housing programs established Additional indicators contingent on execution of new contracts for Housing programs beginning March 1, 2019	20
By July 2019	CDPH HIV Healthcare Access Team	By July 2019, establish 2-3 PCHH for persons living with HIV who have complex medical and/or behavioral challenges (PCHH-Complex), including cisgender Black heterosexual women, to support ARV use for HIV treatment.	Cisgender Black heterosexual women	# PCHH-Complex established Additional indicators contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019	2-3

Objective 3.3: By December 2021, increase viral suppression among Latino gay, bisexual, and other MSM from 58% to 62%.

Strategy 3.3.1: Examine and address root causes of disparities among Latino gay, bisexual, and other MSM.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Community Development Team	Activity 3.3.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of	Latino gay, bisexual, and other MSM	# Community Development initiatives established Additional indicators contingent on execution of new contracts for Community Development initiatives beginning March	1

		ARVs for HIV treatment and PrEP among Latino gay, bisexual, and other MSM.		1, 2019	
By March 2019	CDPH HIV Housing Team	Activity 3.3.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including Latino gay, bisexual, and other MSM, to support ARV use for HIV treatment.	Latino gay, bisexual, and other MSM	# Housing programs established Additional indicators contingent on execution of new contracts for Housing programs beginning March 1, 2019	20
By July 2019	CDPH HIV Healthcare Access Team	Activity 3.3.1.3: By March 2019, establish 2-3 PCHH-Complex, including Latino gay, bisexual, and other MSM, to support ARV use for HIV treatment.	Latino gay, bisexual, and other MSM	# PCHH-Complex established Additional indicators contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019	2-3

Objective 3.4: By December 2021, increase viral suppression among transgender persons who have sex with men⁴.

Strategy 3.4.1: Examine and address root causes of disparities among cisgender transgender persons who have sex with men.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By March 2019	CDPH HIV Community Development Team	Activity 3.3.1.1: By March 2019, establish 1 Community Development initiative aimed at addressing the intersections of HIV and social determinants of health in order to increase use of	Transgender persons who have sex with men	# Community Development initiatives established Additional indicators contingent on execution of new contracts for Community Development	1

⁴ Viral suppression among transgender persons who have sex with men is currently unknown. Investigation to determine this information is underway.

		ARVs for HIV treatment and PrEP transgender persons who have sex with men.		initiatives beginning March 1, 2019	
By March 2019	CDPH HIV Housing Team	Activity 3.3.1.2: By March 2019, establish 20 Housing programs to provide housing opportunities for persons living with HIV, including transgender persons who have sex with men, to support ARV use for HIV treatment.	Transgender persons who have sex with men	# Housing programs established Additional indicators contingent on execution of new contracts for Housing programs beginning March 1, 2019	20
By July 2019	CDPH HIV Healthcare Access Team	Activity 3.3.1.3: By March 2019, establish 2-3 PCHH-Complex, including transgender persons who have sex with men, to support ARV use for HIV treatment.	Transgender persons who have sex with men	# PCHH-Complex established Additional indicators contingent on execution of new contracts for PCHH-Complex beginning July 1, 2019	2-3

Goal #4: A More Coordinated Response to HIV in the Chicago EMA and within the State of Illinois

Objective 4.1: Improve administrative mechanisms within the CDPH to address changes in the delivery of HIV funding and services.

Strategy 4.1.1: Restructure the CDPH HIV/STI Bureau Community Health Services Division to reflect integration of HIV funding sources and services.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
By October 2018	CDPH Leadership	Redesign division management structure to the component areas of the <i>HIV Services Portfolio</i> .	All	Division redesigned	N/A

Strategy 4.1.2: Strengthen coordination across data systems and the use of data to improve health outcomes and monitor use of CDPH funds

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
Ongoing	CDPH Leadership	To be determined	All	To be determined	N/A

Objective 4.2: Continue collaborative efforts with partners in the Chicago EMA and at the state and federal levels to improve the integration and effective delivery of HIV services.

Strategy 4.2.1: Continue close collaboration with CAHISC to monitor implementation and quality improvement of *HIV Services Portfolio*.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
Quarterly	CDPH Leadership	Report on Integrated Plan implementation and evaluation findings in CAHISC Full Body meetings.	All	Data indicators under goals 1-3	Data targets under goals 1-3
Ongoing	CDPH Leadership	Discuss Integrated Plan implementation and develop strategies to address issues in CAHISC committee meetings.	All	Data indicators under goals 1-3	Data targets under goals 1-3

Strategy 4.2.2: Continue participation in the planning and implementation of Getting to Zero for the State of Illinois.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
June – October 2018	GTZ committees	Convene planning group and leadership group calls/meetings to compile recommendations.	All	Recommendation templates completed	N/A
November 2018	GTZ leadership	Compile final draft GTZ plan.	All	GTZ plan draft completed	N/A
December 2018	GTZ leadership	Release GTZ plan for public comment on World AIDS Day.	All	GTZ plan released for public comment	N/A

Strategy 4.2.3: Coordinate Integrated Plan implementation and evaluation with IDPH.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
Quarterly (ongoing)	CDPH Leadership IDPH Leadership	Review Integrated Plan objectives and collaborative activities. Share evaluation findings and develop strategies to meet common objectives.	All	Data indicators under goals 1-3	Data targets under goals 1-3

Objective 4.3: Increase HIV knowledge and reduce disparities in learning scores among the non-medical workforce using data from the Black AIDS Institute survey as baseline.

- 63% overall score
- 42% familiar with PrEP
- 41% familiar with treatment as prevention
- 13-16 percentage point gap between Whites and Blacks on all categories

Strategy 4.3.1: Collaborate with MATEC, AFC, Northwestern University (NWU), the Public Health Institute of Metropolitan Chicago (PHIMC), and CDC-funded Capacity Building Assistance (CDC/CBA) providers to provide low, medium, and high-intensity trainings to the non-medical workforce.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators	Data Targets
March 2019	CDPH CBA Team, MATEC, AFC, NWU, PHIMC, CDC/CBA	Design and deliver low intensity trainings to non-medical workforce. Content to be determined.	Professional and para-professional HIV providers	Post test scores Prep awareness Treatment as prevention Comparison of scores between White and Blacks	63% to 75% 42% to 75% 41% to 75% ↓ gap from 16 to 0
July 2019	CDPH CBA Team, MATEC, AFC, NWU, PHIMC, CDC/CBA	Design and deliver medium intensity trainings to non-medical workforce. Content to be determined.	Professional and para-professional HIV providers	Post test scores Prep awareness Treatment as prevention	63% to 75% 42% to 75% 41% to 75%

				Comparison of scores between White and Blacks	↓ gap from 16 to 0
October 2019	CDPH CBA Team, MATEC, AFC, NWU, PHIMC, CDC/CBA	Design and deliver high intensity trainings to non-medical workforce. Content to be determined.	Professional and para-professional HIV providers	Post test scores	63% to 75%
				Prep awareness	42% to 75%
				Treatment as prevention	41% to 75%
				Comparison of scores between White and AAs	↓ gap from 16 to 0

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health 2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV PREVENTION				
CDC PS15-1506	\$178,916	Esperanza Health Services	Along with a clinical partner conducts outreach, PrEP screening, HIV testing, patient navigation, PrEP prescription, STI screening and treatment	1
CDC PS15-1506	\$228,917	Heartland Human Care Services	Prevention with HIV-Negative Individuals, along with a clinical provider conducts Outreach, PrEP screening, HIV testing, patient navigation, PrEP prescription, STI screening and treatment	1
CDC PS15-1506	\$365,000	Howard Brown Health	HIV screening in a clinical setting and Partners Services, Prevention with HIV-Positive Individuals, PrEP Demonstration	1, 2
CDC PS15-1506	\$328,917	The Division of Adolescent Medicine at Stroger/CORE	PrEP Demonstration Project, Along with other CCHS clinical providers conduct Outreach, PrEP screening, HIV testing, patient navigation, PrEP prescription, STI screening and treatment	1
CDC PS18-1802	\$284,942	Access Community Health	HIV screening and linkage, Prevention with HIV-Positive Individuals, Prevention with HIV-Negative Individuals	1, 2
CDC PS18-1802	\$87,500	Austin Congressional Black Caucus	Prevention with HIV-Positive Individuals	1, 2
CDC PS18-1802	\$165,000	Center on Halsted	HIV screening and linkage	1
CDC PS18-1802	\$165,000	Cermak Health Services	HIV screening and linkage	1
CDC PS18-1802	\$436,601	Howard Brown Health	HIV screening in a clinical setting and Partners Services, Prevention with HIV-Positive Individuals, PrEP Demonstration	1, 2
CDC PS18-1802	\$542,099	Provident Hospital	HIV screening and linkage, Routine Screening in a clinical setting and Partner Services, Along with 2 CBOs provides outreach, PrEP screening, HIV testing, patient navigation, PrEP prescription, STI screening and treatment	1
CDC PS18-1802	\$398,861	The CORE Center	HIV screening and linkage, Prevention with HIV-Positive Individuals, Prevention with HIV-Negative Individuals, Linkage to Care, Re-engagement in Care	1, 2
CDC PS18-1802	\$1,864,167	University of Chicago	HIV screening and linkage, PrEP Demonstration, Prevention with HIV-Negative Individuals, Routine Screening in Clinical Settings, PrEP screening, HIV testing, patient navigation, PrEP prescription, STI screening and treatment, Linkage to Care and Re-engagement in Care	1
CDPH CORPORATE	\$100,000	Asian Human Services	HIV Screening and linkage	1
CDPH CORPORATE	\$87,500	Brothers Health Collective	Prevention with HIV-Positive Individuals	1, 2
CDPH CORPORATE	\$95,000	Chicago Black Gay Men's Caucus	Prevention with HIV-Positive Individuals	1, 2
CDPH CORPORATE	\$150,000	Chicago House and Social Services Agency	HIV screening and linkage	1
CDPH CORPORATE	\$318,232	Chicago Recovery Alliance	Prevention with People who Inject Drugs	1
CDPH CORPORATE	\$100,000	Chicago Women's AIDS Project	Prevention with HIV-Negative Individuals	1

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

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HIV PREVENTION				
CDPH CORPORATE	\$231,768	Community Outreach Interventions Project (UIC)	Prevention with People who Inject Drugs	1
CDPH CORPORATE	\$90,000	FOLA	HIV screening and linkage	1
CDPH CORPORATE	\$50,000	Haymarket Center	Prevention with HIV-Negative Individuals	1
CDPH CORPORATE	\$185,543	Lurie Children's Hospital	HIV screening and linkage, Prevention with HIV-Negative Individuals	1
CDPH CORPORATE	\$95,000	Making A Daily Effort	Prevention with HIV-Positive Individuals	1, 2
CDPH CORPORATE	\$100,000	Puerto Rican Cultural Center- Vida/ SIDA	Prevention with HIV-Negative Individuals	1
CDPH CORPORATE	\$155,015	Rincon Family Services	HIV screening and linkage	1
CDPH CORPORATE	\$165,000	South Side Help Center	HIV screening and linkage	1
CDPH CORPORATE	\$95,000	Stroger Hospital	Prevention with HIV-Positive Individuals	1, 2
CDPH CORPORATE	\$172,000	Test Positive Awareness Network	HIV screening and linkage	1, 2
CDPH CORPORATE	\$100,000	The Night Ministry	HIV screening and linkage	1, 2
CDC-IDPH	\$41,686	Region 7 Subgrantee: Chicago Recovery Alliance	CTR for IDU, MSM/IDU, MSM, HRH; Harm Reduction/RRC for HIV-positive and HIV-negative IDU and MSM/IDU.	1, 2, 3, 4, 5
CDC-IDPH	\$38,636	Region 7 Subgrantee: DuPage County Health Department	RRC for HIV-positive MSM and HRH; Surveillance-based LTC/Adherence Counseling; CTR for MSM; Surveillance-based Partner Services; RRC for HIV-negative MSM and HRH.	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health 2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV PREVENTION				
CDC-IDPH	\$180,064	Region 7 Subgrantee: Lake County Health Department	GPS for HIV-positive MSM and HRH; Surveillance-based LTC/Adherence Counseling; CTR for MSM and HRH; Surveillance-based Partner Services; RRC for HIV-negative MSM.	1, 2, 3, 4, 5
CDC-IDPH	\$13,335	Region 7 Subgrantee: Angles	GPS for HIV-negative YMSM and CTR for YMSM.	1, 2
CDC-IDPH	\$32,819	Region 7 Subgrantee: FCAN	CLEAR, Group Prevention and Support, Risk Reduction Counseling.	1, 2, 3, 4, 5
CDC-IDPH	\$133,326	Region 7 Subgrantee: Open Door Clinic	CRCS for HIV-positive MSM and HIV-negative MSM and HRH; GPS for HIV-positive MSM and HRH; CTR for MSM; RRC for HIV-negative MSM and HRH; STI screening for HIV-negative MSM.	1, 2, 3, 4, 5
CDC-IDPH	\$104,625	Region 7 Subgrantee: Renz Prevention Center	GPS for HIV-positive MSM; CTR for MSM; RRC for HIV-negative MSM.	1, 2, 3, 4, 5
CDC-IDPH	\$59,471	Region 7 Subgrantee: Sisters and Brothers Helping Each Other	CTR for IDU, MSM/IDU, MSM; Harm Reduction/RRC for HIV-positive and HIV-negative IDU and MSM/IDU.	1, 2, 3, 4, 5
CDC-IDPH	\$109,292	Region 8 Subgrantee: Will County Health Department	GPS for HIV-positive MSM and HRH; Surveillance-based LTC/Adherence Counseling; CTR for MSM and HRH; Surveillance-based Partner Services; VIBES for HIV-negative AAYMSM; RRC and STI screening for HIV-negative MSM.	1, 2, 3, 4, 5
CDC-IDPH	\$23,000	Region 8 Subgrantee: Angels	HIV counseling and testing, group prevention services with negative youth	1, 2
CDC-IDPH	\$46,000	Region 8 Subgrantee: Aunt Martha's Youth Services	HIV counseling and testing, group interventions for youth and black HRH and MSM in south suburbs	1, 2
CDC-IDPH	\$88,700	Region 8 Subgrantee: Cook County Department of Public Health	HIV counseling and testing, risk reduction counseling, group prevention services, linkage to care, AC, for almost all risk populations including positive groups at Oak Forest, Maywood, and multiple outreach south suburbs outreach sites	1, 2, 3, 4, 5
CDC-IDPH	\$145,800	Region 8 Subgrantee: Chicago Recovery Alliance	HIV counseling, testing, and referral; risk reduction counseling for almost all identified risk populations; harm reduction counseling for IDUs	1, 2
CDC-IDPH	\$15,250	Region 8 Subgrantee: Evanston Health Department	Surveillance	1, 2, 3, 4, 5
CDC-IDPH	\$57,500	Region 8 Subgrantee: FCAN	CLEAR, Group Prevention and Support, Risk Reduction Counseling.	1, 2, 3, 4, 5
CDC-IDPH	\$74,300	Region 8: Subgrantee: Howard Brown Health Center	HCT and CRCS predominantly in outreach setting in north and west suburbs. Multiple populations including MSM.	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health 2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV PREVENTION				
CDC-IDPH	\$54,000	Region 8 Subgrantee: Making a Daily Effort	HIV counseling and testing, group prevention services with positives	1, 2, 3, 4, 5
CDC-IDPH	\$50,000	Region 8 Subgrantee: Men and Women in Prison Ministries	HIV counseling, testing, and referral; risk reduction counseling for identified risk populations	1, 2, 3, 4, 5
CDC-IDPH	\$20,050	Region 8 Subgrantee: Oak Park Department of Public Health	HIV Surveillance	1, 2, 3, 4, 5
CDC-IDPH	\$12,000	Region 8 Subgrantee: Project VIDA	HIV counseling and testing, risk reduction counseling with negatives	1, 2
CDC-IDPH	\$87,000	Region 8 Subgrantee: Proactive Community Services	HIV counseling and testing, group intervention for black MSM and IDU in the south suburbs	1, 2
CDC-IDPH	\$140,000	Region 8 Subgrantee: Renz Prevention Center	HIV counseling and testing, group intervention for black and Hispanic MSM in the northwest suburbs	1, 2
CDC-IDPH	\$120,700	Region 8: Sisters and Brothers Helping Each Other	HIV counseling and testing, comprehensive risk counseling and services, IDU outreach and syringe exchange, hepatitis activities	1, 2
CDC-IDPH	\$73,500	Region 8 Subgrantee: South Suburban HIV/AIDS Regional Clinic	HIV counseling, testing, and referral; group prevention and support; and risk reduction counseling with multiple populations—the majority positive—through care clinics and collaboration in the south suburbs	1, 2, 3, 4, 5
CDC-IDPH	\$82,000	Region 8 Subgrantee: Puerto Rican Cultural Center, VIDA/SIDA	HIV counseling, testing, and referral for almost all risk populations, RESPECT, risk reduction counseling	1, 2, 3, 4, 5
IDPH-GRF-MAI	\$25,000	AIDS Foundation of Chicago	HIV risk and harm reduction counseling; HIV counseling, testing, and referral; high impact outreach to medically underserved minority populations	1, 2
IDPH-GRF-MAI	\$30,000	Aisian Human Services	HIV risk and harm reduction counseling; HIV counseling, testing, and referral; high impact outreach to medically underserved minority populations	1, 2
IDPH-GRF-MAI	\$50,000	Human Resources Development Institute	HIV risk and harm reduction counseling; HIV counseling, testing, and referral; and high impact outreach to medically underserved minority population	1, 2
IDPH-GRF-MAI	\$40,000	Proactive Community Services	HIV risk and harm reduction counseling; HIV counseling, testing, and referral; and high impact outreach to medically underserved minority population	1, 2
IDPH-GRF-MAI	\$50,000	Puerto Rican Cultural Center- Vida/ SIDA	HIV risk and harm reduction counseling; HIV counseling, testing, and referral; and high impact outreach to medically underserved minority population	1, 2

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health 2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV PREVENTION				
IDPH-GRF-MAI	\$40,000	Renz Addiction Counseling Center	HIV risk and harm reduction counseling; HIV counseling, testing, and referral; and high impact outreach to medically underserved minority population	1, 2
IDPH-QOL	\$57,400	Center on Halsted	HIV counseling and testing for MSM and HRS populations	1, 2
IDPH-QOL	\$70,000	Proactive Community Services	HIV counseling and testing, risk reduction, and STI screening for MSM and HRH populations	1, 2
IDPH-QOL	\$219,999	UIC	Integrated PASEO: Pilot co-location of mental health, substance abuse, HIV and hepatitis screening, testing and treatment within the surrounding campus communities in order to provide seamless prevention, education and care services to at-risk Hispanic/Latino and African American young adults who attend UIC and/or live in surrounding campus communities. The sub-population of focus is LGBT students.	1, 2, 3, 4, 5
IDPH-QOL	\$500,000	Test Positive Awareness Network	TPAN, Lutheran Social Services of Illinois, and Chicago Lakeshore Hospital partner on the Healthy Outcomes through Treatment, Empowerment, and Recovery (HOTTER) program to address gaps in services for young African American men in Chicago. HOTTER aims to decrease substance abuse and HIV transmission by providing education, interventions, HIV and hepatitis testing, and substance abuse treatment.	1, 2, 3, 4, 5
IDPH-QOL	\$519,788	Puerto Rican Cultural Center-Vida/ SIDA	Women for PASEO is expanding access to evidence-based substance abuse, mental health, and HIV services for 1,000 African American and Hispanic/Latina adult women living in Chicago or nearby suburbs	1, 2, 3, 4, 5
IDPH-QOL	\$500,000	Puerto Rican Cultural Center-Vida/ SIDA	Integrated PASEO is a project to expand co-located, evidence-based behavioral health, HIV, and hepatitis services for African American and Latino adults living in Chicago. The populations of focus include: gay, lesbian, bisexual, and transgender adults.	1, 2, 3, 4, 5
IDPH-QOL	\$283,875	Puerto Rican Cultural Center-Vida/ SIDA	L-Act Prevention Project: To expand and enhance capacity to provide culturally competent substance abuse services, viral hepatitis (VH), and HIV and other sexually transmitted infections (STI) prevention services for Latino men ages 13-24. The subpopulations of focus include: gay, bisexual and transgender men, as well as those with co-occurring substance use and mental disorders living with or at risk for HIV/AIDS.	1, 2, 3, 4, 5
IDPH-QOL	\$500,000	Haymarket Center	Chicago's largest provider of treatment for substance use disorders expanded access to residential treatment for 456 primarily African American men who are at high risk for HIV and may have co-occurring mental illness. The project seeks to stabilize clients' substance use, mental illness, HIV, hepatitis and other conditions and provide evidence-based recovery support for one year in the community.	1, 2, 3, 4, 5
IDPH-QOL	\$520,000	Renz Addiction Counseling Center	The Sisters United in Preventing and Protecting Ourselves and/by Recovering Together (SUPPORT) Project offers substance and HIV prevention service to minority women, with a primary emphasis on Kane and western Cook and DuPage Counties' Hispanic and African American females, to reduce behaviors that lead to SA and HIV infection	1, 2
Total HIV Prevention Resources	\$12,545,094			

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV CARE				
RWHAP-A	\$241,758	Access Community Health Network	Outpatient Ambulatory Care Early Intervention Services Psychosocial Services	1, 2, 3, 4, 5
RWHAP-A	\$407,177	Sinai Health System	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services Psychosocial Support Services	1, 2, 3, 4, 5
RWHAP-A	\$6,020,384	AIDS Foundation of Chicago	Housing Services Medical Case Management Non-Medical CM Medical Transportaion Emergency Financial Assistance Health Insurance Premiums Other Professional Services- Income Tax Preparation	1, 2, 3, 4, 5
RWHAP-A	\$117,148	AIDS Healthcare Foundation	Outpatient Ambulatory Care Early Intervention Services	3, 4, 5
RWHAP-A	\$84,578	Alexian Brothers - Bonaventure House	Substance Abuse Residential Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$40,041	Alexian Brothers - The Harbor	Substance Abuse Residential Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$202,308	Ann & Robert H. Lurie Children's Hospital	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services	3, 4, 5
RWHAP-A	\$250,511	Catholic Charities of Lake County	Food Bank/Home-Delivered Meals Substance Abuse Outpatient Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$31,351	Center On Halsted	Psychosocial Support Services	3, 4, 5
RWHAP-A	\$67,701	Chicago House and Social Service Agency	Psychosocial Support Services	3, 4, 5
RWHAP-A	\$159,099	Chicago Women's AIDS Project	Mental Health Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$117,866	Christian Community Health Center	Oral Health Services	3, 4, 5
RWHAP-A	\$89,521	Erie Family Health Center	Outpatient Ambulatory Care Early Intervention Services	3, 4, 5
RWHAP-A	\$33,852	Garfield Counseling Center	Substance Abuse Outpatient Services	3, 4, 5
RWHAP-A	\$104,812	Healthcare Alternative Systems, Inc.	Substance Abuse Outpatient Services Substance Abuse Residential Services	3, 4, 5
RWHAP-A	\$1,446,135	Heartland Health Outreach, Inc.	Outpatient Ambulatory Care Services Oral Health Services Early Intervention Services Food Bank/Home-Delivered Meals	1, 2, 3, 4, 5
RWHAP-A	\$101,004	Howard Area Community Center	Oral Health Services	3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV CARE				
RWHAP-A	\$469,247	Howard Brown Health Center	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services Psychosocial Support Services Substance Abuse Outpatient Services	1, 2, 3, 4, 5
RWHAP-A	\$582,287	Howard Brown Health Center - EPCS	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services Oral Health Services	1, 2, 3, 4, 5
RWHAP-A	\$251,148	Human Resource Development Institute, Inc.	Substance Abuse Outpatient Services	3, 4, 5
RWHAP-A	\$284,000	LAF - Legal Assistance Foundation	Other Professional Services - Legal	3, 4, 5
RWHAP-A	\$372,214	Lake County Health Department	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services Oral Health Services	1, 2, 3, 4, 5
RWHAP-A	\$94,415	Lawndale Christian Health Center	Outpatient Ambulatory Care Services Early Intervention Services	3, 4, 5
RWHAP-A	\$394,900	Legal Council for Health Justice	Other Professional Services - Legal	3, 4, 5
RWHAP-A	\$217,243	Loyola University Health System	Outpatient Ambulatory Care Services Early Intervention Services	1, 2, 3, 4, 5
RWHAP-A	\$788,415	McDermott Center dba Haymarket Center	Substance Abuse Outpatient Services Substance Abuse Residential Services Psychosocial Support Services Outreach Services	
RWHAP-A	\$526,558	Michael Reese Research & Education Foundation-HIV Care Program	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services	1, 2, 3, 4, 5
RWHAP-A	\$31,784	New Age Services Corporation	Psychosocial Support Services	3, 4, 5
RWHAP-A	\$348,854	Open Door Clinic of Greater Elgin	Outpatient Ambulatory Care Services Early Intervention Services Psychosocial Support Services Mental Health Services Oral Health Services Substance Abuse Outpatient Services	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV CARE				
RWHAP-A	\$172,000	Prairie State Legal Services, Inc.	Other Professional Services - Legal	3, 4, 5
RWHAP-A	\$450,000	Public Health Institute of Metropolitan Chicago	Quality Management Technical Assistance	1, 2, 3, 4, 5
RWHAP-A	\$236,415	Puerto Rican Cultural Center	Substance Abuse Outpatient Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$105,849	South Shore Hospital Corporation	Outpatient Ambulatory Care Early Intervention Services	3, 4, 5
RWHAP-A	\$35,467	South Side Help Center	Psychosocial Support Services	3, 4, 5
RWHAP-A	\$1,026,337	The Board of Trustees of The University of Illinois	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services	1, 2, 3, 4, 5
RWHAP-A	\$579,576	The Board of Trustees of The University of Illinois - EPCS	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services	1, 2, 3, 4, 5
RWHAP-A	\$72,540	The Children's Place Association	Mental Health Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$604,568	The Hektoen Institute for Medical Research on Behalf of Austin Health Center	Outpatient Ambulatory Care Services Early Intervention Services Substance Abuse Outpatient Services Psychosocial Support Services Mental Health Services	3, 4, 5
RWHAP-A	\$1,633,323	The Hektoen Institute for Medical Research on Behalf of CORE Center	Outpatient Ambulatory Care Services Early Intervention Services Substance Abuse Outpatient Services Psychosocial Support Services Mental Health Services Oral Health Services	3, 4, 5
RWHAP-A	\$80,487	The Hektoen Institute for Medical Research on Behalf Of Project VIDA	Mental Health Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$1,139,090	The Hektoen Institute for Medical Research on Behalf of Provident Hospital	Outpatient Ambulatory Care Services Early Intervention Services Substance Abuse Outpatient Services Mental Health Services Oral Health Services	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV CARE				
RWHAP-A	\$793,391	The Hektoen Institute for Medical Research on Behalf of South Suburban HIV/AIDS Regional Clinics (SSHARC)	Outpatient Ambulatory Care Services Early Intervention Services Substance Abuse Outpatient Services Psychosocial Support Services Mental Health Services Oral Health Services Outreach Services	1, 2, 3, 4, 5
RWHAP-A	\$142,703	TPA Network	Mental Health Services Psychosocial Support Services	3, 4, 5
RWHAP-A	\$44,263	Universal Family Connection	Psychosocial Support Services	3, 4, 5
RWHAP-A	\$729,119	University of Chicago	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services Psychosocial Support Services Outreach Services	1, 2, 3, 4, 5
RWHAP-A MAI	\$110,600	Healthcare Alternative Systems, Inc.	Substance Abuse Outpatient Services Substance Abuse Residential Services	3, 4, 5
RWHAP-A MAI	\$92,687	Heartland Health Outreach, Inc.	Outpatient Ambulatory Care Services Oral Health Services Early Intervention Services Food Bank/Home-Delivered Meals	3, 4, 5
RWHAP-A MAI	\$185,799	Lawndale Christian Health Center	Outpatient Ambulatory Care Services Early Intervention Services	3, 4, 5
RWHAP-A MAI	\$147,812	McDermott Center dba Haymarket Center	Substance Abuse Outpatient Services Substance Abuse Residential Services Psychosocial Support Services Outreach Services	3, 4, 5
RWHAP-A MAI	\$110,600	Michael Reese Research & Education Foundation-HIV Care Program	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services	1, 2, 3, 4, 5
RWHAP-A MAI	\$34,738	Sinai Health System	Outpatient Ambulatory Care Services Early Intervention Services Mental Health Services Psychosocial Support Services	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

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HIV CARE				
RWHAP-A MAI	\$148,398	The Hektoen Institute for Medical Research on Behalf of Austin Health Center	Outpatient Ambulatory Care Services Early Intervention Services Substance Abuse Outpatient Services Psychosocial Support Services Mental Health Services	
RWHAP-A MAI	\$961,890	The Hektoen Institute for Medical Research on Behalf of CORE Center	Outpatient Ambulatory Care Services Early Intervention Services Substance Abuse Outpatient Services Psychosocial Support Services Mental Health Services Oral Health Services	1, 2, 3, 4, 5
RWHAP-B	\$543,667	AIDS Foundation of Chicago	(Corrections): Intensive case management for positives coming out of prisons and jails	1, 2, 3, 4, 5
RWHAP-B	\$150,000	Cermak Health Services	(Corrections) HIV Prevention education, HIV testing, and referrals to medical services for inmates at Cook County Jail	1, 2
RWHAP-B	\$94,500	Christian Community Health Center	(Corrections): HIV prevention education and HIV counseling and testing services for women involved in the sex trade; access to care facilitation for reentry adults	1, 2, 3, 4, 5
RWHAP-B	\$63,114	Agape Missions	Region 7: Medical Case Management	1, 2, 3, 4, 5
RWHAP-B	\$803,249	AIDS Foundation of Chicago	Lead agent grant Region 7: Ryan White Part B core and supportive services, and peer navigator services	1, 2, 3, 4, 5
RWHAP-B	\$75,538	Alexian Brothers Bonaventure	Region 8: Housing, mental health, psychosocial services	1, 2, 3, 4, 5
RWHAP-B	\$27,584	Alexian Brothers The Harbor	Region 7: Housing, Mental health, Psychosocial services	1, 2, 3, 4, 5
RWHAP-B	\$30,000	Athena Dental Institute	Region 8: Oral health	1, 2, 3, 4, 5
RWHAP-B	\$68,313	Catholic Charities of Chicago	Region 8: Medical case management	1, 2, 3, 4, 5
RWHAP-B	\$53,168	Catholic Charities of Lake County	Region 7: Food assistance, mental health, linguistics	1, 2, 3, 4, 5
RWHAP-B	\$325,064	Chicago House and Social Service Agency	Region 8: Medical case management	1, 2, 3, 4, 5
RWHAP-B	\$73,100	Children's Place	Region 8: Medical case management, housing, mental health	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

Funding Source	Funding Amount	Funded Service Provider Agency	Services Delivered	HIV Continuum of Care Step(s) Impacted: 1 = HIV Diagnosis, 2 = Linkage to Care, 3 = Retention in Care, 4=Antiretroviral Use, 5= Viral Suppression
HIV CARE				
RWHAP-B	\$176,800	Christian Community Health Center	Region 8: Medical case management, oral health, mental health	1, 2, 3, 4, 5
RWHAP-B	\$253,901	Erie Family Health Center	Region 8: Medical case management, outpatient health services, mental health	1, 2, 3, 4, 5
RWHAP-B	\$47,976	Haymarket Center	Region 8: Substance abuse, psychosocial services, housing	1, 2, 3, 4, 5
RWHAP-B	\$14,162	Healthcare Alternative Systems, Inc.	Region 8: Substance abuse, housing	1, 2, 3, 4, 5
RWHAP-B	\$58,500	Howard Area Community Center	Region 8: Oral health	1, 2, 3, 4, 5
RWHAP-B	\$164,292	Lake County Health Department	Region 7: Medical case management, outpatient ambulatory health services	1, 2, 3, 4, 5
RWHAP-B	\$53,360	Legal Council for Health Justice	Region 8: Legal Services	1, 2, 3, 4, 5
RWHAP-B	\$15,000	MATEC	(Corrections): HIV training and education in the form of three statewide trainings focused on IDOC nurses and community-based providers	1, 2, 3, 4, 5
RWHAP-B	\$80,000	Men and women in Prison Ministries	(Corrections) Discharge planning packets to Cook County Jail and CBOs access to care facilitation for reentry adults	1, 2, 3, 4, 5
RWHAP-B	\$51,264	Near North Health Services	Region 8: Medical case management	1, 2, 3, 4, 5
RWHAP-B	\$192,492	Open Door Clinic of Greater Elgin	Region 7: Medical and non-medical case management, outpatient ambulatory health services, oral health, peer services	1, 2, 3, 4, 5
RWHAP-B	\$15,000	Open Door Clinic of Greater Elgin	Region 8: Medical and non-medical case management, outpatient ambulatory health services	1, 2, 3, 4, 5
RWHAP-B	\$114,256	Project Vida	Region 8: Medical case management	1, 2, 3, 4, 5
RWHAP-B	\$50,200	Provident Hospital	Region 8: Oral health	1, 2, 3, 4, 5

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HIV CARE				
RWHAP-B	\$17,254	Regional Care Association	Region 7: Outpatient ambulatory health services	1, 2, 3, 4, 5
RWHAP-B	\$6,636	Ruth M. Rothstein CORE Center	Region 7: Outpatient ambulatory health services	1, 2, 3, 4, 5
RWHAP-B	\$828,935	Ruth M. Rothstein CORE Center	Region 8: Medical and non-medical case management, outpatient ambulatory health services	1, 2, 3, 4, 5
RWHAP-B	\$43,231	South Suburban HIV/AIDS Regional Clinics	Region 8: Medical and non-medical case management, outpatient ambulatory health services	1, 2, 3, 4, 5
RWHAP-B	\$109,318	Test Positive Awareness Network	Region 8: Medical and non-medical case management, psychosocial services	1, 2, 3, 4, 5
RWHAP-B	\$150,863	UIC	Midwest AIDS Training and Education Center (MATEC): Educational trainings, capacity building and technical assistance to IDPH	1, 2, 3, 4, 5
RWHAP-B	\$150,863	UIC	Region 8: Medical and non-medical case management	1, 2, 3, 4, 5
RWHAP-B	\$10,000	Universal Family Connection	Region 8: Psychosocial services	1, 2, 3, 4, 5
RWHAP-B	\$5,541	Vital Bridges	Region 7: Food service	1, 2, 3, 4, 5
RWHAP-B	\$141,763	Vital Bridges	Region 8: Medical case management, food services	1, 2, 3, 4, 5
RWHAP-B MAI	\$60,000	Asian Health Services	Outreach and education services to increase minority participation in ADAP	1, 2, 3, 4, 5
RWHAP-B MAI	\$30,000	Puerto Rican Cultural Center	Outreach and education services to increase minority participation in ADAP	1, 2, 3, 4, 5
RWHAP-B MAI	\$40,000	Sinai Health System	Outreach and education services to increase minority participation in ADAP	1, 2, 3, 4, 5
RWHAP-C	\$907,783	Heartland Health Outreach, Inc.	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$342,948	Lawndale Christian Health Center	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$400,418	Near North Health Services	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$656,966	Access Community Health Network	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$371,426	Christian Community Health Center	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

Funding Source	Funding Amount	Funded Service Provider Agency	Services Delivered	HIV Continuum of Care Step(s) Impacted: 1 = HIV Diagnosis, 2 = Linkage to Care, 3 = Retention in Care, 4=Antiretroviral Use, 5= Viral Suppression
HIV CARE				
RWHAP-C	\$393,601	Erie Family Health Center	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$131,861	UIC	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$343,184	Open Door of Greater Elgin	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$895,659	Hektoen Institute for Research	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-C	\$715,782	Howard Brown Health	EIS Award: Comprehensive Primary Health Care	1, 2, 3, 4, 5
RWHAP-D	\$189,631	Near North Health Services	Family-centered, comprehensive care for women, infants, children, and youth	1, 2, 3, 4, 5
RWHAP-D	\$1,410,197	Hektoen Institute for Research	Family-centered, comprehensive care for women, infants, children, and youth	1, 2, 3, 4, 5
RWHAP-D	\$335,057	Access Community Health Network	Family-centered, comprehensive care for women, infants, children, and youth	1, 2, 3, 4, 5
RWHAP-D	\$474,145	Howard Brown Health	Family-centered, comprehensive care for women, infants, children, and youth	1, 2, 3, 4, 5
RWHAP - CBDPP	\$267,151	UIC	Community-based Dental Partnership: Oral Health Care for PLWH	1, 2, 3, 4, 5
RWHAP- AETC	\$443,121	MATEC	Midwest AIDS Training and Education Center: Education and training of health care professionals	1, 2, 3, 4, 5
RWHAP-SPNS	\$289,500	Hektoen Institute for Research	The Practice Transformative Model (PTM) is a project to develop and implement the	1, 2, 3, 4, 5
RWHAP-SPNS	\$285,500	Access Community Health Network	The project will build system workforce capacity and support the integration of its HIV continuum into its primary care system through a Practice Transformative Model based on the Patient- Centered Medical Home.	1, 2, 3, 4, 5
Total HIV Care Resources	\$37,556,797			

APPENDIX 4 - Chicago EMA HIV Resource Inventory - HIV Prevention Care and Housing

Chicago Department of Public Health

2018 Integrated Plan Chicago EMA HIV Financial and Human Resources Inventory

Funding Source	Funding Amount	Funded Service Provider Agency	Services Delivered	HIV Continuum of Care Step(s) Impacted: 1 = HIV Diagnosis, 2 = Linkage to Care, 3 = Retention in Care, 4=Antiretroviral Use, 5= Viral Suppression
HIV HOUSING				
HOPWA -CDPH	\$114,253	Agape Missions, NFP	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$191,624	Alexian Brothers Bonaventure House	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$68,360	Lwarwe & Rosalie Anixter Center - CALOR	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$625,545	Chicago House and Social Service Agency	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$160,000	Children's Place Association	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$114,950	Christian Community Health Center	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$92,584	Community Supportive Living Systems, Inc.	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$346,589	Haymarket Center	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$245,706	Heartland Health Outreach	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$502,252	Heartland Human Care Services	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$170,262	Housing Opportunities for Women	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$185,000	Human Resources Development Institute, Inc	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$311,000	The Boulevard of Chicago	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$246,000	Open Door Health Center of Illinois	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$80,000	Pilsen Wellnes Center	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$130,000	Puerto Rican Cultural Center	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$100,000	Unity Parenting & Counseling, Inc.	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA -CDPH	\$430,000	AIDS Foundation of Chicago	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$87,000	Asian Human Services	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$63,215	Chicago House and Social Service Agency	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$60,000	FOLA Community Action Services	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$72,000	Human Resources Development Institute, Inc.	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$116,166	Legal Assistance Foundation	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$70,000	Puerto Rican Cultural Center	Housing Information Services	2, 3, 4, 5
HOPWA -CDPH	\$2,495,965	AIDS Foundation of Chicago	Tenant Based Rental Assistance	2, 3, 4, 5
HOPWA-STATE	\$240,000	Alexian Brothers The Harbor	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$90,000	Asian Human Services	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$240,000	Bethany Place	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$165,800	DelaCorda House	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$240,000	Fifth Street Renaissance-SARA Center	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$240,000	The Greather Community AIDS Project	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$240,000	Phoenix Center	Facility-Based Housing Assistance	2, 3, 4, 5
HOPWA-STATE	\$240,000	Puerto Rican Cultural Center	Facility-Based Housing Assistance	2, 3, 4, 5
Total HIV Housing Resources	\$8,774,271			

NEEDS AND GAPS THAT MAY AFFECT THE OVERALL CAPACITY TO PROVIDE HIV CLINICAL CARE IN CHICAGO

Midwest AIDS Training + Education Center,
University of Illinois at Chicago

August 1, 2016

INTRODUCTION

The Midwest AIDS Training + Education Center (MATEC) is a federally-funded training center, providing AIDS and HIV clinical training and support to health care professionals in Illinois, Iowa, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin. MATEC is part of the AIDS Education and Training Centers (AETC) Program (funded under Part F) of the Ryan White HIV/AIDS Program. The AETC Program increases the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage people living with HIV and to help prevent behaviors that lead to HIV transmission.

This report was prepared for the Chicago Department of Public Health (CDPH), for the purpose of their 2017-2021 Integrated HIV Prevention and Care Plan. It describes MATEC's findings regarding the needs and gaps that may affect the overall capacity to provide HIV clinical care in Chicago.

The report does not address any findings related to areas outside of the city of Chicago. A separate report was prepared for the Illinois Department of Public Health as the Ryan White Part B grantee.

This report was prepared in response to the *Guidance for the Development of a Regional AIDS Education and Training Center (AETC) Needs Assessment* provided by the Health Resources and Services Administration (HRSA) in November 2015. In accordance with HRSA's Guidance, the AETC's findings regarding clinical workforce needs and gaps were to be provided to Part A and B programs for them to use when preparing their integrated prevention and care plans. To this end, at MATEC's 2016 Policy Training Advisory Council (PTAC) meeting, representatives from all Part A and B programs in MATEC's region were invited to discuss (among other issues) MATEC's plans to approach the assessment of the HIV workforce and to reach consensus regarding the definition of "workforce". At the PTAC meeting, the group agreed to define the HIV workforce: Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Dental Providers and Clinical Pharmacists. For the purpose of this report, workforce is also referred to as the *clinical workforce*. However, given the nature of the data sets used to describe the findings, in some cases other HIV professionals (e.g., social workers, case managers, public health providers, etc.) were also taking into consideration.

Any questions pertinent to this report may be directed to Richard Zimmerman (MATEC-IL Director) at richardz@uic.edu.

DATA SOURCES

At the 2016 PTAC meeting, Part A and B representatives agreed to provide to MATEC the following data sets:

- Most recent HIV prevalence data by counties, city/town, or zip codes
- Most recent list of providers reporting CD4 counts and viral load by zip codes, otherwise by county
- Any other lists by zip codes or by county (e.g., CTR test sites, linkage to care personnel, etc.)

From the Chicago Department of Public Health, the following data sets were received which were used in this report:

- List of Facilities Reporting CD4 and Viral Load values
- Current List of Chicago HIV Providers/Facilities Reporting CD4/VL values By Zip Code
- Chicago - 2014 HIV Prevalence by Zip Code

Additional data sets utilized for the purpose of this report include:

- MATEC's trainees data:
 - From Participants Information Forms submitted by participants who receive trainings-including HIV clinical consultation- between July 1, 2014 and August 31, 2016.
 - Regional Needs Assessment completed in the fall of 2014. MATEC surveyed participants from its then seven-state region who attended at least one of their training programs during the past three years.
- The Black AIDS Institute HIV Work Survey: *When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States*. Black AIDS Institute, 2015 (<https://www.blackaids.org/reports/when-we-know-better-we-do-better>).

The Black AIDS Institute, in collaboration with the CDC, the Latino Commission on AIDS, and the National Alliance of State and Territorial AIDS Directors, conducted the US HIV Workforce Survey between 2012 and 2013. The 62-question web-based survey was completed by more than 3,600 workers in the HIV field and assessed the knowledge, attitudes and beliefs of the HIV workforce in the United States. Data were reported for three knowledge categories: 1) basic knowledge and terminology, 2) treatment, and 3) clinical knowledge (biomedical interventions). The survey report describes the results of the HIV Workforce Survey and includes fact sheets for 16 states and 14 major metropolitan areas with knowledge scores for each of the three knowledge categories, attitudes towards biomedical interventions, and demographic data of the respondents including a work profile. For the Midwest region, the states included in the state fact sheets were Chicago EMA, Michigan, Missouri, and Ohio. Chicago was the only Midwestern metropolitan area included in the fact sheets for major metropolitan areas.

- Data Warehouse, Health Resources and Services Administration. Data extracted on June 15, 2016. (<https://datawarehouse.hrsa.gov/tools/dataPortal.aspx>)
- County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. *JAIDS Journal of Acquired Immune Deficiency Syndromes* Publish. (June 2016, Ahead of Print.) (<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=ovft&AN=00126334-900000000-97209&PDF=y>)

Several maps were created to visualize and analyze data across Chicago. ArcInfo version 10.2.2. was used to develop the maps and geospatial data were downloaded from the U.S. Census Bureau, and included TIGER/Line 2010 Decennial Census files.

FINDINGS

The findings described in this section are based on the analysis and interpretation of the existing data listed in the introduction. These data begin to inform us on current needs and gaps that may affect the overall capacity to provide HIV clinical care in Chicago.

1. GEOGRAPHIC GAPS OF HIV CLINICAL WORKFORCE

1.1 Prevalence data *(See Map 1/page 11)*

- i. Although HIV cases have been reported in every Chicago zip code except 60635, it is important to highlight the following zip codes with an HIV prevalence between 414 and 1,347 during 2014: 60608, 60613, 60617, 60619, 60620, 60623, 60626, 60637, 60640, 60647, 60649, 60651, 60657, and 60660. It is important to note that one zip code, 60640 had a prevalence of 1,347.
- ii. In addition, the five most northern zip codes that border Lake Michigan: 60657, 60613, 60640, 60660, and 60626, have the highest prevalence rates ranging from 614-1,347.

1.2 Providers/Facilities who reported CD4 and Viral Load (VL) values in 2015.

(See Map 2/page 12)

- i. A total of 169 providers/facilities reported CD4/VL values.
- ii. Most zip codes (86%) had providers that reported CD4/VL values.
- iii. The following zip codes (14%) did not have providers reporting CD4/VL values: 60633, 60827, 60638, 60606, 60635, 60630, 60656, 60646, and 60660. It is important to note that zip code, 60660 had a prevalence of 785, but there were no providers in that zip code that reported CD4/VL values.
- iv. Zip code 60635 had zero prevalence and zero providers reporting CD4/VL values.
- v. Some of these providers/facilities reporting CD4/VL values are not on MATEC's distributions lists and may not be aware of the training and TA services available through MATEC.

1.3 Community Health Centers currently providing HIV clinical care *(See Table 1/page 9 and Map 3/page 13)*

- i. A total of 37 Community Health Centers (CHCs) —some of which also receive Ryan White funds—are currently providing HIV clinical care according to HRSA's Data Warehouse.
- ii. All 37 CHCs are in or close to counties and cities with high reported prevalence of HIV.
- iii. Four Chicago community health centers are serving low HIV patient counts: Asian Human Services Family Health Center, Inc. (0.03%), Alivio Medical Center (0.02%), Esperanza Health Centers (0.06%), and TCA Health Inc. (0.03%).
- iv. Alivio Medical Center and Esperanza Health Centers (60608) are community health centers located in a zip code (60608) with an HIV prevalence of 558.

- v. Asian Human Services Family Health Center, Inc., Esperanza Health Centers, Near North Health Service Corporation, Prime Care Community Health, Inc., and TCA Health Inc. are providing HIV clinical care (according to HRSA's Data Warehouse) but they do not appear on the list of providers/facilities reporting CD4/VL values.
- vi. The following two health care centers are the current recipients of intense assistance from MATEC under its HIV Practice Transformation Project: Mile Square Health Center in Cook County and Regional Care (a Ryan White funded site) in Will County.

2. NEEDS OF THE HIV CLINICAL WORKFORCE

2.1 Based on MATEC's Data (See Figure 1/page 10 and Map 4/page14)

- i. The majority of zip codes (81%) have had persons that have attended a MATEC sponsored training. Zip codes: 60659, 60631, 60656, 60630, 60634, 60635, 60638, 60652, 60655, 6827, 60633, (19%) had no persons that attended a MATEC sponsored training.
- ii. There has been limited participation in MATEC sponsored trainings by some southern zip codes areas. MATEC is aware of the need for training in the southern zip codes and has been proactive by developing programs entitled, "SouthLands" programs which are held in the evening to allow HIV providers to attend after hour programs.
- iii. Specific training and technical assistance needs in the zip codes mentioned above are unknown.
- iv. High volume clinicians who provide HIV care (most frequently, clinicians in urban and/or Ryan White settings) have the highest level of HIV related knowledge and low-volume clinicians (frequently rural and private practice clinicians) have the lowest level of knowledge.
- v. As low volume providers are more likely to refer HIV-positive patients for HIV care, there is an opportunity for MATEC to increase their knowledge and skill levels so that they are able to provide more advanced HIV care and retain HIV positive patients in their practices. The data from Figure 1 suggest that trainings of low volume providers need to focus on initiating Anti-retroviral treatment (ART), monitoring adherence, and treating drug resistance.
- vi. Across MATEC's region, PrEP and Treatment as Prevention was mentioned as the highest priority topic, following by Clinical Management of HIV and Testing/Routine Screening. Additional topics that were mentioned but did not make the top of the list are: Cultural Competence with special populations (transgender clients, LGB, MSM, women), STI's, Adherence, and Primary Care/Co-Morbidities.
- vii. According with new HRSA guidelines for funding allocations for the AETC grantees, a significant proportion of funds have to be allocated to new projects (i.e., HIV Practice Transformation and HIV Interprofessional Education). Hence, the funding

level for AETCs to fulfill other training and technical assistance needs has significantly decreased for Fiscal Years 2016 through 2019.

2.2 Based on The Black AIDS Institute HIV Work Survey (See Table 2/page 10)

Although respondents from Illinois scored better across all question categories compared to the average scores for the United States, there is a 13-16 percentage point gap between Whites and African Americans across all categories. While this gap also exists on a national level, it is not as wide as in Illinois (8-11 percentage points at the national level). This indicates the need for Illinois to focus its training and capacity building assistance on increasing the HIV science, treatment, and prevention knowledge among African Americans clinicians.

A number of studies have examined issues of racial concordance in clinical care and training programs. A multicenter study that examined the role of cultural distance between HIV-infected patients and providers in perceived quality of care found that patients who rated lower perceived cultural similarity with their providers rated significantly lower quality of care and lower trust in their providers. Cultural concordance was assessed in terms of speech and language, reasoning, communication style, and values, which, based on the findings of the study, indicated the importance of positive patient-provider interactions and cultural competency in provision of HIV care (Saha et al., 2011). Given these realities, the need for culturally competent clinicians, particularly from the communities most affected by HIV, is crucial.

Based on data from the report on familiarity with and belief in biomedical interventions, Illinois' HIV workers are less familiar with the topics of Topical Microbicides and HIV vaccines than the US HIV workforce; only 42% indicate that they are familiar with PrEP, and 41% are familiar with Treatment as Prevention, suggesting a need for training in these topics.

3. Retirement Creating Workforce Gaps

The Institute of Medicine in examining workforce needs for *HIV Screening and Access to Care* (2011) acknowledged that the HIV/AIDS workforce is aging. They estimated nationally that 33 percent of physicians, 24 percent of pharmacists and 45 percent of nurses will likely reach retirement age by 2020. Meanwhile the population is increasing and the age of the population is increasing, both of which place greater demands on health professionals. A survey of HIV Medical Association (HIVMA) members, a physician group specializing in HIV care, found in 2010 that at least 45% of its members were 51 years and older, with 17% over the age of 61. In 2010, 60% of nurses with the Association of Nurses in AIDS Care (ANAC), the HIV/AIDS nursing association, were between the ages of 40 and 50, and only 7% were between the ages of 20-29, indicating young nurses were not choosing HIV/AIDS as their specialty. The National Alliance for HIV Education and Workforce Development made recommendations regarding this issue: "The early cohort of experienced HIV-care

clinicians, who brought passion and commitment to patients early in the epidemic, entered the field 20 or more years ago and are nearing retirement. As they leave, a service gap will be created, and these providers will need to be replaced with well-educated, skilled clinicians who are able to provide comprehensive HIV care” (NAHEWD, 2014, p. 8). Further investigation into retirement and its affects upon the Chicago EMA workforce need to be carried out.

MATEC efforts such as the HIV Interprofessional Education Project (HIPEP) and the Clinician Scholars Program are programmatic activities which specifically aim to prepare the next generation of skilled and dedicated HIV practitioners.

HIPEP is a regional collaborative that includes six University-based Inter Professional Education programs to develop, implement and evaluate interprofessional team-based training programs for health professions students to prepare a workforce which is ready and able to optimize care and outcomes for persons living with HIV/AIDS.

The MATEC Clinician Scholars Program is a 12-month training program specifically designed for minority or predominately minority serving, front line clinical care providers (Physicians, Physician Assistants, Nurse Practitioners, and Pharmacists), who are interested in the diagnosis, treatment, medical management, and prevention of HIV/AIDS.

4. Areas Vulnerable for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs in Chicago EMA

The recent HIV outbreak in Scott County, Indiana, prompted MATEC to explore the literature about areas in our region which may be vulnerable to similar outbreaks. In doing so, we found an article (recently accepted to be published in the *Journal of Acquired Immune Deficiency Syndrome* cited above) in which the authors identified “U.S. counties potentially vulnerable to rapid spread of HIV, if introduced, and new or continuing high rates of hepatitis C virus (HCV) infections among persons who inject drugs”. Although Chicago was not identified in this article nor does Chicago fit into the rural county category, it might be worthwhile for the Chicago Department of Public Health HIV/AIDS Surveillance section to closely monitor HIV surveillance reporting as it relates to injection drug use as a risk factor.

SUMMARY

This report summarizes findings related to the HIV clinical workforce in Chicago. The focus includes the need for additional training and technical assistance to enhance the current and future workforce. Specific findings include:

- a. HIV cases have been reported in every zip code in Chicago except 60635, with 60640 showing the highest prevalence.
- b. The five most northern zip codes that border Lake Michigan: 60657, 60613, 60640, 60660, and 60626, have the highest prevalence rates ranging from 614 - 1,347.

- c. Most zip codes (86%) had providers that reported CD4 and VL values.
- d. Zip code, 60660 had a prevalence of 785, but there were no providers in that zip code that reported CD4/VL values.
- e. Four Chicago community health centers are serving low HIV patient counts: Asian Human Services Family Health Center, Inc. (0.03%), Alivio Medical Center (0.02%), Esperanza Health Centers (0.06%), and TCA Health Inc. (0.03%).
- f. Alivio Medical Center and Esperanza Health Centers (60608) are community health centers located in a zip code (60608) with an HIV prevalence of 558.
- g. MATEC has provided programs to enhance the workforce in almost all of the zip codes, but there has been limited participation in MATEC sponsored trainings by some southern zip codes areas.
- h. Given shifting national priorities for the AETCs, close collaboration and resource sharing may be needed to expand programs.
- i. Topics needing attention include PrEP, Treatment as Prevention, Clinical HIV Management and routine testing and screening.

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Table 1. Community Health Centers Providing HIV Care in Illinois

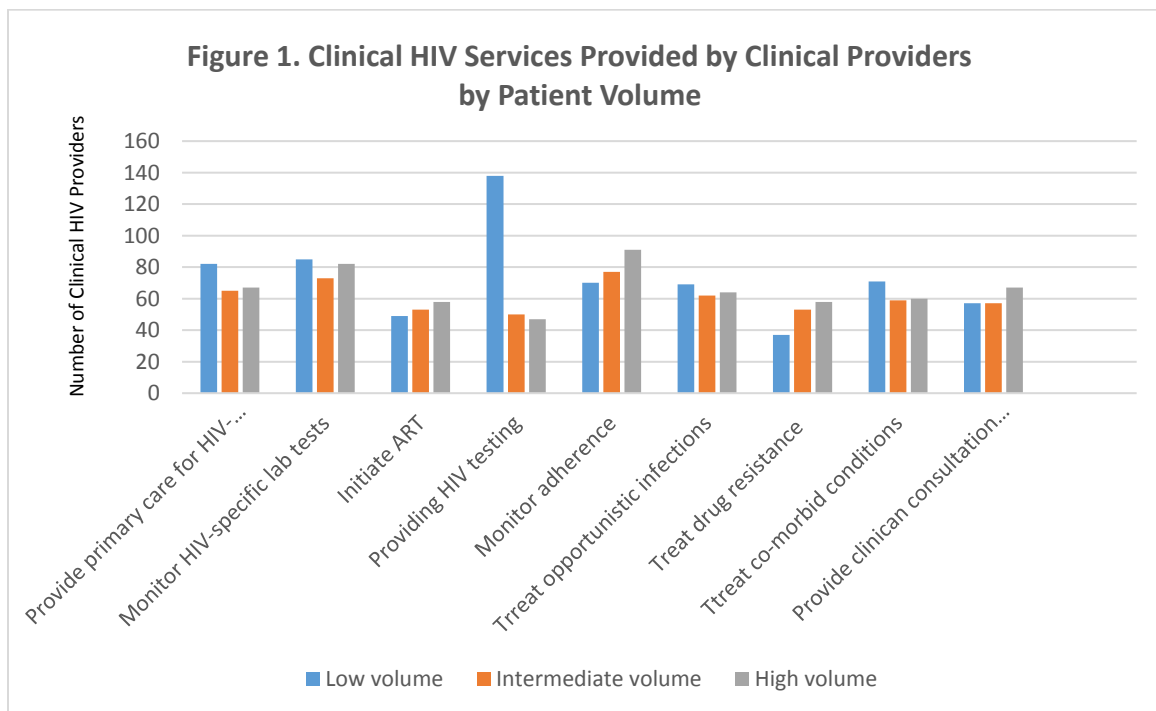
Health Center Name	City	Zip Code	Percentage of HIV Patients
Access Community Health Network	Chicago	60661	0.54%
Alivio Medical Center	Chicago	60608	0.02%
Asian Human Services Family Health Center, Inc.	Chicago	60640	0.03%
Aunt Martha's Youth Service Center, Inc.	Olympia Fields	60461	0.08%
Beloved Community Family Wellness Center	Chicago	60621	0.19%
Board of Trustees of Southern Chicago EMA University	Springfield	62794	0.25%
Central Counties Health Centers, Inc.	Springfield	62703	0.13%
Chestnut Health Systems	Bloomington	61701	0.06%
Chicago Family Health Center, Inc.	Chicago	60617	0.14%
Christian Community Health Center	Chicago	60438	2.42%
Christopher Greater Area Rural Health Planning Corporation	Christopher	62822	0.02%
Circle Family Healthcare Network, Inc.	Chicago	60644	1.96%
Community Health & Emergency Services, Inc.	Cairo	62914	0.03%
Community health improvement	Decatur	62526	0.13%
Community Nurse Health Association	La Grange	60525	0.04%
County of Lake, dba Lake County Health Department and Community Health Center	Waukegan	60085	0.83%
Crusaders Central Clinic Association	Rockford	61104	0.74%
Erie Family Health Center, Inc.	Chicago	60622	0.55%
Esperanza Health Centers	Chicago	60608	0.06%
Family Christian Health Center	Harvey	60426	0.07%
Friend Family Health Center, Inc.	Chicago	60629	0.38%
Greater Elgin Family Care Center	Elgin	60120	0.02%
Heartland Community Health Clinic	Peoria	61603	0.11%
Heartland Health Outreach, Inc.	Chicago	60604	17.05%
Heartland International Health Center	Chicago	60657	9.95%
Lawndale Christian Health Center	Chicago	60623	0.50%
Near North Health Service Corporation	Chicago	60610	0.52%
PCC Community Wellness Center	OAK PARK	60302	0.33%
Prime Care Community Health, Inc.	Chicago	60622	0.26%
Rural Health Inc.	Anna	62906	0.02%
Shawnee Health Service and Development Corporation	Carterville	62918	0.11%
Southern Chicago EMA Healthcare Foundation	East Saint Louis	62207	0.40%
TCA Health Inc.	Chicago	60628	0.03%
The Board of Trustees of the University of Chicago EMA	Chicago	60607	0.26%
VNA Health Care	Aurora	60506	0.03%
Whiteside County Health Department and Whiteside County Community Health Clinic, Inc.	Rock Falls	61071	0.01%
Will County Health Department	Joliet	60433	0.09%

Source: Data Warehouse, Health Resources and Services Administration.

Table 2. Knowledge Scores by Question Category, Whites and African Americans, 2012-13 HIV Workforce Survey

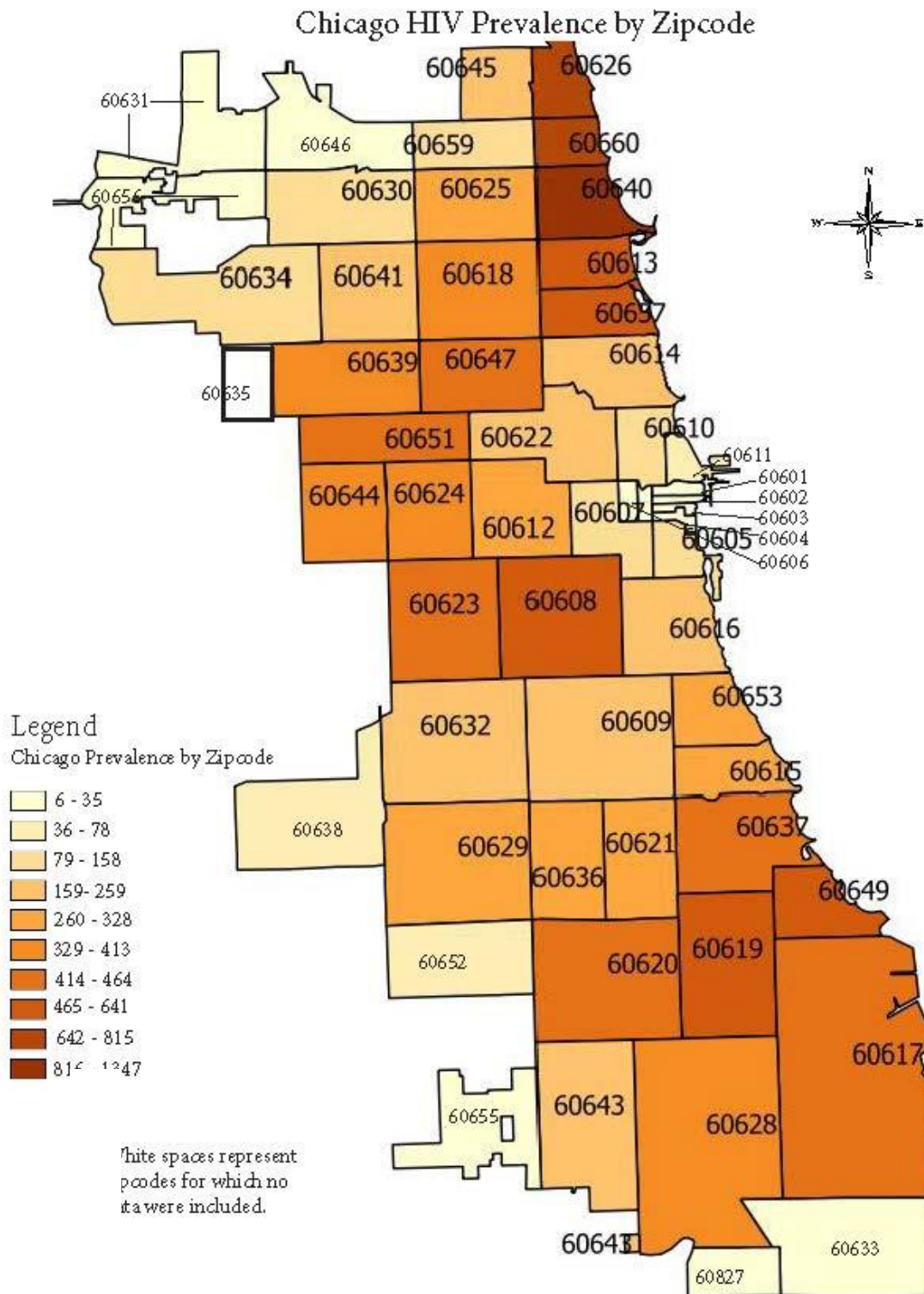
		All Questions	Basic Knowledge and Terminology	Treatment	Biomedical Interventions
IL	All respondents	63%	73%	56%	52%
	Af Am (n = 68)	57%	67%	50%	44%
	White (n = 69)	71%	82%	63%	60%
USA	All respondents	61%	73%	54%	45%
	Af Am (n = 68)	57%	69%	51%	41%
	White (n = 69)	67%	80%	59%	49%

Source: The Black AIDS Institute HIV Work Survey: When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States. Black AIDS Institute, 2015



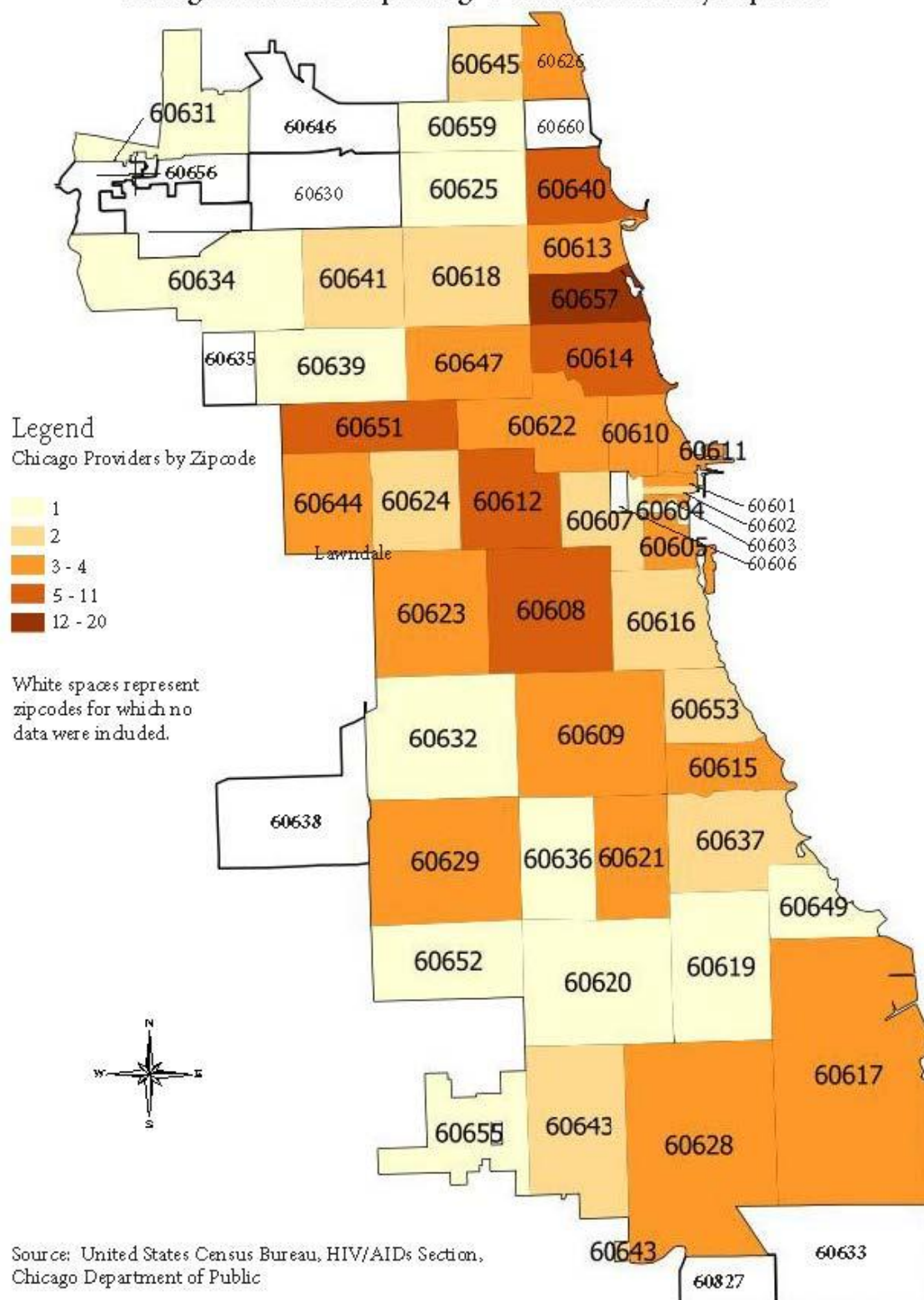
Source: Regional Needs Assessment

Map 1.

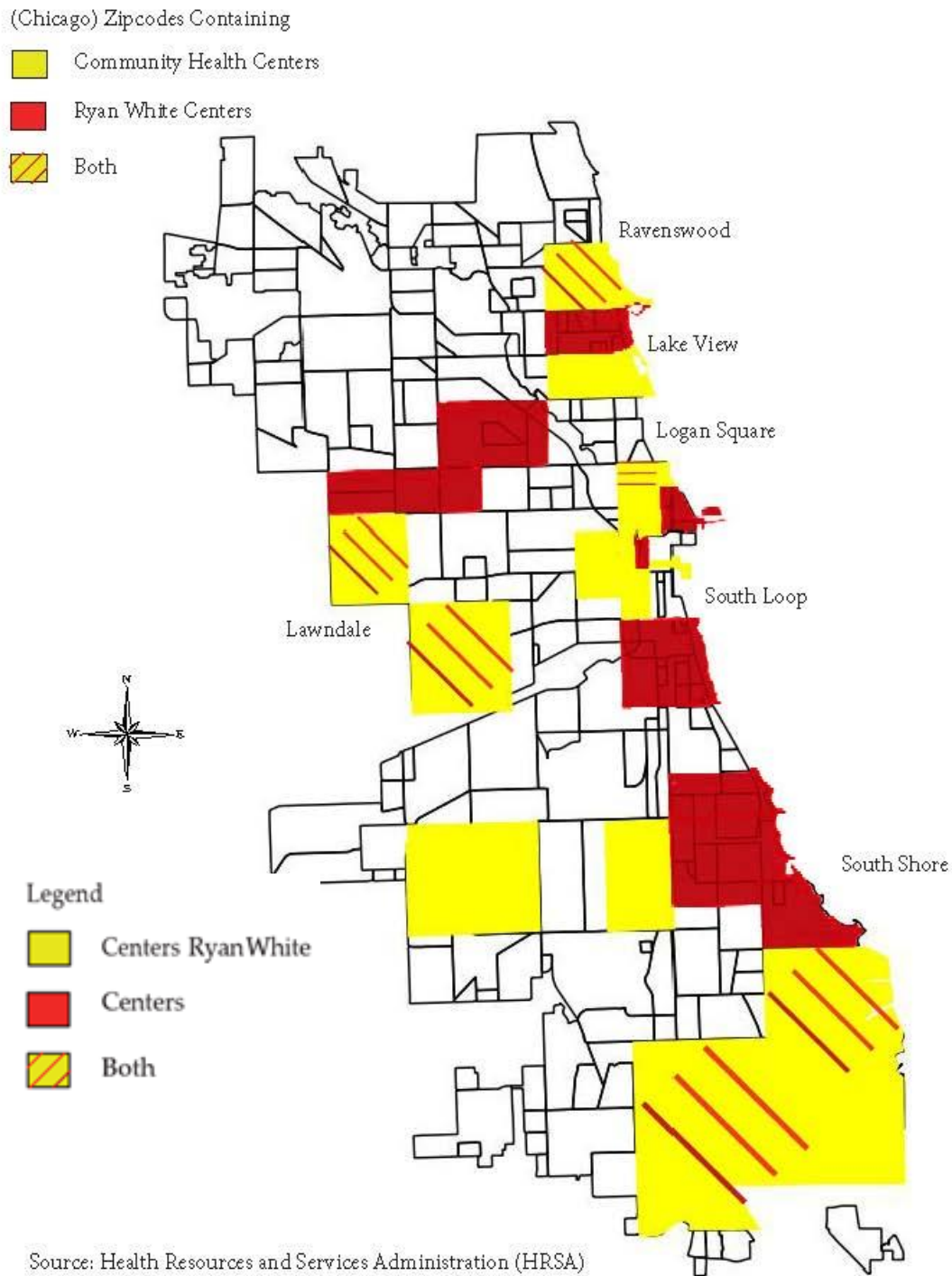


Map 2.

Chicago Providers Reporting CD4/Viral loads by Zipcode



**Map 3. Chicago Community Health Centers currently providing HIV clinical care
And Ryan White Clinical Sites**



Map 4.

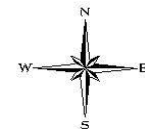
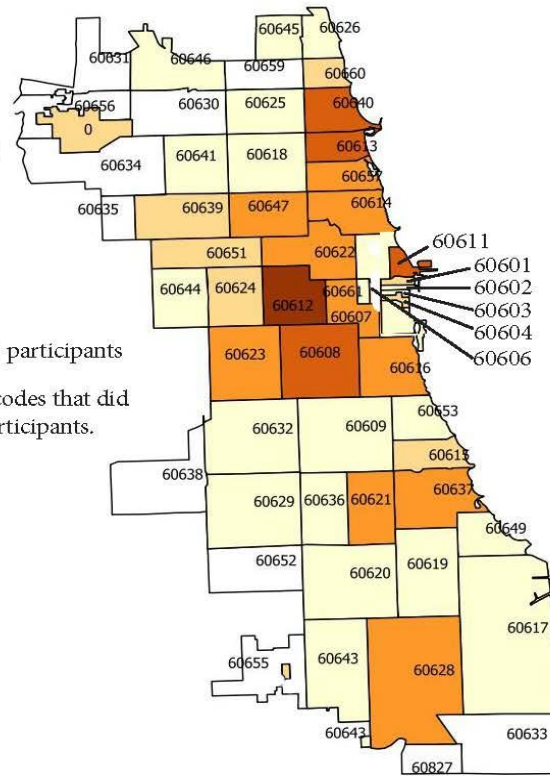
Chicago Midwest AETC Training Participation by Zipcode

Legend

Chicago Midwest AETC Training
Participation by Zipcode

- 1 - 7
- 8 - 16
- 17 - 41
- 41 - 67
- 60612 is an outlier with 321 participants

White spaces represent zipcodes that did
not contain any training participants.



Source: United States Census Bureau, Midwest Aids Education & Training Center (Midwest AETC)

Describe how committees reviewed each component.

- In January 2017, the CAHISC Steering Committee discussed the need to pause discussion on Centers of Excellence and talk about other components that have been intended as additions to this model, described at this point as the “larger HIV service portfolio.” The remaining portfolio components were discussed in the January 2017 Steering Committee meeting:
 - Population Centered Health Homes (PCHH)
 - Community development through engagement and mobilization
 - Marketing and media
 - Housing
 - Services for persons who use drugs
- In March 2017 the new name of the model was confirmed as the *HIV Services Portfolio*. Centers of Excellence were replaced in the model by PCHH. The Steering Committee initiated a plan for committees to review the individual portfolio components at monthly meetings. Discussions would be led by CDPH staff/CAHISC members or content experts. This review process continued through all the subcommittees each month, followed by summary and/or presentation at the CAHISC Full Body through November 2017:
 - **Community development through engagement and mobilization** – March, facilitated by CDPH
 - **Services for persons who use drugs; and Marketing/media** – April, facilitated by content experts
 - **Housing** – May, facilitated by content experts. Discussions included PCHH.
 - **PCHH** – Reintroduced and fully discussed in October and November, facilitated by CDPH and CAHISC membership
 - In addition, the PCHH discussion added a structured element of review, in which each committee was asked to focus on some themes/areas for developing recommendations to be presented at the November Full Body meeting. The themes/areas for discussion were:
 - Geographic equity including the collar counties;
 - Racial equity;
 - What evaluation would look like/how to make sure that the new system is functioning adequately; and
 - What types of support agencies need in order to successfully address what CAHISC and CDPH are planning.

What were some of the concerns about each portfolio component?

- Community development through engagement and mobilization
 - How do we make sure that community partnerships will actually be implemented in a way that’s fair?
 - Does the community development need to be a new thing or a refinement of existing systems?
 - How do we make community development able to respond to something like a meningitis outbreak?
 - How do we have an infrastructure that allows that same model to be integrated and roll-off so that we can continue to make space for new ideas?
 - Community development interventions should be directly connected to the social determinants of health.

- Will EIS fit into here? What is an example of a program that will go after the Community development funding?
- Creation of safe spaces and creation of a safe place (i.e., youth council or a drop in) would actually be the community development intervention.
- How do we address these clients that drop in and out of care for years?
- Ideas of barriers surrounding mental health, transportation to increase and facilitate access, case manager sustainability, a pregnant positive women community or support group, language or linguistically competent services are needed because there are limitations due to literacy and health literacy, culturally competent services, mentoring and development of the future of the workforce, employment, populations (i.e., need to revisit which populations to prioritize and emerging populations as well).
- How often will priority populations be evaluated?
- How can the people of Lake County work together with some funding from this to come up with something to address the lack of services?
- We also need to make sure that we are casting a wide enough net for when the RFP goes out; groups will need to know that this opportunity is available.
- There are still a lot of problems with understanding from the community. There are still questions surrounding the PCHH that are unanswered.
- CAHISC are constituents to the community, so if we introduce something, we need to be able to explain them.
- Services for persons who use drugs
 - A normalization of persons who use drugs prevention and health needs to occur so that people aren't shamed/stigmatized. Not just telling people that this is their fault, but trying to understand people and meet them where they are.
 - Incorporation of persons who use drugs health into the PCHH: training and capacity building for HIV services distribution. Making sure that these service providers are adequately equipped to provide competent care to drug users → inclusive of substance use disorder treatment options.
 - Understanding regulations for methadone—prevention as treatment.
 - Advocating for policy change in addition to structural change.
 - Services for persons who use drugs living with and without HIV.
 - Engagement of active users.
 - Substance use disorder counselors and case managers—more support yields better results.
 - Equip outreach workers with the tools they need to be effective in the community and meet the needs of their target population (naloxone, syringes, condoms, etc.).
 - Substance use training for medical providers.
 - Looking at the unintended consequences for policy change: risks to pharmacists, other consumers filling prescriptions, etc.
 - Consider/think about safer injection facilities, which are currently illegal.
 - Treatment services on demand need to be prioritized.
 - Bundling of services is really important. Rather than having separate specialists on one thing, bundling as many of these services as possible will be better.
 - Is there a possibility of receiving snowball incentives or driven data where clients can provide info regarding how many people they distribute those syringes to? More like a snowball social network for persons who use drugs?

- Would the person who uses drugs get training for how to provide naloxone? During overdoes training, there needs to be a way to assess that people will be able to retain the training so that it will be used.
- Marketing/media
 - No notable concerns during the committee presentations.
- Housing
 - What is needed in regards to housing in the PCHH model?
 - Do we still need supportive services within the housing facility, or do we rely on the PCHH to supply the services?
 - What are the crisis emergency shelter options?
 - Ambulatory care sites that have referrals for housing.
 - Medical community collects housing data, but there is no follow up.
 - What makes housing services appealing to youth?
 - The lack of identity cards especially for the homeless. Perhaps access to Cook County municipal ID's could be facilitated at the PCHH.
 - Place outreach workers at the PCHH to increase and facilitate access to services by initially meeting clients in the street.
- PCHH
 - Some initial confusion about the PCHH and what they entail.
 - Supporting and providing consultation on effective partnerships.
 - Roll out in phases should be considered.
 - Making sure agencies can see how they fit into the model.
 - There was some discussion about linkage to care for those people who are not in care but already know they are HIV positive, specifically the needs/issues of people who need to re-link to care.
 - Making sure that clients are not lost and still have a level of choice in their care.
 - Data sharing opportunities.
 - Being careful about what is being measured and making sure hard-to-serve clients are not shut out because of impact on our outcomes.
 - Having a good liaison between housing and the PCHH.
 - Have PCHH be a clearing house for benefits and credentialing.
 - There is still not conversation about the aging population – everything seems to be about prevention.
 - Where does research fit it?
 - Will the new case management model be part of the new model?
 - One of the concerns to be open about is that, because these are biomedical outcomes, that all of these models will be based around a hospital. Few existing models, if any, are based around a non-medical provider, but it should be kept a possibility.
 - Concern was expressed that some of the earlier contention in discussing PCHH was around how the money will look when it is rolled out and divided among agencies. There are going to be questions about structure, distribution of dollars and how are they going to be monitored, as well as health insurance contracting.
 - Need to preserve the ability to focus on the gaps in services and how to structure this to reach those gaps and populations (relevant to the argument about small organizations is that they are able to provide a niche service for a niche population or community).

Recap of recommendations on PCHH:

General

1. We strongly recommend a phased-in pilot, of at least a couple of different models which will allow evaluation and assessment of the feasibility and success of PCHH to meet the needs of our EMA, and that CAHISC would carve out a % of our RW and prevention allocation for this pilot.
2. We need to ensure there is a tracking/data system across agencies in the PCHH.
3. We need to ensure there is case management system integration into PCHH.
4. We recommend that CDPH spell out how the contracting is going to work and that there be clear expectations for contracting and subcontracting.
5. CDPH should be asked to elaborate on how partnerships are built.
6. CAHISC should be a part of the evaluate process or ask CDPH to report on the evaluation process.
7. There needs to be clarity on how case management would be handled in this new model and what happens going forward, whether it is valued, and how existing case management will be integrated into the PCHH. It was suggested to add the recommendation that CAHISC values the current Ryan White model for coordinated case management and wants it to be included in the PCHH model.
8. There was also the suggestion to add connection to housing navigation.

Geographical equity recommendations:

1. Have a combination with a minimum of 5 PCHH in the south, north, and west corridors and a sufficient amount in the collar counties.
2. There should be combination of clinical and non-clinical health homes.
3. Have a minimum of 1 collaboration with partnerships between university, community based organization, and public health service provider.
4. Do not have population-specific PCHH due to the stigma that it causes.
5. There should be a requirement for PCHH to work in partnership/collaboration with other PCHH.

Social and racial equity recommendations:

1. One PCHH in each geographic area should be minority-based.
2. Each one of the selected PCHH must participate in capacity building services that include cultural sensitivity and undoing racism.
3. Each PCHH should have continual capacity building throughout the life cycle of the PCHH funding.

Evaluation recommendations:

1. Each organization should have a quality improvement/quality assessment plan that they actually submit.
2. Each organization should have a community advisory board (CAB) of the population they are working with/encourage CAB for the PCHH that has development built-in for that board.
3. Each organization should have an in-house evaluator or an academic partner to do true evaluation.

What were some of the concerns about the portfolio overall?

- There is need to remind people how PCHH fits into the portfolio.
- CAHISC spent a lot of time in understanding the portfolio and it should now work to ensure that the components fit within the RFP and to make sure that agencies are prepared to help people living with HIV along those lines.
- There needs to be a better understanding of the definitions of the portfolio components in order for CAHISC to better stewards of the model and to provide better information to the community. This included discussion focused on working on/talking through an example of how to describe the Health Care Access component.

APPENDIX 7 - Integrated Plan Partners List

Organization Names

Access Community Health
Agape Missions, NFP
AIDS Foundation of Chicago
AIDS Healthcare Foundation
AIDS Legal Council of Chicago
Alexian Brothers Bonaventure
Ann & Robert H. Lurie Children's Hospital
Asian Human Services
Brothers Health Collective
CALOR
Catholic Charities of The Archdiocese Of Chicago
Center for Justice and Respect
Center On Halsted
Chicago Black Gay Men's Caucus
Chicago House And Social Service Agency
Chicago Recovery Alliance (CRA)
Chicago Women's AIDS Project
Childrens Place Association
Christian Community Health Center
COIP/University of ILL.
Community Supportive Living
DHHS Region 5
EdgeAlliance
Erie Family Health Center
Esperanza Health Center
FOLA Community Action Services
Garfield Counseling Center
Haymarker Center
Healthcare Alternative Systems, Inc.
Heartland Health Outreach
Heartland Human Care Services
Hekteon/Cermak
Hekteon/Core
Hekteon/Provident
Hekteon/Stroger
Hektoen/Austin
Housing Opportunities for Women
Howard Area Community Center
Howard Brown Health Center

APPENDIX 7 - Integrated Plan Partners List

Organization Names

Human Resources Development Institute
Illinois Department of Public Health
Illinois Pulic Health Association
Interfaith House
Legal AIDS Foundation
Lake County Health Department And Community Health Center
Lawndale Christian Health Center
Legal Assistance Foundation
Loyola University Health System
Michael Reese Research & Education Foundation-HIV Care Program
New Age Services Corporation
Northwestern University
Open Door Clinic of Greater Elgin
Pilsen Wellness Center
Prairie State Legal Services, Inc.
Public Health Inst. Chicago
Puerto Rican Cultural Center
Regional CARE Association
Rincon Family Services
Sinai Health System
South Shore Hospital Corporation
South Side Help Center
The Board of Trustees of The University of Illinois
The CORE Foundation/ Division of Adolescent Medicine
The Night Ministry
TPA Network
Unity Parenting & Counseling
Universal Family Connection
University of Chicago