Assumptions
Where are we now?
Why are we here?
Where are we going?
How will we get there?
Summary
Assumptions

• The environment in which we do our work impacts us – professionally and personally – and the communities we serve.
  • Election
  • Economy
  • Affordable Care Act
  • Black Lives Matter
  • Immigration reform
  • Lesbian, Gay, Bisexual and Transgender rights
  • National HIV/AIDS Strategy
  • Healthy Chicago 2.0
  • Many more!

• Environmental factors must be considered as the HIV/STI Bureau plans for the future.
Assumptions

• Consistent and sustained funding for public health programming is never guaranteed.
  • City budget
  • State budget
  • Federal funding priorities

• We are closer than we’ve ever been to seeing the end of the HIV epidemic in the United States.

• We KNOW what will decrease HIV transmission.
Where are we now?

Success? Or time for a new approach?
Where are we now?

HIV Continuum of Care, Chicago & US 2012

We estimate:
- 4,345 people living with HIV (PLWH) don’t know their status
- 12,221 PLWH aren’t retained in care
- 13,036 PLWH aren’t on ART
- 14,937 PLWH aren’t virally suppressed

Chicago Department of Public Health – STI/HIV Services Bureau
Where are we now?
Where are we now – Gay/Bi Men?

Proportion of HIV Infection Diagnoses among MSM from 2000-2014
Chicago (as of 3/24/2016)
## Where are we now – Gay/Bi Men?

### 2014 Incidence of HIV Diagnoses by MSM Risk – Chicago (as of 03.24.2016)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Age</th>
<th>Behavior</th>
<th># New HIV Dx (2014)</th>
<th>% New HIV Dx (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Black (NHB)</td>
<td>20-29</td>
<td>MSM</td>
<td>183</td>
<td>20.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>20-29</td>
<td>MSM</td>
<td>75</td>
<td>8.6%</td>
</tr>
<tr>
<td>NHB</td>
<td>30-39</td>
<td>MSM</td>
<td>54</td>
<td>6.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>30-39</td>
<td>MSM</td>
<td>52</td>
<td>5.9%</td>
</tr>
<tr>
<td>Non-Hispanic White (NHW)</td>
<td>20-29</td>
<td>MSM</td>
<td>46</td>
<td>5.3%</td>
</tr>
<tr>
<td>NHW</td>
<td>30-39</td>
<td>MSM</td>
<td>41</td>
<td>4.7%</td>
</tr>
<tr>
<td>NHB</td>
<td>13-19</td>
<td>MSM</td>
<td>40</td>
<td>4.6%</td>
</tr>
<tr>
<td>NHW</td>
<td>40-49</td>
<td>MSM</td>
<td>39</td>
<td>4.5%</td>
</tr>
<tr>
<td>NHB</td>
<td>40-49</td>
<td>MSM</td>
<td>29</td>
<td>3.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>40-49</td>
<td>MSM</td>
<td>29</td>
<td>3.3%</td>
</tr>
<tr>
<td>NHW</td>
<td>50-59</td>
<td>MSM</td>
<td>21</td>
<td>2.4%</td>
</tr>
<tr>
<td>NHB</td>
<td>50-59</td>
<td>MSM</td>
<td>17</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>626</strong></td>
<td><strong>TOTAL</strong></td>
<td><strong>71.6%</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Where are we going – Black Hetero Women?

## 2014 Incidence of HIV Diagnoses by Female Hetero Risk – Chicago (as of 03.24.2016)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Age</th>
<th>Behavior</th>
<th># New HIV Dx (2014)</th>
<th>% New HIV Dx (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHB</td>
<td>40-49</td>
<td>Hetero Female</td>
<td>25</td>
<td>2.9%</td>
</tr>
<tr>
<td>NHB</td>
<td>20-29</td>
<td>Hetero Female</td>
<td>22</td>
<td>2.5%</td>
</tr>
<tr>
<td>NHB</td>
<td>50-59</td>
<td>Hetero Female</td>
<td>17</td>
<td>1.9%</td>
</tr>
<tr>
<td>NHB</td>
<td>30-39</td>
<td>Hetero Female</td>
<td>16</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL Hetero Female</td>
<td>80</td>
<td><strong>9.1%</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL MSM</td>
<td>626</td>
<td>71.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL ALL</td>
<td>706</td>
<td><strong>80.7% (706/875)</strong></td>
</tr>
</tbody>
</table>

Where are we going – Black Hetero Women?
Where are we now?

TAKE-AWAYS:

• Gay/bisexual and other MSM of all races/ethnicities make up a disproportionate share of new and prevalent HIV cases in our jurisdiction, more the 70%. New infections have remained unchanged for more than a decade, while overall cases continue to decline.

• Young Black gay/bisexual men and other MSM account for more than 1 in 4 new HIV infections.

• Among women, Black heterosexual women make up a disproportionate share of new and prevalent HIV infections.

• HIV remains concentrated in select community areas on the north, west and south sides of the city.
Why are we here?

- Current HIV programs and services:
  - Only reach a fraction of those who can (and need to) benefit.
  - Tend to be high-intensity and narrowly focused.
  - Are driven primarily by grant funding and deliverables.
  - Are managed in siloes.
  - Exist in parallel with one another and with other systems of care.
  - Represent a legacy.
- We have not made necessary in-roads with the healthcare sector, including providers and payers.
Where are we going?

• Embrace a vision of a sexually healthy Chicago.

• Focus on outcomes that have the potential to drive down new HIV infections by directly influencing HIV transmission.
  1. Suppressing viral load in all persons living with HIV (PLWH).
  2. Increasing use of pre-exposure prophylaxis (PrEP) among gay and bisexual men of all races/ethnicities and Black women.

• Create a foundation for ending the HIV epidemic in Chicago and Illinois.
How do we get there?

- Our central challenge:
  - Using current-level resources, how do we rapidly expand the number of customers who achieve viral suppression and achieve sufficient Truvada® levels to maintain HIV-negative status (i.e., successful PrEP)?
How do we get there?

• Develop and follow an outcomes-based blueprint.

• **Align** our investments, influence and human **resources** with our blueprint.

• **Integrate programming** across prevention, care and housing to reflect the lived experiences of the communities we serve.

• **Increase scale and effectiveness** of relevant programs and services.

• **Scale back** or stop work that doesn’t meaningfully support our outcomes.

• Develop **new approaches and partnerships** with the healthcare sector to extend the reach of HIV/STI services and to accelerate our progress.

• Identify and address **policy and structural drivers** that impact our work.
How do we get there?

• To achieve our central challenge, we must optimize investments in and influence on three interdependent sectors: Community Health Services, Public Health Services and Healthcare Services.
How do we get there – ARV Pathway?

*Sufficient concentration of ARV to confer protection

**PrEP/HIV Treatment**

Successful PrEP Use*/
Viral Suppression

**Persons Living with HIV**

**At-Risk Persons**

Common pathway

*Common indicator of success: appropriate use of ARVs

*Sufficient concentration of ARV to confer protection
ARV use for PrEP/HIV Treatment

Outcomes and Process Evaluation; Surveillance and Data Collections, Assessment and Dissemination

SUPPORTIVE SERVICES: Oral health care, housing, substance use disorder services, mental health services, financial assistance, transportation, psychosocial support services, health education, food assistance, legal services, linguistic services, etc.

Successful PrEP Use*/Viral Suppression

- Highly targeted recruitment
- Social networking strategy
- Partner Services
- Routine HIV testing
- Marketing, media and mobilization
- EIS

Fourth generation HIV testing

- ARTAS
- Patient navigation
- Community health work
- Health insurance enrollment
- Premium assistance
- EIS
- RW Outreach

Data-to-Care
- Care coordination
- Case management
- RW Outreach
- Outpatient/ambulatory

ADAP
- Med assistance support
- Adherence and retention supports

SUPPORTIVE SERVICES: Oral health care, housing, substance use disorder services, mental health services, financial assistance, transportation, psychosocial support services, health education, food assistance, legal services, linguistic services, etc.

Outcomes and Process Evaluation; Surveillance and Data Collections, Assessment and Dissemination

Community Health Services

Public Health Services

Healthcare Services
**Summary**

- HIV remains concentrated in specific populations and community areas. New infections have plateaued.

- We must focus on outcomes that reduce HIV transmission: increasing the number of persons who use ARVs for treatment and PrEP.

- We must align our investments, influence and human resources with these outcomes.

- We must prioritize programs and services across three sectors – community health services, public health services and healthcare services – to maximize our impact.

- **FINALLY,** we must act with the conviction of knowing that we can end the HIV epidemic.