Vermont Department of Health
HIV/AIDS Community Advisory Group
MEETING MINUTES
February 2, 2015; 11:00am - 3:00pm
Randolph, VT

ATTENDING: Tom Aloisi, Agency of Education; Mike Bensel, Vermont Pride Center; Laura Byrne, H2RC; Dan Chase; Rick Dumas, APSV Board Member; Kim Fountain, Vermont Pride Center; Pat Gocklin, DHMC; Jonathan Heins; Peter Jacobsen, VT CARES; Grace Keller, Safe Recovery; Chuck Kletecka; Zpora Perry, CCC; Karen Peterson, APSV; Donna Pratt, Twin States Network; Amy Tatko, PWA Coaltion.
GUESTS: Sally Cook, Public Health Nurse Specialist; Infectious Disease Epidemiology; Vermont Department of Health
VERMONT DEPARTMENT OF HEALTH: Roy Belcher, Daniel Daltry, Erin Larose
CENTER FOR HEALTH & LEARNING: Alexander B. Potter

Meeting called to order at 11:05 am.

I. HIV Outbreak – Presentation by Sally Cook

A. Following analysis after the Indiana HIV outbreak, Daniel identified that Windham and Essex Counties in Vermont are on the list of identified United States counties at risk for HIV outbreak. Introduced SALLY COOK, a Public Health Nurse Specialist who was mobilized to go to Indiana to assist in the outbreak, when the governor of Indiana requested assistance.

B. Sally presented on her experiences in Indiana and took questions.
   1. Overview of Austin Indiana – center of outbreak. Size of town – a bit bigger than Richmond, VT, slightly smaller than Randolph and Hinesburg.
   2. April 2015 – 23 cases, by end of summer 181. As of February 1, a total of 188 newly diagnosed HIV positive individuals since April.
   3. Targeted effort to test, then second focused effort to retest, and test new people as well. Brought three additional positives.
   4. Community demographics of affected: Network of around 500 individuals who inject drugs, with sharing. Over 90% co-infected with Hepatitis C. Almost entirely white, age range from 18 – 70s, not quite 50/50 gender split – slightly more men. County with lowest ranking health indicators (Scott County).
   5. Drug pinpointed – Opana, oxymorphone, an oral opiod that is very potent and can be crushed/prepared as an injection.
   6. Indiana Public Health Resources: Clear to Sally Vermont had much more in the way of resources.
      a. IN has different State Health Department/County Health Department organization, under which counties must rely on own resources.
      b. Only one public health nurse for the entire county who was responsible for 100% of public health programs from immunizations to follow up on any infectious diseases.
      c. No HIV testing available at the Health Department. Once approved, nurse tested at the public health department and drove mobile van.
   7. Set up a very effective "one stop shop" in a larger temporary location.
      a. Vital records, testing, exchange, and health department office would provide transportation. Other support services available. Could apply for the HIP2 program – Indiana health plan.

b. Fell under emergency services at the time, but they still have it running on a smaller scale now. When Sally was there it was 7 days with lots of help – it has been very much scaled down.
c. Syringe exchange still paid for by county. Vital records and job counseling mostly funded by state agencies.

8. Field work – very long days, sometimes with names/phone numbers, sometimes just physical descriptions.
    a. OraQuick for HIV, venipuncture for Hepatitis and syphilis. Prior to this free testing, Planned Parenthood had been the only tester and had been shut down – no free testing available since then.
    b. Go out in pairs and try to find people, meet them where they were, test in the field. Went to high risk venues such as local motel, areas for potential contact with sex workers. (10 commercial sex workers tested positive so far.) Offered anonymous and confidential testing.
    c. Testing efforts at truck stops/rest areas. It's an area with a lot of trailer traffic. The Trucking Association supported efforts, supported a big awareness campaign to post in rest areas.
    d. Offered testing at jail.
        i. Revolving door problem with people arrested for drug use, released, arrested.
        ii. Once enrolled in the exchange program, people would get a card, and if stopped with paraphernalia *with a card*, much smaller chance of going to jail.
    e. Sometimes would set up testing in an area and people would come in; sometimes drove around and stopped when there were groups of people. If could get a rapport going with one person could often engage a larger group.
    f. People were not surprised to see them. Number of people very anxious to have a test done. Some resisted but not many. Most open to at least having the conversation. People more willing to get tested as word made it out that there were services available if testing positive. People didn't realize they could get treatment. Thought they were just going to die. People weren't aware that you could have HIV and stay healthy.
    g. People were expecting to be positive. Lot of intergenerational sharing of syringes – family networks.
9. When Sally last checked, 40% of the new cases were virally suppressed, the one stop shop was still in place (scaled down), the syringe exchanges were in place for one year (self-funded by the counties), and the state lifted the ban on starting up new medication-assisted treatment. A nurse position has been established at the jail.
10. Incentives? Very limited and a lot of it came out of people's pockets and the community. Store front churches would put on a meal and everyone could come eat and get information. Didn't care who you were. Had some grocery cards for a while. It was summer: had bottled water (there were people with their water turned off), took personal care products, popsicles.
11. State was sending blood samples to CDC for serotyping – did ID one HIV strain that was identified as newly introduced to that area. People were highly infectious – had very high viral loads.
12. Best part of experience was seeing the community pitching in and people coming together. People going out on a limb to offer support.

C. Vermont – risks, successes.
    1. Grace: VT has been doing the gold standard, but now laying off people, resources low, and VT has a waiting list. Put people on one year waiting list for treatment, need to be giving them clean syringes, naloxone, etc.! Safe Recovery is now very vulnerable – we've been doing well because the services have been in place; with services dropping risk goes up.

2. Laura: Not as much of a wait in her area and some take Vermont Medicaid, so helping people apply for services. Very concerned about OD prevention. People have been ODing and dying. Education getting out that you can't share ANYTHING, not just the syringes.
3. Peter spoke of need to expand services around the state. CARES has been working on sites in Barre, Middlebury, St. Albans, and Grand Isle in addition to St. Johnsbury and Rutland.

II. Hepatitis C – Roy Belcher

A. Roy's role at VDH: Federally funded Hepatitis C surveillance position, syringe exchange grant monitoring, community education, disease intervention specialist (mostly with HCV but also gonorrhea, syphilis, etc.). Very little in way of resources so a lot of leveraging other connections.

B. Risk of health care associated infections. Nursing homes, small long-term care – one way nationally HCV is spread is through reuse of glucose monitors. CONTACT ROY if you encounter places that might warrant a universal precautions workshop.

C. Major change coming in 2016 – consolidated appropriations language around syringe exchange. Potential to use federal money for syringe exchange associated costs like employees. Have not seen this play out anywhere yet. "It is a minor change that has potential to be a wonderful thing or may not be a significant thing after all." Have put together a literature review on efficacy of syringe exchanges but not easy to convince.

D. Roy distributed materials.
1. Distributed surveillance numbers. Last ten years or so – 7,721 cases. We don't have a lot of acute cases that we know of.
2. Case definitions have been revised by CDC. Contact Roy if interested in details.
3. Roy distributed "treatment advances and access" sheets. Currently six medications available and most have a cure rate of 90% or better. Access concerns – high cost of HCV meds. This is the big fight to pursue in HCV right now. Amazing treatments now available that are cost prohibitive for most people. Roy working on the landscape of insurance in Vermont – who will cover what at what rate. Pharmaceutical companies have assistance programs but has heard varying reports of success with that. Hopefully soon Gilead will need to change their price structure to remain competitive, as a new maker with a new medication has come on the scene.
4. Reviewed gross Medicaid spending on HCV in VT – $7.5 million. VT Medicaid is trying, but they are struggling, and this is one of the reasons for that. Demonstrates that people are getting treated... it is just so expensive.

E. Roy reviewed criteria on treatment restrictions and adherence criteria. Adherence now looks very different given a 12 week regimen compared to a year-long regimen on previous meds. Most of the restrictions overlap as the private insurers are taking their cues from Medicaid.

F. <u>Roy asked group to please consider following questions</u>: **Should VT have an HCV Task Force?** .
1. Do CAG members think that HCV in Vermont warrants such a stand-alone group?
2. Does it make sense to combine it and make it part of the HIV CAG?
3. If it is worth splitting off, what would a schedule look like? Bimonthly? Quarterly?
4. DISCUSSION:
    a. Many states have Community Advisory Groups dedicated to HCV.

b. Would Roy like/could Roy use a CAG for HCV? Yes, but really wants to see it discussed carefully. Does not have to be in person meetings, could be Google Hangout meetings.
c. Large number of people affected by this. Would make sense to have this kind of community advisory presence.
d. Jonathan moved that an HCV Advisory Group be formed for the purpose of advancing HCV eradication in VT. Discussion that would like to hold on making a motion yet, for further future discussion.
e. Discussion on combination vs separate. Makes sense to have HCV as part of the entity that works with HIV, given the coinfection and similarities. Support from the HIV community important to HCV efforts. However, would like to see additional reps from the HCV world that are not necessarily part of the HIV world.
f. Roy suggested he do a Survey Monkey soliciting thoughts. Show of hands for support demonstrated that the majority present thought this was a good way to proceed.

III. **NEW MEMBER:** Jo Schneiderman is stepping down as Executive Director of Twin States Network, and **Donna Pratt, founder of Twin States in 1991,** will now be the Executive Director and their representative to the CAG.

IV. **Needs Assessment – Syringe Exchange portion:** Alex presented on Needs Assessment Syringe Exchange portion.

V. **National HIV/AIDS Conference Attendees**

A. Mike Bensel – Great! First time attending.

1. Felt a lot of energy, really felt like a movement.
2. First seemed that everything was about getting everybody on board with PrEP, and resistance from providers. Got through to better conversations about bringing PrEP into communities.
3. There is a lot of assistance available but so much navigation necessary for people trying to access – connecting with insurances, getting enrolled health care. Need for navigators to assist people.
4. CDC still strongly supports Mpowerment. The Mpowerment people got together and had affinity sessions that were very helpful. National Mpowerment is working hard to adapt the program to include PrEP and TasP as part of program.
5. New apps and technology: Reminder apps for meds, labs. New CDC campaign "Start Talking. Stop HIV." Good website with videos, tools, etc. CDC.gov launched new risk reduction tool. www.cdc.gov/hivrisk Enter in customizable information and you can ID your own risk level, then look at "what can I add, do different, etc." to adjust that risk level. Mike has used it on a tablet at one of his Mgroups and in a testing session so far.
6. Dating/hook up app (Scruff, grindr, etc.) developers were there and were all in the room with the prevention folks, talking about shifting the way we talk about HIV. Scruff just changed to add "what's your form of HIV prevention" on profiles. Working together to create opportunities for people to have conversations about HIV.
7. Mike has worked hard to get Scruff to target a specific Vermont market and they have one now! Burlington, Brattleboro, Montpelier and Rutland. Yay Mike!! They allow 501c3's to do free advertising.
8. Chuck asked what providers are objecting to, what their arguments against PrEP are. Mike said he heard a lot of the standard arguments:
    a. "We're encouraging people to not use condoms"
    b. "STI rates will go through the roof"
    c. "It's a license for unprotected sex"

d. "Condoms will be gone"

B. Karen reported – Sue Conley (CLEAR provider) attended.
   1. Got a lot of the same information/impressions about PrEP as Mike did.
   2. Her big take away was how VDH does an exceptional job as compared to other state health departments – she sees that every time she goes to a national conference.
   3. Connected with the people from her CLEAR training cohort, but disappointing – most are not doing CLEAR anymore. Incentives have not brought in participants. They were offering only $25 overall and it hasn't been working.
   4. Sue expressed seeing the common challenge that the linkage to care is just not there in the incarceration/criminal justice system.

C. Daniel
   1. Very different experience than two years ago. Then it was "to PrEP or not to PrEP" and this time it felt much more like everyone was promoting PrEP strongly. However, only one third of general practitioners know about PrEP. Information on PrEP --
   2. Good information on community action planning framework, care prevention planning documents.
   3. The national epidemiological picture continues to be interesting. MSM represent 63% of new infections nationwide. Over time, MSM is continuing to rise, and IDU has experienced a staggering drop.
   4. Vermont had the lowest death rate per 100,000, at 7.9. VT quality markers for care are excelling, and leading the nation. Looking surveillance numbers, 96% or greater HIV positive individuals in Vermont are virally suppressed, and under 30 individuals with a detectable viral load.
   5. Under the domain of provider practice, options and needs, the option of having "start-up packs" in major clinics was discussed – go in for that first appointment, and the medication could be right on site for when someone comes back to get their lab results.
   6. In Vermont, Daniel thinking about "start-up packs" for PrEP. Planned Parenthood is providing PrEP for individuals at risk for HIV, and the Medical Director has already reached out and asked about starter PrEP packs. Daniel is looking at the logistics on financing and working hard on this.
   7. Interesting information was shared about advances in HIV and life expectancy. It was stated at the conference that if one contracted HIV at 20, and did not go on treatment, they could expect to live until age 50. If that person went on treatment, they could expect to live to 71. Remaining HIV negative, life expectancy is 79. Getting on treatment as soon as diagnosed can mean having a usual life expectancy.
   8. Daniel also keyed in on the need for navigators, as Mike described. Would like to think about if there is a place for this, as we look at the RFP.
   9. Testing: LA presented on pay for performance – whereby a specific amount is awarded to an agency to do a certain amount, with added incentives for organizations, rather than a test-by-test reimbursement model. Big push to make your services be part of the mobile network. Guys using the mobile network apps averaged 6.8 partners in the previous 12 months. More than 68% indicate grindr is preferred app. Market analysis indicates that while sexy eye catching ads are frequently targeted at the MSM market, more traffic is attracted to ads that clearly identify the question the community needs answered. In this case, keys such as "interested in prep?" and "need help finding it?" will likely draw more attention and response.

VI. GETTING TO ZERO Update: Still a priority, not moving forward at this time due to other commitments, etc. Peter will communicate with those interested.

VII. VDH REPORT: Legislative Session Updates

A. Has been a very active legislative year for HIV. Commissioner was trying to make money available for syringe exchange – some until the end of June. There is hope for additional funding following that

B. $75,000 in a budget adjustment for the current year has been identified, however in the house it was reduced to $35,000. Stay tuned on what the final amount will be. Regardless of the final amount the current SEP recipients will meet to discuss how these funds should be distributed among the agencies. This money must be spent by 6/30/2016. Additionally, there is talk that next fiscal year there might be an additional $150,000 for SEP services. This will depend on how the legislative session advances. All of these funds would be in addition to and separate from the current HIV prevention fund of $100,000. These funds would become available as of 7/1/2016.

C. In separate legislative issue, when the $475,000 state general funds that were allocated got replaced by rebate dollars, it was set up to be guided by HRSA. HRSA now has stated their "advice is funds go out via an RFP." In replacing the general funds with the rebates, it was not know that it would tie us to an RFP, but the language necessitates an RFP. The language has been stated and will go out to the community as "$475,000 to be awarded by RFP." There will be an extension granted to people to go to the first of the year – one extension of six months that will get people to January 1, 2017. As of January 1, that money will be guided by RFP. The goal would be an RFP out by July, a 90 day submission period, and announcement in October. The extension would cover people until the new funding begins 2017.

1. Chuck expressed concerns about the language changes.
2. Peter noted that the circumstances changed as the meetings with the commissioner were set up. By the time of the meeting, the syringe exchange was the pressing issue, and there was little discussion about an RFP in the meeting. The following week, received an email that the RFP would be happening much sooner than expected.
3. The language that "the CAG advises on how the funds are distributed" is still in the language, along with "we are committed to working with the community on the creation of the RFP."
4. Chuck expressed that he would like to create a motion around this issue, to the effect of not supporting the current language, asking the VDH to keep the formula that is now in place until fiscal year 2018 and that CAG take 2016 to establish criteria. The final motion made: "The CAG opposes the language VDH has introduced and proposes that the CAG work in the coming year to develop the RFP that will be implemented in FY 2018."
    a. Concerns expressed by CAG members: Is there a consequence to being out of line with HRSA's statement?
    b. That is unknown at this time. VT has a HRSA site visit in August. They could say we are not in compliance
    c. Daniel asked if there was a second to the motion, and Pat seconded.
    d. Grace said she would like to know the consequences of not complying with HRSA before anything else.
    e. Daniel stated that it is known that there were practices in NH that cause them to be placed on "draw down." It is not known what exactly caused this. We would not be meeting the guidance that is offered, but it is unclear if that would be deemed "noncompliant."
    f. Pat clarified what happened in NH. The provider of any service paid for by HRSA must have a contract with the state. If no contract, you cannot provide that service any longer.
    g. Jonathan expressed that he does not fear an RFP process, and that he had never been in a state that DIDN'T have one.

h. Chuck expressed his concern was that the previous process had been put in place for a reason, and moving to a competitive process without knowing what the RFP will say is concerning.
i. Donna expressed she was in favor of an RFP as well, and was surprised that there currently isn't one.
j. A vote was called on the motion. One in favor, three abstentions, and nine opposed. Motion defeated.

5. Jonathan suggested a counter motion, that he understood the concerns, and would table the discussion for future months. He could not see a reason to vote against an RFP but would like to talk more about it.
6. Peter stated that as co-chair he mandates that CAG will have equal discussion on the RFP at the next two CAG meetings. No motions required.

VIII. CAG BUSINESS

A. Minutes: November minutes reviewed. No discussion. Karen moved, Daniel seconded. Approved unanimously.

B. Public comments: none.

C. Announcements:
1. The play Mothers and Sons will be at Flynn for three weeks, and is an exploration of a mother losing her son to HIV. It is part of a community effort to address stigma, and there will be a panel of speakers every Thursday. Chuck and Peter will participate February 11.
2. Thanks were extended to Chuck for having served as co-chair, and having done such a great job at it.
3. Peter announced that he had reached out to the other ASOs on the possibility of a collaborative grant but the initial letter of intent was denied.
4. Chuck noted next Tuesday is AIDS Awareness Day in the State House.
5. Tom announced he is putting together an advisory group for his grant – around sexual education in schools, with a special emphasis on HIV. He will send out a brief form. The group is expected to meet twice per year in person, and have one or two consultations.

Meeting adjourned.

Respectfully submitted,
Alexander B. Potter